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LEARNING FROM THE STATES: INDIVIDUAL STATE EXPERIENCES WITH THE HEALTHCARE REFORM COVERAGE INITIATIVES IN THE CONTEXT OF NATIONAL REFORM (ROUNDTABLE DISCUSSION)

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

ON

EXAMINING INDIVIDUAL STATE EXPERIENCES WITH HEALTH CARE REFORM COVERAGE INITIATIVES IN THE CONTEXT OF NATIONAL REFORM

APRIL 28, 2009

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LEARNING FROM THE STATES: INDIVIDUAL STATE EXPERIENCES WITH THE HEALTH-CARE REFORM COVERAGE INITIATIVES IN THE CONTEXT OF NATIONAL REFORM (ROUNDTABLE DISCUSSION)

TUESDAY, APRIL 28, 2009

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 2:31 p.m., in Room SD–430, Dirksen Senate Office Building, Hon. Edward Kennedy, Chairman of the Committee, presiding.

Present: Senators Kennedy, Mikulski, Bingaman, Murray, Sanders, Hagan, Merkley, Enzi, Alexander, Burr, Isakson, Hatch, and Coburn.

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. We will come to order.

Senator Enzi was telling us about the good old days, when this committee was really called to order, and had great success in bringing together different colleagues to consider the work of this committee.

It's good to see all of you today and I appreciate it very much.

I think most of you have a pretty good idea about where we are—I think our committee, over a period of time, has been looking at a variety of different issues. The Medicare, Medicaid, and CHIP programs—those have all been issues that we have been focused on, over the past several years.

We still have very important work to do and we are very, very hopeful that our committee will be able to deal effectively in these areas, as we have in some of the others.

We have an extraordinary group of individuals whom we have called on to be of help and assistance to this committee. Rarely have we had a group of individuals who have worked as conscientiously and thoroughly on the issues which we're facing before the committee. We are enormously grateful to all of those who have been a key part of all of our efforts.

We are especially thankful for Jon Kingsdale and Eileen McAnneny who are joining us today from Massachusetts. We will have a chance to introduce all of those who are here, and we will start with our members, and start with Senator Enzi.

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We are very thankful that Senator Enzi has been willing to take on so much of the responsibility of this committee for these past weeks, and he has just done an extraordinary job, and we're all very, very appreciative and grateful to him.

I will ask him to start, and then we'll go along with the other members of the committee.

[The prepared statement of Senator Kennedy follows:]

PREPARED STATEMENT OF SENATOR KENNEDY

Today, America stands at an historic crossroad for our health care system. Unlike earlier attempts at health reform dating back to President Harry S. Truman, there is no realistic alternative. Either we join together and put our Nation on the right track to affordable, accessible health care for all, or our system will collapse from its own weight and contradictions.

A few key facts demonstrate the magnitude of this problem. More than one in six Americans—nearly 50 million individuals—are uninsured.

- 25 million more are underinsured.
- Nearly 80 percent of the uninsured are from working families.
- 40 percent belong to the middle class.
- The uninsured lack insurance because they can't afford it.

Our Nation spent about $2.4 trillion on health care in 2008—more than twice as much as in 1997 and half as much as projected for 2017.

Employer-sponsored health insurance premiums have grown four times faster than wage increases over the last 8 years.

These increases have affected businesses profoundly. GM spends more money on health care than on steel. Starbucks spends more on health insurance premiums than on coffee.

The impact is particularly harsh on small businesses. In 2007 only 45 percent of firms with 3–9 employees offered health benefits (compared to 99 percent of firms with 200 or more employees).

What harms businesses also harms families. Non-elderly Americans spend more than 10 percent of their income on health insurance premiums, and the percentage rises every year. For those without access to employer-sponsored insurance and who have preexisting health problems, insurance is often unavailable at any price. Elderly couples must have average savings of $300,000 to pay for their lifetime health expenses not covered by Medicare.

Job losses resulting from the current economic crisis are making this problem even worse. For every 1 percent increase in the unemployment rate, another 1.2 million persons lose their health insurance. For every 100 people losing their jobs, the ranks of the uninsured grow by 85. Lack of health insurance results in postponement of needed care, worsening of illness, increased absence from work and decreased productivity, and higher costs when these people are treated for acute illnesses, through expensive emergency care, with poor follow-up.

These problems will worsen as health costs accelerate beyond the growth of the overall economy. Without reform, Medicare spending will consume 25 percent of Federal income tax revenues by 2025,

and 40 percent by 2035, according to the Trustees of the Medicare Trust Fund.

Medicaid, funded by Federal and State budgets, will face equally large financial challenges. Employers will be unable to absorb the growth in insurance premiums, and the ranks of the uninsured will continue to swell.

Congress must deliver strong medicine to America's health care system to break this cycle. As we have learned from successful State experiments, the foundation for an affordable and accessible health care system rests on a three-legged stool: The first is system-wide reform of health insurance markets, especially the individual and small employer markets. The second leg is shared responsibility by individuals, their employers and government, with each having an essential role to achieve full participation. Finally, we need realistic support and subsidies for those who cannot afford to purchase health insurance on their own.

Today, we will hear from experts from four States which have pioneered different approaches to expanding coverage for reforming their delivery systems: Utah, Vermont, California, and Massachusetts. We will hear about their successes and failures, the obstacles they have yet to overcome, and most importantly, the lessons from their experience for national health reform.

I take particular pride in the achievements of the Massachusetts health reform, which has increased coverage from 90 percent of all residents to about 97.5 percent in less than 3 years, and provides valuable lessons based on its successes and shortcomings. No other State has achieved this level of success, and it has faced up to problems in primary care, quality of care, and other aspects of this issue with courage and tenacity.

I appreciate the remarkable progress made by each of these States and I look forward to learning more today about the lessons they can teach us in preparation for effective national health reform.

OPENING STATEMENT OF SENATOR ENZI

Senator ENZI. Thank you, Mr. Chairman. I want to thank you for the way you've distributed the workload on your side, while it's been necessary for you to be gone. You've had some outstanding people who have been willing to work, and as a result we've gotten results.

Since everybody's kind of concentrating on healthcare a little bit today, because of what's happened in Mexico and is now spreading to the United States, I do want to mention that Senator Burr spent about a year and a half of his life working on a bioterrorism bill, and everybody on this committee got to work on it, and because of the efforts of this committee, they're in place already, 50 million doses of Patamaflu vaccine, which will take care of what we have so far. And puts in place a way to develop the vaccine through the fall, for the fall epidemic that could hit, that will make a huge difference to people, possibly, all over the world.

But just as importantly, it put in place some of the tools for quickly identifying the kinds of things that are happening right now, and it's not very often that a committee or a person can take

a look into the future, and find something that actually becomes necessary and lifesaving in the future.

I congratulate the committee, Senator Burr, and Senator Kennedy for the particular work that they did on it.

I do want to thank you for holding this roundtable today on State-based healthcare reform initiatives. The States are always kind of, mini labs for what can happen, and they find a lot of the successes, and they find a lot of the problems for us, so that we don't have to experience them on a national level.

I do believe it's crucial for us, as we consider national reforms, to hear from people across the country, about what they've learned while enacting healthcare reforms.

I always say, "If you want to know how things are really going on the ground, you just talk to the folks that have actually done something." That's what we're going to do today.

This isn't a normal situation where the Chairman invites four people, and I invite one, and then both sides show up to beat up on everybody. This is where we actually want to know what you did, how you did it, what the effect was, and then a chance for some interaction among the people on the panel about how one person's idea might work pretty well with another person's idea—and that's very helpful for us, as we begin drafting a bill.

National healthcare reform will impact the lives of millions of Americans in every State. In fact, probably before we're done, it will affect every single American. It's important for us to remember that our States are sometimes very different, and that is what makes America great. We're a diverse country with differences of opinion, and unique ways of solving problems.

Represented here today are States that span both the political spectrum, and the geographic width of our Nation. They've all taken on the laudable goal of improving the health of our citizens, but have done so in different ways. I feel strongly that we need to keep this in mind as we continue to pursue national reforms.

Throughout my discussions on healthcare reform, I've insisted that we cannot just focus on expanded coverage. We also have to focus on improving quality, and getting more value out of our healthcare system. Our current pace of spending is not sustainable, and we must get healthcare costs under control.

I believe we can do that, and I'm interested in hearing ideas from those on the panel and have experience in working to bring down costs.

Another topic of discussion I'm interested in is insurance market reforms. I understand in Massachusetts reforms like guarantee issue and modified community rating were imposed several years prior to the development of the connector, and the implementation of the individual mandate. I do worry that forcing States to dramatically change their insurance market rules too quickly could result in some very serious unintended consequences.

I also note that in Massachusetts, there is no public plan option. While it is crucial that we get the policy of insurance market reform right and increase the value of healthcare dollars, I would be remiss if I didn't at least mention the perils of process. Without the right process, we can't move forward on the best healthcare reforms for the American people.

The first real test of whether the new Administration and Senate leaders are serious about developing bipartisan solutions was how the Budget Conference Report addressed healthcare reform. The majority failed that test. Reconciliation would cut off most avenues for real debate in the Senate, and is intended primarily as a tool to reduce the deficit. If those in the majority do use the budget reconciliation to jam the healthcare reform through the Senate, they'll be sending a clear signal that they're not interested in truly bipartisan effort, and I hope that's not true.

With that, I will look to our witnesses to make recommendations for how we should shape the policies of healthcare reform.

Mr. Chairman, I thank you for holding this roundtable today.

The CHAIRMAN. Thank you very much. I'll let that comment that you aimed at the Democrats go by.

[Laughter.]

Senator ENZI. We'll talk later.

The CHAIRMAN. This is pretty early in the game—but we want to have Senator Bingaman, and Senator Hatch, if you would make a comment, and then we'll call on Senator Bingaman to make an additional comment.

STATEMENT OF SENATOR BINGAMAN

Senator BINGAMAN. Mr. Chairman, let me thank you for having the hearing. This is, I think, the third of these hearings we've had on the whole subject of coverage, and how to expand coverage, and I do think it's very useful to have people here from these four States that are represented, and your own State of Massachusetts has probably done more than any State to take on this difficult job of reforming healthcare and expanding coverage.

I know we have a couple of witnesses here from Senator Sanders' State of Vermont, and that's very welcome, as well. We have two witnesses from Utah, Senator Hatch's State, and a representative from California. We're glad to have all of these witnesses.

I do think there's a lot we can learn at the Federal level from the experiences we've observed with individual States, and I think they can start us down the path toward a solution at the national level, as well.

Again, I thank you for having the hearing, and I look forward to hearing from each of these witnesses.

[The prepared statement of Senator Bingaman follows:]

PREPARED STATEMENT OF SENATOR BINGAMAN

Welcome, I am pleased to participate in today's hearing with Senators Kennedy, Enzi and the other members of the committee. States face many health care challenges including: the rising number of uninsured, the rising cost of health care, and a fragmented medical and insurance system. In the end almost 50 million Americans are left without any access to health insurance and many millions more have inadequate coverage.

Today we will hear about reform experiences in Massachusetts, California, Vermont, and Utah. These States have taken bold steps in attempting to address the complex healthcare problems they face.

Perhaps one of the most successful models of reform has been Massachusetts. Although their uninsurance rate was low before reform—around 13 percent—they have cut this unisurance rate by 75 percent. Now more than 97 percent of the population has coverage. In addition, the State has nearly cut in half the cost of premiums in the individual market and remarkably, the cost premiums of policies sold through the Connector is even expected to decline this year—at a time when medical inflation continues to outpace other sectors of the economy. It's not surprising that the reform enjoys a 75 percent public approval rating in Massachusetts.

I want to thank the panelists for their participation today. I look forward to hearing about the efforts in their States.

It is my hope that this hearing will serve to inform and encourage the Senate's important work to achieve national health reform.

The CHAIRMAN. Thank you very much. We'll now hear from Senator Hatch.

STATEMENT OF SENATOR HATCH

Senator HATCH. Thank you Mr. Chairman. I appreciate you, and appreciate your leadership on this committee and your leadership in healthcare, in particular.

I welcome all of you to the committee, we're very grateful to you, to come and spend time with us, and help us to understand these problems better.

We would especially like to recognize speaker David Clark from my home State and Dr. Brent James, who has a world reputation in healthcare—both from my great State of Utah—for lending their time and their expertise to this important conversation.

Just like me, I'm sure that every member will find their insights extremely helpful, as we move toward reform in our Nation's healthcare system. Before talking about policy, let me take a couple of minutes to talk about process.

Healthcare reform is an important national priority that is too big for political gamesmanship. We're talking about an issue that makes up one-sixth of our total economy. I'm very disappointed that the upcoming Budget Conference Report will include partisan reconciliation instructions for healthcare reform.

Any successful healthcare reform proposal must be subject to the full scrutiny of both parties of the Senate and House of Representatives, and the American people. Using the budget reconciliation process in the Senate, for example, would limit debate to only 20 hours, and restrict the ability of Senators to amend and perfect a proposal that is intended to steer one-sixth of our economy in a new direction.

Now, this would make it difficult—if not impossible—to gain broad, bipartisan support for the effort, and I think it would be a tremendous disservice to the American people, and our Nation. The notion of a 50-vote healthcare reform legislation that is jammed through after being debated only 20 hours, with a limited amendment process, should scare every person in this room.

Now, having said that, let me now focus on the incredibly important policy being discussed in the room today. As we move forward on comprehensive reform, it is important to recognize that all States are not created equal. Every State has its own unique mix

of challenges, based on everything from an insurance market, to demographics, and regulations. I'm sure that both Speaker Clark, and Jon Kingsdale will agree with me when I say that Utah is not Massachusetts, and Massachusetts is not Utah. Although, Senator Kennedy has been trying all of these years to make Utah like Massachusetts.

[Laughter.]

What works in one State will not necessarily——

The CHAIRMAN. The issue is cut.

[Laughter.]

Senator HATCH. Yes, this is cut, yes. I'm just beginning.

[Laughter.]

There's an enormous reservoir of expertise, experience and field-tested reform at the State level, which is represented well on this panel. I personally believe in 50-State laboratories that help us to arrive at final conclusions on things as important as this.

We should take advantage of that, of you folks here, by placing States at the center of efforts to meet coverage and affordability goals.

There will be, naturally, an important role for the Federal Government in the partnership, but it will have to give the States flexibility and assistance to meet coverage and affordability objectives. We should not make the mistake of assuming that the Federal Government is the solution to all problems. I think the focus should be on families, not Washington.

Having said that, let me just say that I, unfortunately, have to leave at the conclusion of my remarks to attend a very important briefing in the Senate Intelligence Committee in the Secure Room. I just want to thank you, Mr. Chairman, for this courtesy. I want to thank all of you for the great testimony I know you will give, and the help that you will give to every member of this committee, and I hope we all pay strict attention to what you have to say.

I'm grateful to you, welcome to you, and of course, we'll learn from you and I'll pay attention to what you have to say, regardless.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much. We are very lucky to have Jeff Bingaman and we'd ask him if he'd be good enough to moderate this for us today.

Jeff.

Senator Bingaman [presiding]. Good, I'm glad to do that, let me just briefly re-introduce our witnesses and then we'll just start over at the left, and have each of you tell us what you think we need to know about this subject.

Jon Kingsdale is the Executive Director of the Commonwealth Health Insurance Connector in Boston. Thank you very much for being here, you're right at the center of the reform efforts there in Massachusetts, and we're anxious to hear your views on those.

Ms. McAnneny is the Senior Vice President with Associated Industries of Massachusetts, also in Boston. Thank you for being here.

Ms. Liu is the Senior Director of Health Policy and Health Reform with Kaiser Permanente in California, thank you for being here.

Let's see, in Vermont we have Susan Besio, who is the Director of the Office of Vermont Health Access with the Human Services Agency in Vermont, in Burlington.

Harry Chen is an M.D., and emergency room physician and Board of Vermont Program for Quality in Healthcare, also in Burlington. Thank you for being here.

Then, as Senator Hatch indicated, we have the majority leader of the Utah House of Representatives here, the Honorable David Clark. Thank you for being here, we appreciate it very much.

And Brent James is the Executive Director with the IHC Institute for Healthcare Delivery Research with Intermountain Healthcare, Inc., in Salt Lake City.

Thank you all for being here, why don't we start with you, Mr. Kingsdale, if you'd advise us as to the things you think we need to know about the experiences you've had in Massachusetts.

STATEMENT OF JON KINGSDALE, Ph.D., EXECUTIVE DIRECTOR, COMMONWEALTH HEALTH INSURANCE CONNECTOR, BOSTON, MA

Mr. KINGSDALE. Good afternoon, and thank you so much. With my 60 seconds, I won't re-introduce myself, but just jump right into it.

Perhaps the most important lesson from Massachusetts is that it can be done, with Senator Kennedy's help. With all but 2.6 percent of our residents insured, we enjoy near-universal coverage. We're learning, of course, as we go, but I would offer five lessons for your consideration.

First, the individual mandate has proven essential to covering the uninsured as the keystone of our theme of shared responsibility among many parties.

Second, that implementing health reform is a campaign built on the theme of shared responsibility and supported by coalitions of progressive advocacy groups, health insurers, employers—such as Eileen McAnneny represents.

Third, that there are, of course, many twists and turns to implementing complex reform, which really could not be anticipated in statute. Rather, the legislature, wisely delegated some key decisions to a representative Board of the Connector, which conducts its activities in public, with great transparency, and has kind of a learning organization. I think Senator Daschle made a similar point in his cogently argued book about the importance of delegation.

Fourth, that exchanges can be a valuable component of a broader set of reforms and I've supplied committee staff with some thoughts on their design. Here, I would stress the need for independence, if a public agency is to create and regulate a market.

Then, finally, I would point out that Massachusetts has succeeded in covering most of our people by starting with coverage expansion. We are now moving to address costs, and I would urge you to consider Massachusetts' example in not holding the uninsured hostage to cost control, but I would hope that you would devise a political strategy for progressing from the very difficult challenge of covering expanding coverage, to the nearly impossible challenge

of controlling costs. Thank you, and I look forward to your questions.

[The prepared statement of Dr. Kingsdale follows:]

PREPARED STATEMENT OF JON KINGSDALE, PH.D.

Thank you for this opportunity to share my State's experience with health reform, in the context of your effort to expand financial access to medical care for the Nation. My name is Jon Kingsdale and I am the Executive Director of the Commonwealth's Health Connector. This is an independent State authority, established under the landmark health reform law, Massachusetts' Chapter 58 of the Acts of 2006, as one of several State agencies charged with expanding health insurance coverage. The Health Connector operates two new coverage programs, makes policy and regulatory decisions, and orchestrates public outreach and education efforts.

Perhaps the most important lesson from Massachusetts' effort to achieve near-universal health insurance is to demonstrate that it can be done, here in the United States. Two years after Chapter 58 took effect, the State's uninsurance rate had fallen to just 2.6 percent, by far the lowest in the country and about one-fourth of what it had been prior to reform.[1] This is not quite universal coverage, but it is only 1 percent or so above the uninsurance rates of some European countries commonly considered to have "universal" coverage. In the course of implementing Chapter 58, we have learned many lessons and we continue to evaluate and re-think our reforms. We do not have any "silver bullets" to offer, but I would suggest five lessons from the Connector's experience that might help inform national efforts.

First, the individual mandate has proven essential to covering large portions of the uninsured. As evidence, I would cite the contrast with Hawaii, which enacted a mandate on employers and employees only. Yet, the rate of uninsurance there still fluctuates around 8 percent.[2]

Not only does the individual mandate work to enroll those who might otherwise choose to remain uninsured—whether subsidized or not—it also works indirectly to lower the cost of insurance. The uninsured are disproportionately young, single male, and poor[3]: some considerable numbers of them are quite healthy and prefer to take the chance of not being covered. As a result, these so-called "invincibles" do not contribute through insurance risk pools to subsidize those in poor health; moreover, when trauma or serious illness do strike the uninsured, they actually add to providers' bad debt and charity care, which is ultimately born by premium-payers and taxpayers. Massachusetts has found ways to cover many of the young "invincibles" at rates they can afford, and with coverage that helps lower premiums for others. Non-group enrollment in Massachusetts more than doubled in the year after the individual mandate took effect and, judging from the Connector's enrollment, some 55 percent of new, non-group enrollees were aged 17–35 and some 85 percent purchased single coverage.[4]

The individual mandate is controversial. It polls less favorably than reform generally or than a mandate for children alone.[5] But it is the keystone of our reform. So, Massachusetts has taken special care to implement the requirement that adults have insurance, if affordable, in such a way as to build support for it over time. Importantly, it is enabled by complimentary initiatives, which exemplify our law's theme of "Shared Responsibility:" (a) the commitment of employers with over 10 employees to make a "fair and reasonable" contribution toward group health insurance;

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[1] Long, S., Cook, A., & Stockley, K. (2009, March). *Health Insurance Coverage in Massachusetts: Estimates from the 2008 Massachusetts Health Insurance Survey*. Boston, MA: Division of Health Care Finance and Policy. Available online at, *http://www.mass.gov/Eeohhs2/docs/dhcfp/r/survey/08his_access.doc*.

[2] DeNavas-Walt, C., Proctor, B., & Smith, J. (2008, August). U.S. Census Bureau, Current Population Reports, P60–235, *Income, Poverty, and Health Insurance Coverage in the United States: 2007*. U.S. Government Printing Office: Washington, DC.

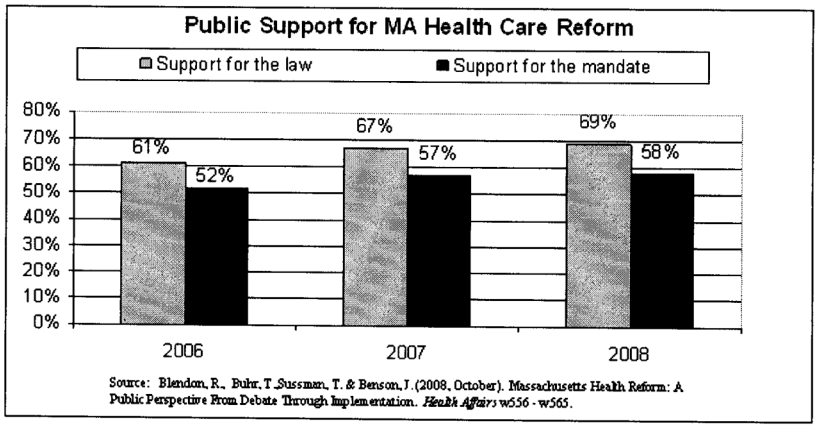
[3] Long, S., Cook, A., & Stockley, K. (2009, March). *Health Insurance Coverage and Access to Care in Massachusetts: Detailed Tabulations Based on the 2008 Massachusetts Health Insurance Survey*. Boston, MA: Division of Health Care Finance and Policy. Available online at, *http://www.mass.gov/Eeohhs2/docs/dhcfp/r/survey/08his_detailed_tabulations.pdf*; and Massachusetts Department of Revenue (2008). *Massachusetts Department of Revenue, Data on the Individual Mandate and Uninsured Tax Filers*, Tax Year 2007. Boston, MA: Author. Available online at, *http://www.mass.gov/Ador/docs/dor/News/PressReleases/2008/2007_Demographic_Data_Report_FINAL_(2).pdf*.

[4] Commonwealth Health Insurance Connector Authority, Commonwealth Choice Enrollment Data.

[5] Sussman, T., Blendon, R.J., & Campbell, A.L. (2009, April 21). Will Americans Support the Individual Mandate? *Health Affairs* Web Exclusive w501–w509.

(b) the commitment by government to subsidize insurance for low-income people without other access to coverage; and (c) the requirement that the larger health plans participate in the Connector and the non-group market, under regulations that guarantee issue and renewal of insurance policies using adjusted community rating.

The individual mandate is part of a broader commitment from various parties, including business and health insurers, to "Shared Responsibility." The second point I would make is that implementing health reform in Massachusetts is a campaign, built around this theme of "Shared Responsibility." Because individual responsibility is a critical element, which generates bi-partisan support and resistance, its acceptance cannot be taken for granted, but must be earned. Having done so, tax compliance is very high—98.6 percent in the first year—and the popularity of reform overall and even of the mandate have risen steadily.



As part of this campaign, Massachusetts phased in penalties for the mandate only after expanding new sources of coverage, and the Connector allows case-by-case exceptions to the individual mandate through a generous appeals process. We evaluate the results of our experiment, both to celebrate its victories and to identify and correct the problems. The State's legislature follow reform's progress closely, even enacting follow-up reforms in 2008 (Chapter 305), and Governor Patrick has been steadfast in his support of Chapter 58 throughout this very challenging economic climate. The coalitions of interest groups that helped pass Chapter 58, on a bi-partisan basis and with nearly unanimous votes, continue to campaign for its implementation. These coalitions include liberal advocacy groups, employers and insurers. Third, because implementing this "experiment" is so challenging, Chapter 58 created new State entities to guide the reforms. Anything so ambitious as reforming one-sixth of our economy cannot be captured in a single piece of legislation, but involves some degree of trial and error, learning by doing. The Massachusetts legislature built a sturdy statutory framework for reform, but delegated many key policy determinations and provided the resources to oversee coverage expansions. It provided special funding for the first-year administrative activities of a half-dozen existing State agencies, capitalized the newly-established Health Connector, and authorized an ongoing source of administrative revenues for new programs.

Chapter 58 authorizes the Connector's semi-independent and broadly representative Board of Directors to make tough policy calls.[6] The Connector conducts all its activities in public and very transparently, and it prides itself on being a "learning organization." For example, the Board defined "Minimum Creditable Coverage" and

[6] By statute (M.G.L. c. 176Q § 2(b)), the Connector's 10-member Board of Directors is chaired by the Commonwealth's Secretary of Administration & Finance and also includes, *ex officio*, the Director of Medicaid; *ex officio*, the Commissioner of Insurance; *ex officio*, the Executive Director of the Group Insurance Commission; three members appointed by the Governor, one of whom shall be a member in good standing of the American Academy of Actuaries, one of whom shall be a health economist, and one of whom shall represent the interests of small businesses; and three members appointed by the attorney general, one of whom shall be an employee health benefits plan specialist, one of whom shall be a representative of a health consumer organization, and one of whom shall be a representative of organized labor.

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"Affordability" by unanimous votes in 2007, only to significantly revise these determinations in 2008 (also by unanimous votes). The Connector launched its small-group offering in early 2009 as a *pilot*, with a commitment to evaluate and revise it in light of preliminary experience.

By contrast, a statute is not a "learning organization" and Chapter 58 could not have anticipated the many twists and turns of implementing such complex change. Similarly, Senator Daschle has argued for delegating implementation of national health care reform to a new Federal authority with expertise, independence and flexibility.[7]

Fourth, properly constituted, resourced and empowered, an exchange can be a valuable component of a broader set of reforms. The Health Connector actually runs two different insurance exchanges, serving distinct functions and clients. Commonwealth *Choice* is a distribution channel for individuals in the non-group market to buy health insurance with their own money at premiums which are, by law, the same in or outside the Connector. "Commonwealth *Care*" offers a choice of plans, *purchased* by the Connector for uninsured adults earning 300 percent or less of the Federal Poverty Level (FPL)—to which some enrollees make a premium contribution, but those below 100 percent of the FPL do not. Commonwealth *Care* negotiates premiums and drives a hard bargain with its own dollars in a way that Commonwealth *Choice*, as a free-market exchange, simply cannot do.

Each program uses competitive solicitations and offers a choice of plans to enrollees at different price points. Both programs add value, but the two exchanges operate in very different ways, reflecting their different objectives, statutory rules, and target populations. If the Congress authorizes exchange(s) as part of broader reform, there are important decision points about how aggressive the exchange(s) should be in influencing premium rates, which populations an exchange should serve, whether the exchange(s) should try to stimulate change in the surrounding market, how best to promote coverage and inform the public about insurance, and whether there should be one national exchange or many State exchanges. These decisions must be coordinated with each other and the larger reform context. I have elsewhere supplied the committee's staff with some thoughts on these questions.

The Commonwealth's Health Connector does enjoy considerable, though by no means total, independence from politics, and I would urge the committee to consider the advantages of semi-independence for a public agency administering a market or exchange. On the one hand, an exchange's efficacy derives from its capacity, as a public agency operating in the context of larger reform, to exert market forces and prudent purchasing to improve the value of health insurance. On the other hand, its credibility and authority to improve competition and benefit consumers depends on its objectivity and independence from overt political influence. I would draw an (imperfect) analogy to the SEC, the Federal Reserve Board, and other such Federal entities designed to improve the functioning of markets and cite, again, Senator Daschle's argument.[8]

Fifth, as ambitious as Chapter 58 is, comprehensive reform was simply too much for Massachusetts to digest in one gulp. Rather, we are *trying* to sequence reform, starting with near-universal coverage and moving now to address costs. Massachusetts is very proud of having achieved 97.4 percent coverage, compared with a national average below 85 percent. Doing so has *not* exacerbated the underlying problems of run-away health care costs, shrinking supply of primary care clinicians, and fragmented, uncoordinated care which characterize American medicine. Neither has it solved these problems.

Having made the commitment to near-universal coverage, Massachusetts now confronts the challenge of controlling costs. This is the more difficult challenge. On the one hand, in enacting Chapter 58, the Commonwealth did not hold the uninsured hostage to first controlling medical costs. On the other hand, the Commonwealth will not be able to sustain near-universal coverage, if we cannot now control costs. So, we now confront costs from the moral high-ground of protecting near-universal coverage, but without any guarantee of success. The fifth lesson is that the nation must *not* hold the uninsured hostage to cost control, but that the Nation will need a political strategy for progressing from the very difficult challenge of expanding coverage to the even greater challenge of controlling medical costs.

Comprehensive health reform is a marathon, not a sprint. Massachusetts has chosen to start with coverage and pace its reforms, but it also runs the risk of not finishing the race.

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[7] Daschle, T., Lambrew, J. & Greenberger, S. (2008). *Critical: What We Can Do About the Health-Care Crisis*. St. Martin's Press: New York, NY.

[8] Daschle, T., Lambrew, J. & Greenberger, S. (2008).

Senator BINGAMAN. Thank you very much. Ms. McAnneny. I'm mispronouncing your name, it's——?

Ms. MCANNENY. McAnneny.

Senator BINGAMAN. McAnneny.

Ms. MCANNENY. There's an N missing.

Senator BINGAMAN. Yes.

Ms. MCANNENY. Thank you.

Senator BINGAMAN. All right. Please, go right ahead.

STATEMENT OF EILEEN McANNENY, SENIOR VICE PRESIDENT, ASSOCIATED INDUSTRIES OF MASSACHUSETTS, BOSTON, MA

Ms. MCANNENY. I, like Jon Kingsdale, won't waste part of my 60 seconds on an introduction. I would like to thank you for the opportunity, it's truly an honor and a privilege to participate in this, and especially to appear before Chairman Kennedy, who has been an outstanding Senator for the State of Massachusetts, and whose Herculean efforts and influence really made healthcare happen in Massachusetts. Thank you, Senator.

Robert Blendon, who is a professor at Harvard School of Public Health spoke recently, and he had mentioned that there have been 61 prior efforts, to date, between the States and the Nation to attain universal healthcare coverage, and 60 of those efforts have not succeeded—Massachusetts is the exception.

I believe Massachusetts' success—at least in part—can be attributed to the support of the business community, so I think that that is a critical component to any healthcare reform on the national level.

I also agree with Jon Kingsdale that the individual mandate has been a critical component in motivating people to purchase the insurance. Often it has been available to them, and for whatever reason they have not taken it. That has been a great motivating force. I also think our incremental approach has been key, because it has allowed us to deal with the bumps in the road, and it did not up heave our current system, it didn't require an employer mandate, rather, or it didn't repeal the employer-sponsored insurance. Rather, it worked within those confines, and targeted populations that needed insurance, and was successful as a result.

I look forward to the discussion. Thank you.

[The prepared statement of Ms. McAnneny follows:]

PREPARED STATEMENT OF EILEEN MCANNENY

Good afternoon. For the record my name is Eileen McAnneny, Senior Vice President and Associate General Counsel of Associated Industries of Massachusetts (AIM), the State's largest nonprofit, nonpartisan association of Massachusetts employers. AIM's mission is to promote the well-being of its 6,500 members and their 680,000 employees and the prosperity of the Commonwealth of Massachusetts by improving the economic climate, proactively advocating fair and equitable public policy, and providing relevant, reliable information and excellent services.

On behalf of our membership, I am honored to provide the employer perspective on Massachusetts health care reform. AIM has a very diverse membership, representing employers in all sectors of the economy, of all sizes and from all regions of our State. A common denominator for them, however, is that they all offer health insurance to at least a portion of the workforce. This fact certainly shapes AIM's point of view.

1. KEY LESSONS LEARNED

Chapter 50 of the Acts of 2006, the most recent attempt by Massachusetts to adopt and implement major health care reform, has been very successful to date for several reasons. Although Massachusetts health care reform is often touted as a "bold experiment" and "landmark legislation," it was prompted by several far more mundane factors. The need to win Federal approval of the Commonwealth's Section 1115 Medicaid Waiver under which the State's Medicaid program had operated for more than a decade to retain hundreds of millions of dollars in Federal funds certainly served as an impetus. In 2005, the Center for Medicaid and Medicare Services ("CMS") urged Massachusetts to devise a plan to provide health insurance coverage more efficiently to the uninsured. Rather than making payments to the disproportionate share providers, CMS wanted the money to go directly to individuals to pay for health insurance premiums.

In addition, there were two ballot initiatives pending that were problematic to the business community. The first would have made very comprehensive health care a right under the Massachusetts' Constitution. The second established a payroll tax on Massachusetts' employers that would be used to fund an expansion of public health care programs. Because both initiatives required the business community to pay significantly more for health care but did not change the delivery system in any way or give the employer community a say in how the money would be spent, neither ballot question was appealing. This served to motivate employers to engage in the dialogue among major stakeholders about how to cover the uninsured more efficiently in Massachusetts. Lastly, Speaker of the House Salvatore DiMasi, Senate President Robert Travaglini and Governor Mitt Romney all demonstrated unflagging leadership and commitment to ensuring that Massachusetts devised a way to cover the uninsured in a way that would win CMS's approval, improve the lives of the uninsured and win the approval of employers.

Equally important was the participation in the dialogue of all major stakeholders—doctors, hospitals, consumers, insurers, employers and lawmakers—and the consensus among them that the status quo was not optimal. Their participation allowed for very thoughtful and well-informed dialogue, and perhaps more importantly, made them vested in the long-term success and sustainability of health care reform as we moved forward with implementation and encountered the inevitable "bumps in the road."

Massachusetts took an incremental approach to its reform. We did not seek to fundamentally revamp the way people obtained coverage, to eliminate employer-sponsored coverage or conversely, to impose an employer mandate. Instead, we sought to adapt the existing sources of coverage and fill in the gaps. For example, Medicaid income-eligibility thresholds were expanded to cover children under 300 percent of the Federal poverty level. All insurance policies sold in Massachusetts were required to expand the definition of "dependent" to include children: (1) until they reached 26 years of age or (2) for full-time students for 2 years after they lost their status as a dependent under the Internal Revenue Code, whichever came first. This change was designed to get more young adults covered in a cost-effective manner. A young adult plan was also introduced into the marketplace that did not include all the mandated benefits as a way to make the insurance more affordable. This targeted approach, although not universally supported, allowed Massachusetts to move forward.

Massachusetts policymakers did not let the perfect get in the way of the good. At the time the legislature enacted Chapter 58, for example, future funding sources for some of the expansions remained uncertain, and several of the elements were met with a healthy dose of skepticism by various stakeholders. Public policymakers forged ahead to ensure approval of the Medicaid Waiver, but also because the goal of universal coverage was a worthy one and the challenges were not insurmountable.

2. KEY ELEMENTS OF MASSACHUSETTS HEALTH REFORM CRITICAL IN THE CONTEXT OF NATIONAL REFORM

Massachusetts was well-suited relative to many other States to address the issue of the uninsured and to strive for universal coverage. Prior to enactment of Chapter 58, Massachusetts: had one of the lowest rates of uninsured in the Nation (between 6–9 percent); spent over $1 billion annually in reimbursement to hospitals for coverage for the uninsured already through the Uncompensated Care Pool; had a higher rate of employers providing health insurance to employees than the Nation as a whole and a higher percentage of employees taking that coverage. In many ways, this made Massachusetts uniquely situated to address the challenge of covering the uninsured.

Nevertheless, there are key elements included in the Massachusetts plan that are readily transferable and key to the success of a national model.

Massachusetts reform was premised on the concept of shared responsibility and central to that is the individual mandate requirement. In fact, much of Massachusetts' success in reducing the number of uninsured can be attributed to the individual mandate. Many of the 432,000 newly-insured had access to coverage prior to enactment of health care reform in 2006, but chose not to enroll. Of those, 160,000 people, who were offered employer-sponsored plans and refused them prior to imposition of the individual mandate, are today covered through their employer's plan. Similarly, of the 72,000 people newly signed up for MassHealth, many were eligible prior to health care reform but did not enroll. Thirty-two thousand individuals purchased coverage for themselves when they opted not to before. The balance of the newly-insured, about 175,000 covered lives, is covered by Commonwealth Care, the State's subsidized insurance product. While the compliance burden of the health care mandate falls on the individual, employers and the State largely shoulder the cost. From the employer perspective, it is critical that lawmakers recognize the increased cost implications of the individual mandate on the employer community.

In addition, the requirement that all residents of the Commonwealth have insurance begs the question about how much insurance is enough to satisfy this requirement. The debate about what is "minimum creditable coverage" in Massachusetts evoked strong reactions from employers. While individuals ultimately must comply or face tax consequences, employers wanted to make sure that the benefits they offered met the MCC standard. Otherwise, employers would be in the untenable position of providing health insurance coverage at great expense yet their employees would still be subject to fines. The challenge is defining MCC in a way that ensures adequate coverage while allowing employers to be flexible in the coverage that they provide.

Creation of the Commonwealth Health Insurance Connector was one of the more innovative provisions of the Massachusetts health care reform law. Its purpose was threefold. Its primary function was to facilitate the purchase of health insurance by individuals by serving as a clearing house for all products that provided good value to consumers. These products received the Commonwealth's seal of approval. In addition, the Connector administered the Commonwealth Care product (subsidized insurance on a sliding scale for those with income below 300 percent of the Federal poverty level) and Commonwealth Choice, a product offered to all individuals without any income limitations. Last, the Connector was charged by the legislature with making some critical public policy decisions such as what is minimum creditable coverage and when is an individual excused from the health care mandate because insurance is unaffordable.

3. THE MOST DIFFICULT ASPECTS OF THE MASSACHUSETTS HEALTH REFORM

The most difficult aspects of health care reform, from the employer perspective, were the provisions that were adopted as "workarounds" to Federal law and are therefore not directly relevant to the national discussion. For example, to provide all individuals with the Federal tax benefits available to employer-based insurance, Massachusetts requires all businesses with 11 or more full-time equivalents to establish and maintain a section 125 plan. This enables employees who are ineligible for employer-sponsored insurance to pay for the entire health insurance premium in pre-tax dollars and those that are eligible for employer-sponsored insurance to pay for their portion of the premium in pre-tax dollars. Should Congress enact national health reform and want to provide a tax exemption for the cost of health insurance, the necessary changes could be made to the Internal Revenue Code.

The most contentious aspect of the health care reform debate in Massachusetts was whether or not to impose an employer mandate. Predictably, the consumer advocates wanted to impose an employer mandate and the employer community vehemently opposed it. The compromise requires certain employers that do not offer health insurance to a sufficient number of their employees or subsidize it adequately to make a monetary contribution to the State towards the cost of subsidized care. The "fair share contribution" provision has proven very difficult to understand and comply with. Since its initial implementation, the FSC requirements have been amended to impose more frequent reporting requirements and additional burdens on business, particularly those with part-time, seasonal or temporary help. This issue, along with the definition of minimum creditable coverage, threatened to undermine the consensus that Massachusetts had carefully built around health care reform.

In many ways, the most difficult aspect of health care reform in Massachusetts lays ahead. Massachusetts health care reform was intended to cover the uninsured.

Although the employer community's we preference was to address the increasing cost of health care before we expanded coverage, and warned that the long-term viability of health care reform would be jeopardized if cost was not addressed, we did not stand in the way of the Commonwealth's efforts to provide health insurance to the uninsured, and in fact, are committed to that goal.

The high cost of health insurance, which serves as a barrier to purchasing health insurance for many small businesses and individuals and acts as a competitive disadvantage for the businesses located here, must be addressed. The cost of health insurance in Massachusetts exceeds the national average by 30 percent and health care reform has done nothing to moderate premium trends to date. In fact, as a result of health care reform, some businesses now must pay a fair share contribution. Others are now providing coverage to more of their employee population or have increased their benefit offerings to comply with the minimum creditable coverage standard. Despite these additional costs, nearly three-quarters (72 percent) of Massachusetts employers offer health insurance to their employees and this offer rate has held steady, even as the employer offer rate nationally has declined from 68 percent to 60 percent between 2001 and 2007.

The economic challenges confronting Massachusetts employers, and their willingness and/or ability to offer coverage going forward, will be a key determinant in whether Massachusetts reform is sustainable absent significant progress on reducing health care costs.

On behalf of Associated Industries of Massachusetts and the employers we represent, I thank you for the opportunity to provide comments and look forward to working with members of the committee as you explore national health reform.

Senator BINGAMAN. Thank you very much.

Ms. Liu, you're going to give us the word on what's happening in California and what we can learn from that?

STATEMENT OF RUTH LIU, SENIOR DIRECTOR OF HEALTH POLICY AND HEALTH REFORM, KAISER PERMANENTE, CA

Ms. LIU. Yes, I'm happy to do so, and I want to thank you for the invitation to be here today to discuss lessons from California.

I think as you know, the California effort didn't quite succeed, so my testimony may be a little different than some of my colleagues. I still think there are many lessons that we can learn from the effort.

I am currently with Kaiser, I did want to inform the committee that, at the time of the California Health Reform Effort, I was Associate Secretary at the California Health and Human Services under the Schwarzenegger administration. My views here today are my own, and not that of the Governor or the Administration.

I think there are really three key lessons to learn from the California experience. The first is that, in the California effort, we did focus on a broad definition of health reform, including prevention and wellness strategies, a strategy for universal coverage and financing, and a focus on cost containment. I believe that is essential to focus on all three aspects, simultaneously, to ensure that any reform effort is financially sustainable in the long-term.

Second, we wrestled with issues around affordability—both affordability for purchasers of coverage, and keeping the cost of the reform proposal affordable for the State.

There are many lessons learned in terms of benefit design, subsidy design, and shared responsibility that I think will translate well nationally.

And finally I want to say that we spent considerable time and effort designing an approach that would allow us to transition—as smoothly as possible—from an underwritten, but fairly robust individual market, to a guaranteed issue market without health status rating, that preserved comprehensive offerings. I think it would

make sense to look at that transition very carefully, as Senator Enzi has raised.

Once again, I want to thank you for the opportunity to be here, and I want to thank you—especially Senator Kennedy—for your efforts in Massachusetts, and for the national reform effort that we're all looking forward to in California.

[The prepared statement of Ms. Liu follows:]

PREPARED STATEMENT OF RUTH LIU

Thank you for the invitation to be here today to discuss lessons from the California health reform effort and implications for national reform. I am Ruth Liu, Sr. Director of Health Policy in the Legal and Government Relations Department of Kaiser Foundation Health Plan ("Health Plan") and Kaiser Foundation Hospitals ("Hospitals"). Health Plan and Hospitals, together with the contracting Permanente Medical Groups, constitute the Kaiser Permanente Medical Care Program. Kaiser Permanente is the Nation's largest private integrated health care delivery system, providing comprehensive health care services to more than 8.7 million members in nine States (California, Colorado, Georgia, Hawaii, Maryland, Ohio, Oregon, Virginia, Washington) and the District of Columbia. At the time of the California health reform effort, I was Associate Secretary at the California Health and Human Services Agency in the Schwarzenegger administration. The views reflected in this testimony are my own, not that of Governor Schwarzenegger or his Administration.

OVERVIEW OF KEY LESSONS

In the California reform effort, we focused on a broad definition of health reform, including prevention and wellness initiatives; a strategy for universal coverage and financing; and a focus on cost containment. I believe it is essential to focus on all three aspects simultaneously to ensure that any reform effort is financially sustainable in the long-term.

Second, we wrestled with issues of affordability, both affordability for purchasers of coverage and keeping the cost of the reform proposal affordable for the State. There are many lessons learned in terms of benefit design, subsidy design and shared responsibility that would translate well nationally.

Finally, we spent considerable effort in designing an approach that would allow us to transition as smoothly as possible from an underwritten, but robust, individual market to a guaranteed issue market without health status rating that preserved comprehensive offerings.

BROAD DEFINITION OF HEALTH REFORM

The California reform effort was designed around three overarching principles:

• **A focus on prevention and wellness to ensure that the health reform effort had the objective of keeping people healthy at the center.** In this area we focused on strategies to foster individual responsibility for health through benefit product design; to promote more effective chronic care management; to engage communities in broad public health campaigns and initiatives; and to promote higher standards of patient safety in our hospitals.

• **Universal coverage to ensure that all Californians had access to high-quality, affordable health care.** To achieve universal coverage we felt it was imperative to have an individual mandate, as a purely voluntary system will leave many individuals uninsured. The mandate also needed to be accompanied by subsidies for low-moderate income individuals and changes in market and rating rules in the individual market to ensure access and affordability for those with pre-existing health conditions. Effective enforcement of the mandate was also essential to spread risk broadly and keep premiums affordable.

• **Cost containment to move towards making health care more affordable for all purchasers of coverage and to promote strategies for more efficient health care delivery.** A key component in the area of cost containment for the currently insured was our focus on what we labeled the "hidden tax" or the cost shift that exists for commercial purchasers from both the uninsured and the underpayment of public programs. Medi-Cal, (California's Medicaid program) has one of the lowest provider reimbursement rates in the country and accounts for a significant shift of costs onto the private sector. A major financial component of our effort included increasing provider reimbursement rates for Medi-Cal by over $4 billion. This strategy was intended to both reduce the cost shift and improve access to pro-

viders for an expanded Medi-Cal program. Any significant expansion of the Medicaid program nationally under reform should take into account this issue. We also pursued a number of other initiatives to address the underlying costs of health care including promotion of health information technology and e-prescribing, pay for performance, fostering a greater reliance on evidence-based medicine and the prevention and wellness strategies noted above. Nationally, there are additional steps and policy levers at the government's disposal to drive more efficient care delivery and payment reforms.

AFFORDABILITY FOR INDIVIDUALS AND THE STATE: BENEFIT DESIGN

A key consideration in designing a coverage proposal is the trade-off between the comprehensiveness and cost of a specified benefit design. For the subsidized benefit, this dilemma will affect both the overall cost of the program and the cost for the individual, in terms of any contribution towards the premium and associated cost sharing with the product. For the unsubsidized benefit, the question becomes what minimum level of comprehensiveness is appropriate in conjunction with an individual mandate. In the California proposal, we determined that it did not make sense to have one standard benefit for all income levels of the uninsured. Subsidized lower income individuals clearly needed a more comprehensive benefit with minimal cost sharing, but that same benefit design might be quite costly for individuals who were not subsidized, particularly for those with incomes just above the subsidy threshold level.

An addendum to this statement provides further detail, but in general the Administration proposed the following:

- Expanded public coverage for the lowest income individuals (Medic aid or CHIP for children up to 300 percent FPL; Medicaid up to 100 percent for all documented adults);
- Subsidized coverage with a sliding scale contribution towards premium for documented adults between 100–250 percent FPL. Subsidized coverage included a broad scope of benefits and moderate cost sharing;
- Mandated minimum coverage of a high deductible plan ($5,000), with preventive services, some office visits and some drug coverage outside the deductible for those above 250 percent FPL. The scope of benefits covered was similar to the subsidized benefit.

During negotiations with the Legislature these parameters were modified, and the minimum benefit was never defined, but there was general agreement that a variable benefit design approach dependent on the income level of the individual was preferable for both individuals and the State.

AFFORDABILITY FOR INDIVIDUALS AND THE STATE: SUBSIDY DESIGN

Closely associated to the issue of benefit design and affordability was the issue of subsidy design. As indicated above, the lowest income individuals received a full subsidy with a sliding scale subsidy for those with slightly higher incomes, and no subsidy for those above 250 percent FPL. Several factors were considered in designing the sliding scale subsidy level including affordability for individuals, minimizing employer crowd out and Federal cost sharing rules.

During negotiations, it became clear that a subsidy design with the income cutoff levels we had proposed would be particularly problematic for older individuals. We had taken steps to phase out health status rating, but we allowed a continuation of age rating (and rating based on family size and geography). This meant that older individuals over 250 percent FPL would face quite high premiums. We felt that some difference in premium between younger and older individuals was appropriate given that: (1) older individuals have less constraints on their budget than young families (no child care or education expenses and lower housing expenses); and (2) health coverage is of greater value since average utilization increases with age. However, we concluded that some additional financial assistance would be needed for this population.

There was considerable discussion around what level of subsidy could be offered and what the subsidy should be benchmarked against. Several stakeholders argued that subsidies should be based on all possible out-of-pocket costs rather than on premium alone which would have been prohibitively expensive for the State. In the end, we decided that additional subsidies would be provided on a sliding scale basis for those between 250–400 percent FPL if the premium cost for a product with moderate cost sharing ($2,500 deductible) exceeded 5.5 percent of gross income. This allowed the subsidy costs to remain affordable, while ensuring that individual out-of-pocket expenses would be limited.

AFFORDABILITY FOR INDIVIDUALS AND THE STATE: SHARED RESPONSIBILITY

One of the underlying principles articulated by Governor Schwarzenegger was his desire to have all stakeholders in the health care system bear some responsibility for reforming the health care system. This proved to be a fairly popular approach because the proposal was designed such that all stakeholders both benefited in some way from the proposal and also bore some new responsibility, financial or otherwise. While some of the specific measures used in the California proposal would not translate well nationally, the general principle should. At the national level there are also additional opportunities for shared responsibility that States cannot pursue. For instance, an employer mandate at the State level generally has to be considered as a "pay or play" mandate due to ERISA concerns, but at the national level policymakers could mandate at least larger employers to simply "play" at some minimum level.

MARKET REFORM

One of the most difficult policy challenges we faced in California was determining the most appropriate way to move from a highly underwritten, but quite robust, individual market to an individual market with guaranteed issue, no health status rating, but still preserving more comprehensive benefit offerings for those who preferred them.

Here we could not look to other States that had adopted broad health reforms such as Massachusetts since the market conditions and regulatory rules were completely opposite. In California, the individual market is quite robust with relatively low premiums and younger and healthier individuals that can pass medical underwriting in the market. In Massachusetts, guaranteed issue and rating rules were already in existence before broad reform, and the individual market was quite expensive and generally much higher risk than in California. An influx of new individuals into the market in Massachusetts, some higher risk, but others lower risk, would generally lower premium costs. In California, an influx of individuals, particularly a large number of higher risk individuals, would likely increase premiums considerably.

In particular, this meant that if we were to have a guaranteed issue, we needed to ensure that the mandate would be well enforced so that younger healthier individuals would be more likely to comply with the mandate and moderate the risk pool and overall premium increases. This was quite a controversial issue and the compromise bill left much to be determined by the State during implementation. However, the enforcement measures widely discussed included a concept called "seamless coverage" which would permit the State to adopt a number of education and enrollment steps to improve compliance with the mandate. It would also allow the State to default enroll individuals who did not comply with the mandate after a specified period of time in the mandated minimum coverage and pay their premium until the individual was in compliance.

We certainly could not find a perfect solution to solve the complexity of issues this transition engendered, but we agreed on several approaches that would: gradually transition to our stated end goal while minimizing disruption of the current market; moderate likely premium increases for those currently in the individual market; and keep premiums relatively affordable for those entering the market for the first time. We also wanted to ensure that a broad choice of benefits, from less comprehensive to more comprehensive would be available on a guaranteed issue basis with rating appropriate to the difference in benefits, not expected risk. A summary of reforms and proposed market changes submitted by a coalition of health plans in California are included as an addendum to this statement. Some of the key reforms in addition to guaranteed issue and an enforceable mandate included:

- A gradual phasing out of health status rate bands;
- Grandfathering of individuals with current insurance if they had that insurance 18 months prior to the mandate;
- Requiring risk adjustment among plans across the newly insured pool and the grand fathered pool to ensure all plans shared the new "risk" in the market equitably;
- A requirement to offer a wide variety of products and to price them in relation to the rest of an insurer's portfolio. These requirements would preserve broad choice for consumers with rating appropriate to the difference in benefits, not anticipated risk.
- Corresponding rules for the purchase of guaranteed issue products by individuals to ensure that the comprehensive plans were not adversely selected against and prices remained affordable.

Determining a single strategy for a smooth transition in a national reform effort may prove very difficult given the wide variation in market conditions and regulations across the country. It may be preferable to establish Federal standards around benefit design and financial subsidies along with rules and regulations to ensure broad choice and fair rating for consumers and appropriate risk adjustment across plans. Implementation benchmarks could also be established through Federal regulation. States could be allowed to design their own transitional strategies to meet these benchmarks with provision of Federal subsidy dollars tied to meeting these standards and benchmarks.

The goal of national health reform is an ambitious, but much-needed policy reform in this country. I look forward to discussing these lessons from California with you in greater depth and discussing additional opportunities not available at the State level as you move forward with the national health agenda.

ADDENDUM

1. BENEFIT DESIGN CONSIDERATIONS IN THE CALIFORNIA REFORM EFFORT

One of the key issues policymakers face in determining an appropriate benefit design for the currently uninsured population is the trade-off between comprehensiveness of the product and the cost.

In the California reform effort, the Administration's health reform team considered comprehensiveness of the benefit from the standpoint of both the scope of covered benefits and the cost sharing associated with the product. Likewise cost was considered from the standpoint of the cost of the premium for the individual and the ability of an individual to afford associated cost sharing. In the case of the subsidized product, consideration was also given to the subsidy costs for the State, the impact on employer "crowd out", and Federal cost sharing rules that would impact the ability to draw down Federal funds.

In terms of the scope of benefits, all individuals were required to purchase a product that met the "Knox Keene" standard required for all HMO products in the State, plus prescription drug coverage. Knox Keene requires coverage of all "basic health care services" including physician services, hospital inpatient and ambulatory care services, diagnostic lab and radiological services, home health services, preventive health services, emergency health care services and hospice care. In addition to these general categories, State lawmakers have included specific mandates that are a subset of these categories.

Cost sharing for the products varied dependent on the income level of the individual. Since lower income individuals have less discretionary income, the subsidized population had a benefit with zero to moderate cost sharing. Individual contributions towards the cost of the subsidized product were established as part of the shared responsibility principle for all but those with the lowest incomes, to offset some of the subsidy costs for the State, and to mitigate employer crowd out. Cost sharing for the unsubsidized product was set with much higher parameters. The rationale for this approach was two-fold: higher income individuals generally have more discretionary income, and with no subsidy for the premium costs, might prefer a benefit design with higher cost sharing parameters. In a guaranteed issue world, an individual could purchase a more comprehensive benefit design if they preferred.

The Administration team originally modeled costs based on the following parameters:

- All children regardless of documentation status up to 300 percent FPL eligible for either Medicaid (up to 100 percent) or SCHIP (101–300 percent).
- Documented adults up to 100 percent FPL—Eligible for Medicaid.
- Documented adults 101–250 percent—Eligible for subsidized coverage.
  - Subsidized coverage defined as Knox Keene benefits plus prescription drugs.
  - Individual cost towards premium—100–150 percent FPL—3 percent of gross income, 151–200 percent FPL—4 percent of gross income, 201–250 percent FPL—6 percent of gross income.
  - $500 deductible, $3,000 out-of-pocket maximum. Prevention, physician office visits and Rx outside the deductible with limited co-pays.
- Documented adults above 250 percent—mandated to purchase minimum coverage. Minimum coverage never defined in legislation, but modeled at:
  - Knox Keene benefits plus prescription drugs.
  - $5,000 deductible; $7,500 individual/$10,000 family out-of-pocket maximum. Prevention, some physician office visits and some drug coverage outside the deductible with low-moderate co-pays.

During the negotiations with the Legislature the benefit parameters were modified somewhat, to reflect the following changes:

• Documented adults from 101–150 percent would have no contribution towards the premium.

• Adults from 151–250 percent would be required to contribute up to 5 percent of their income based on a sliding scale.

• Subsidized coverage benefits would be based on a modified SCHIP product with similar cost sharing parameters.

• Minimum benefit standard for those over 250 percent would be determined at a later date by a State agency through a public hearing process.

• Additional subsidies would be provided on a sliding scale basis for those between 250–400 percent FPL if the premium cost for a product with moderate cost sharing ($2,500 deductible) exceeded 5.5 percent of gross income.

2. CALIFORNIA HEALTH REFORM MARKET REFORMS OVERVIEW

• *Individual Mandate for the purchase of coverage.*

Intent: Necessary to attain universal coverage. Can better meet affordability concerns if all individuals are required to purchase coverage.

Exemptions may be provided for the following reasons: new California residents, individuals who apply for and are granted an affordability or a hardship exemption by the Managed Risk Medical Insurance Board (MRMIB), and persons with incomes below 250 percent of the Federal Poverty Level (FPL) if the cost of premiums for minimum creditable coverage exceeds 5 percent of their income. (*The last exemption is basically for undocumented adults below 250 percent who would not be eligible for subsidized coverage. Documented adults below 250 percent would qualify for either Medi-Cal or new subsidized coverage and would not have to pay more than 5 percent of income for that coverage.*)

• *Guaranteed Issue of all products from onset of the mandate,* with carriers required to offer a diversity of products from high-deductible to comprehensive.

Intent: Broad choice of guaranteed issue products for consumers.

Guaranteed issue corresponds to the mandate. If you are exempt from the mandate, you do not qualify for GI coverage.

• *Use the "seamless coverage" approach to ensure that people comply with the mandate.*

Intent: Enforcement of the individual mandate is essential for guaranteed issue to work properly. The State will adopt a number of education and enrollment steps to improve compliance with the mandate and will default enroll individuals in coverage after a specified period of time and pay their premium until the individual is in compliance.

• *Grandfather products that are below the minimum standard for those who have had those products for 18 months prior to the mandate.*

Intent: Don't require people who have been purchasing insurance to change their coverage. By grandfathering these people their rates will also initially be protected from major rate increases as a consequence of the new market rules.

• *Individuals are allowed to purchase and renew coverage below the mandated minimum up to enactment of the mandate, but individuals purchasing this type of coverage will not be grand fathered, unless they had this coverage 18 months prior to the mandate.*

Intent: Ensure that a variety of low-cost products are available to consumers before the individual mandate goes into effect.

• *Prohibit the introduction of new products below the minimum standard 18 months in advance of the mandate.*

Intent: While people with long-standing existing coverage below the minimum should not be forced to change their coverage, insurers should be discouraged from selling coverage that doesn't meet the minimum standards to get around our new policy. Over time, individuals with coverage lower than the minimum will shift over voluntarily to products that meet the minimum standard.

• *Establish coverage choice categories and require insurers to offer choice in a variety of levels using a similar rating portfolio.*

Intent: Ensure that a broad range of products are offered on a guaranteed issue basis from less comprehensive to more comprehensive in the reformed market and that they are priced in relationship to each other based on differences in benefit design, not based on possible risk selection.

• *Gradually phase out increased charges for health status by limiting the amount insurers can "rate up" for those with health problems.*

  • For the first 2 years insurers can rate 20 percent above or below based on a person's health status.

- For the next 2 years insurers can rate 10 percent above or below based on a person's health status.
- After 4 years insurers cannot vary their rates based on a person's health status. Insurers will only be allowed to vary rates based on age, family composition, and geography.

Intent: "Soften" the transition from a market that is not guaranteed issue and where rates differ dramatically according to health status, to a market that is guaranteed issue and rates vary only by age, family and geography. Individuals who are older and sicker will pay more, but the differential is limited and they are guaranteed issue coverage. By allowing health status rate bands initially, there will not be *as big* a premium increase for young, healthy individuals who had coverage or who will be buying coverage for the first time. Individuals who had coverage that exceeds the minimum will still see premium increases estimated at about 20 percent more than they pay today. To minimize that expected rate increase we would need to either broaden the health status risk bands or "re-insure" products for these individuals at a cost of approximately $300 million. In our language we give authority for this reinsurance mechanism if we choose to pursue this strategy.

• *Apply an overall maximum ratio (for example; rates for a 60–64 year old cannot be more than XXX higher than rates for a 30–34 year old) for individuals between 30–34 and the 60–64 rate categories.*

Intent: Health status rate bands will mean that older individuals in general will pay more than younger individuals both because of their age and their higher health risk. By requiring an overall rate ratio for middle age to the oldest category we protect the oldest individuals from very high rates. We exclude the youngest (19–29) because we need to keep prices affordable for the youngest who will be the least likely to comply with the mandate.

• *Require plans to redistribute funds among themselves based on the number of high risk individuals each health plan has.*

Intent: Make sure that all health plans share the new "risk" in the market equitably. This component is particularly important because we are grandfathering a large number of individuals who have coverage that does not meet the minimum standard. Without this structure some plans may not participate fully and fairly in the guaranteed issue market. All plans should bear an equitable cost for reforming the market.

• *Authorize a shared reinsurance provision, should the age adjusted risk of individuals enrolled in the unsubsidized market, significantly exceed the incidence of risk of those enrolled in the subsidized program.*

Intent: Split the cost of reinsurance by having the plans bear the first portion of risk if the risk is up to 10 percent higher. This methodology will incentivize plans to better manage risk as they will be on the hook for the first level of reinsurance. The State then bears the additional cost of reinsurance above 10 percent as a means to keep rates more affordable for the majority of individuals.

3. Proposed Rules to Safeguard Market Viability under Guaranteed Issue

Proposals mandating guaranteed issue of health insurance are among the ideas for health care reform recently advanced. However, as the experiences of a number of other States attest, instituting guaranteed issue in the individual market can trigger severe unintended consequences, such as large, destabilizing premium increases and insurer flight from the market. It is therefore critical that in implementing guaranteed issue, careful attention be paid to minimizing these risks and assuring that a wide variety of benefit packages can continue to be offered at reasonable rates.

Mandating coverage for all individuals is an absolute requirement for successful implementation of guaranteed issue, but it alone is not sufficient for a good outcome. The two-phase proposal described below represents our initial thinking about how guaranteed issue could be established without harming the people currently served in the individual market and assumes that other elements of health care reform proposed do not undermine a viable market.

PHASE ONE: TRANSITIONING TO FULL GUARANTEED ISSUE

Because of the major risks involved in moving to guaranteed issue, it is important that there be a transition period to assure that persons currently in the market do not experience a sudden increase in rates and that the individual market remains viable. We propose the following transition rules:

• The State will define a baseline HMO benefit plan and a baseline PPO benefit plan with the same actuarial value.

• At some reasonable time after the baseline plans have been defined, a carrier must offer at least one baseline plan on a guarantee issue basis. If a carrier chooses to offer more than one product in the individual market, it must offer the baseline benefit plan for each product. A product offered in the subsidized pool would be excluded from this requirement.

• In offering the guaranteed issue benefit plans, a carrier shall continue to have flexibility in establishing and maintaining provider networks as long as the carrier meets regulatory requirements for access to care and as long as guaranteed issue is available in at least one product using each network offered by the carrier.

• The baseline product for each network offered by the carrier shall be its lowest priced product and be subject to guaranteed issue.

• Carriers may also offer other benefit plans not subject to guaranteed issue. Carriers will be able to develop benefit plans and price as they do now.

• At the same time that plans begin offering the baseline benefit, the individual mandate shall commence and the State shall begin enforcement activities.

• The State will continue to operate a high-risk pool similar to MRMIP and shall continue to subsidize its cost by an appropriation of no less than the amount now provided for support of MRMIP, which is $40 million from the Tobacco Tax.

End of Transition Period

• The transition period will end when there is full compliance with the individual mandate. We will work together and with the Governor's Office and the legislature to define full compliance.

• When it is determined that there is full compliance with the individual mandate, the phase two framework will go into effect.

PHASE TWO: IMPLEMENTATION OF FULL GUARANTEED ISSUE

Objective

To establish a functional, sustainable market where Californians who are not eligible for subsidized coverage and are required to purchase coverage through the individual market have guaranteed access to affordable coverage, regardless of health status.

Assumptions

• All Californians are mandated to obtain health coverage through direct purchase, employment or a public plan.

• The individual mandate is fully effective and the State actively monitors and enforces the enrollment requirement.

• The individual mandate requires minimum coverage of a plan with high cost-sharing, such as a $5,000 deductible plan, with a $7,500 out-of-pocket maximum. Californians could also satisfy the mandate by purchasing any plan which meets Federal qualification for an HSA-compatible HDHP plan.

• These rules would apply to adults above 250 percent of poverty and children above 300 percent of poverty who are ineligible for other public programs.

Benefit Plans

• The State will define five classes of benefit plans, each class having an increasing level of benefits.

  • Within each class, the State will define one baseline HMO and one PPO plan, and a baseline for any other type of product that meets the minimum mandated benefit.
  • The State will define reasonable benefit variation from the baseline that will allow for a diverse market within each class.
  • The benefits within each class could be standard and uniform across all carriers, or the benefits offered in each class could be defined based on actuarial equivalence.
  • Each carrier in the individual market will offer at least one plan in each class.
  • Carriers are not obligated to offer all product options, but if a carrier chooses to offer a product option in one class, it must offer that product option in all classes.
  • All plans will be offered to individuals on a guaranteed issue basis once full application of the individual mandate has been achieved.

• Carriers participating in the individual market must offer all plans in all of their approved service areas.

• Any coverage that does not at least equal the minimum State-mandated plan does not qualify as meeting the individual coverage requirement.

• Classes defined by the State must reflect a reasonable continuum between the class with the highest and lowest level of benefits.

Rationale

• This allows an individual to choose a benefit plan with the appropriate level of coverage for the individual's needs.

• Carriers should compete on the basis of price, quality and service, not risk selection. The State would act as "referee" establishing the rules and preventing carriers from designing plans to avoid high risk enrollees.

Guaranteed Issue Requirements

• Individuals would elect a plan within a benefit classification. An individual may change plans as follows:

- Annually, in the month off the individual's birthday, within the same benefit classification.
- Every 3 years, in the month of the consumer's birthday, the consumer may move up one level of benefits.
- At any time, within the same carrier's portfolio, a consumer may move to a lower class.
- At significant life events, the individual would have broader open-enrollment choices and can move up 2 or 3 bands (upon marriage, the death of a subscriber).

• Individuals applying for coverage would be required to fill out a standard health status questionnaire to assist plans in identifying (a) persons in need of disease management, and (b) high-risk applicants.

Rationale

The time limitation on enrollment protects the more comprehensive plans from accruing a high level of risk that would result in making them unaffordable. It would encourage people to choose benefit plans that will meet their needs over the long term.

• Prior identification of persons in need of disease management allows plans to reach out to these people to encourage them to get the care they need.

• Prior identification of high risk applicants will facilitate the re-insurance mechanism discussed below. The identification of "high risk" applicants would be invisible to the enrollee, except to the extent they are candidates for disease management.

Rating Rules

• Carriers may rate the entire portfolio in accord with expected costs or other market considerations, but the rate for each plan would be set in relation to the balance of its portfolio.

• Each plan would be priced as determined by each carrier to reflect their expected costs with appropriate cost-subsidization across the entire individual risk pool. Additional rules would require the following:

• If a carrier offers different provider networks on different plans, it may consider the effect on health care costs.

• Rates may vary from applicant to applicant by:

(1) Age—Legislation to define specified age bands.

(2) Family—Legislation to define 5 family sizes (Single Sub, Sub/Sp, Sub/Ch, etc. . . .). Carriers can chose to offer only member level rates (a family rate would be the sum of the individual rates for each family member).

(3) Geographic rate regions, limited to 9 regions, of a carrier's choice. A region may not split a county more than once, and within a county, may not split any block of zip codes sharing the first three digits.

(4) Health Improvement Discounts. A carrier *may* reduce co-payments or offer premium discounts for non-smokers, individuals demonstrating weight loss through a measurable health improvement program or individuals actively participating in a carrier's disease management program. Any discounts must be approved by the State.

• A carrier must use the same rating factors for age, family size and geographic location for each plan.

• No artificial constraints will be placed on differences in rates by age, family composition, or region.

Rationale

• These are similar to the current rules in the small group market.

• Allowing pricing flexibility between plans allows carriers to reflect the differences in their costs structure and anticipated experience under each plan.
• This structure must be linked with an effective re-insurance pool to protect the richest plan category from the selection costs likely to occur.

Reinsurance Pool

• Carriers would be allowed to cede high risk enrollees into a subsidized pool.
• This process would be invisible to the enrollee as it would be a financial arrangement between the carrier and the State.
• Financing for this pool would be broad-based and shall not rely only on the premiums from the individual market.
• There are various approaches to re-insurance that have been used and that are being developed. We could discuss the details of what would be best in California as part of development of the final proposal.

Rationale

• This would help to maintain affordability for individuals.
• This also helps to ensure a level playing field so that carriers compete based on price, quality and service rather than risk selection.

Senator BINGAMAN. Ms. Besio, tell us about Vermont.

STATEMENT OF SUSAN BESIO, Ph.D., DIRECTOR, OFFICE OF VERMONT HEALTH ACCESS, HUMAN SERVICES AGENCY, STATE OF VERMONT, BURLINGTON, VT

Ms. BESIO. OK. First, I'm going to correct the pronunciation of my name, which is Besio (Bes-eye-o), Susan Besio.

I'm actually the Director of Healthcare Reform for Vermont, and also the Director of the State's Medicaid Program. I want to thank you, along with the other panelists, for asking the States to be here today, and for your leadership.

Vermont has long valued coverage as important for our residents. However, Vermont's reforms were very, very comprehensive, in that they did address both coverage, care delivery, prevention and wellness, and trying to control costs. Hopefully we'll get a chance to talk about all of those aspects today.

In terms of coverage, Vermont has always had coverage as a key component of our State's values. We have a very expansive Medicaid program, we actually cover children up to 300 percent of Federal poverty level, childless adults up to 150 percent, and adults with dependents up to 185 percent of Federal poverty level.

That was a key cornerstone of our coverage expansions that we initiated in 2006. We're also one of the few States in the country that has guaranteed issue and community rating which, again, is part of our Vermont values that we want to provide affordable and comprehensive coverage to all of our residents, regardless of age or health status.

Since the fall of 2007, when we implemented our reforms, our uninsured rate has dropped from 9.8 percent to 7.6 percent for all of our residents, and from 4.9 percent to 2.9 percent for our children. We're very proud of that progress, we did this without an individual mandate, but we did do it with new, comprehensive, private market product called Catamount Health, premium assistance for people up to 300 percent of the Federal poverty level for both Catamount Health and for their employer-sponsored insurance, for people with employer-sponsored insurance.

We did integrated private and public outreach and marketing, and enrollment, and we insisted that coverage be comprehensive and affordable, with low deductibles and low out-of-pocket cost.

The reason that is so important to us is because we recognize that if people have high out-of-pocket costs, they're not going to access preventative care, even if preventative care is free, because the follow-up care is not. And so, we think that's a very important value to consider when you're developing benefit designs that might be standardized at the national level.

We also would think that we have some experience around the role of insurance regulation, implications of Medicaid and Medicare in terms of the complexity of those systems, and how they interface with our States' abilities to expand and maintain coverage. Obviously, the importance of simultaneous system redesign in terms of care delivery which has to go hand-in-hand with the coverage initiatives.

We very much appreciate you asking Vermont to be at the table today. We think that we have a lot of learning to offer, we also believe that—as Senator Hatch mentioned—each State has unique values, conditions, and State and local regulations that can not be dismantled in any kind of healthcare reform effort, because we have made significant progress, and we do not want to go back.

Again, thank you very much for having us here today, and we look forward to our discussion.

[The prepared statement of Ms. Besio follows:]

PREPARED STATEMENT OF SUSAN BESIO, PH.D. AND HARRY CHEN, M.D.

INTRODUCTION

My name is Susan Besio. I am the Director of Health Care Reform for the State of Vermont, and also was recently appointed Director of the State's Medicaid Program. With me today is Dr. Harry Chen, who is a practicing emergency room physician and board member of Vermont Program for Quality in Health Care, and former Vice-Chair of the Vermont Legislative Committee on Health Care. We would like to thank Senator Kennedy, Senator Enzi, Senator Bingaman, Senator Sanders, and the rest of the members of the committee for giving us the opportunity to speak today about our State's experiences with health care reform related to coverage and how they can inform national reform efforts.

VERMONT HEALTH CARE REFORM CONTEXT

Per capita health care costs are lower in Vermont when compared to the United States, but the spending gap has been narrowing since 1999. Health care spending growth rates in Vermont have exceeded national averages for each of the last 4 years, and health care costs were 17.1 percent of Vermont's gross State product in 2007. We cannot afford our current health care system.

Universal health care coverage is a key mechanism to help bring down the costs of health care. Covering the uninsured will help lower uncompensated care costs, which affect premiums paid by the insured. In addition, people who do not have *affordable, comprehensive* coverage do not access preventive or primary care, and instead use costly emergency room services; they also develop more significant illnesses which require more costly services. For example, data from the Vermont 2005 Family Health Insurance Survey[1] showed that 45 percent of uninsured children did not see a physician for routine care (compared to 7 percent of insured children); this has significant implications for both short-term and long-term wellness, and health care expenditures.

In 2005, before our reforms began, Vermont had an uninsured rate of 9.8 percent (61,056) compared with a national rate of 15.7 percent, and an uninsured rate for children of 4.9 percent.[1] This relatively low uninsured rate is partially due to Vermont use of its Medicaid 1115 waiver authority to expand coverage for the uninsured. The Dr. Dynasaur program provides Medicaid coverage to all children with

[1] Vermont Family Health Insurance Survey, 2005. The survey report can be found at *http://www.bishca.state.vt.us/HcaDiv/Data_Reports/healthinsurmarket/2005_VHHIS_Final_080706.pdf*.

household incomes under 300 percent FPL, to pregnant women with household incomes under 200 percent FPL, and to parents and caretakers with household incomes under 185 percent FPL. The Vermont Health Access Plan (VHAP) provides coverage for uninsured adults with household income under 150 percent FPL and adults with children on Dr. Dynasaur who have income under 185 percent. Approximately 19 percent of Vermonters (125,000) have health insurance provided by the State through these programs.

Regarding private insurance, Vermont is one of a handful of States that requires guaranteed issue and community rating—reflecting the State's values of wanting to provide affordable, comprehensive health coverage regardless of age or health status (matters largely outside the individual's control). However, affordable coverage is becoming more difficult, especially in the individual market, where enrollment has decreased 44 percent from 2000 to 2007. And while Vermont employers appear to be maintaining coverage for their employees, the cost-sharing within the plans is increasing each year, making it more difficult for Vermonters to get the care they need, when they need it.

VERMONT HEALTH CARE REFORM LEGISLATION

On May 25, 2006, Vermont Governor James Douglas signed into law Acts 190 and 191 (Acts Relating to Health Care Affordability for Vermonters). These Acts, augmented by portions of the State Fiscal Year 2007 Appropriations Act and Act 153 (Safe Staffing and Quality Patient Care), along with Acts 70 and 71 in 2007 and Acts 203 and 204 in 2008 provide the foundation for Vermont's Health Care Reform Plan.

Vermont's comprehensive package of health care reform legislation is based on the following reform design principles:

- It is the policy of the State of Vermont to ensure universal access to and coverage for essential health care services for all Vermonters.
- Health care coverage needs to be comprehensive and continuous.
- Vermont's health delivery system must model continuous improvement of health care quality and safety.
- The financing of health care in Vermont must be sufficient, equitable, fair, and sustainable.
- Built-in accountability for quality, cost, access, and participation must be the hallmark of Vermont's health care system.
- Vermonters must be engaged, to the best of their ability, to pursue healthy lifestyles, to focus on preventive care and wellness efforts, and to make informed use of all health care services throughout their lives.

Using these principles as a framework, Vermont's health care reform legislation contains over 50 separate initiatives designed to simultaneously achieve the following three goals:

- Increase access to affordable health insurance for all Vermonters.
- Improve quality of care across the lifespan.
- Contain health care costs.

It is significant that Vermont's landmark 2006 Health Care Reform legislation was the product of extensive negotiation and collaboration by the Douglas administration, legislative leaders of the Vermont General Assembly, and the private sector participants—including providers and payors—in Vermont's health care system. While there were multiple ideas and political agendas as part of the discussions, there is agreement that the final legislation was comprehensive in its breadth and significant in its potential impact on health care in Vermont. There also was a commitment to move forward with implementation in a collaborative, non-partisan manner to maximize its success, as evidenced by the subsequent, collaborative work embodied in additional legislation passed in 2007 and 2008 and under development in the current legislative session.

VERMONT COVERAGE REFORMS

These reforms are making a real difference. In contrast to many other States where the number of uninsured is increasing, Vermont's coverage reforms instituted in the past 2 years have reduced the number of uninsured from 9.8 percent in 2005 to 7.6 percent in 2008, and the uninsured rate for children has fallen from 4.9 percent in 2005 to 2.9 percent in 2008.

Data from the 2005 Vermont Family Health Insurance Survey on the demographics of the uninsured in Vermont helped focus the design of our coverage reforms. According to the survey, 51 percent of the uninsured in Vermont were estimated to be eligible for a Medicaid program but not enrolled in the program; 27 per-

cent of the uninsured in Vermont had household income under 300 percent FPL but were not eligible for a Medicaid program; and 22 percent of the uninsured in Vermont had household income greater than 300 percent of FPL. Over three-quarters of Vermonters indicated that cost was the major reason for being uninsured.

In response, Vermont's coverage reforms:

- designed and implemented the new Catamount Health insurance plan,
- developed income-sensitive premium assistance programs for Catamount Health and for employer-sponsored insurance,
- developed the new brand name "Green Mountain Care" to include the State's Medicaid and Medicaid expansion coverage programs, Catamount and the new premium assistance programs under a single umbrella, and
- implemented mechanisms to assist with comprehensive outreach to every uninsured Vermonter that is matched with application assistance, tracking, follow-up, and referral.

Mandated in statute, the new coverage initiatives were designed with very specific underlying values. These included ensuring *comprehensive* coverage and *affordable* coverage; (premiums and out-of-pocket); promoting preventive care and chronic care management; augmenting, not supplanting, employer-based coverage; and avoiding contributing to the cost shift via inadequate provider payments in any new coverage plans.

Catamount Health Plan: Act 191 of 2006 created a separate insurance pool in the individual market for the purpose of offering a lower cost comprehensive health insurance product for uninsured[2] Vermonters. The Catamount Health Plan is modeled after a preferred provider organization plan with a $250 in-network deductible and $800 out-of-pocket maximum for individual coverage. Cost sharing is prescribed in statute, and includes a waiver of all cost-sharing for chronic care management and services for subscribers who agree to participate in a defined chronic care management program offered through the carrier, and a zero deductible for prescription drug coverage. Lower premium costs as compared to equivalent benefit plans on the individual market were achieved due to estimates concerning the claims costs of the uninsured relative to the claims costs of the general population, and based on provider reimbursement rates established in the law that are lower than commercial rates (but 10 percent higher than Medicare rates). Catamount Health policies began being offered by Blue Cross Blue Shield of Vermont and MVP Health Care on October 1, 2007. As of the end of March 2009, over 8,200 people have enrolled in Catamount Health Plans, and enrollment continues to increase by several hundred each month.

Catamount Health Premium Assistance Program.—Of the 8,200 beneficiaries covered by Catamount Health Plans, 85 percent are receiving premium assistance, which is available to Vermont residents who have been uninsured for at least 12 months (with exceptions) and who are not eligible for a public insurance program such as Medicaid. Premium assistance is based on household income, and eligible individuals are able to purchase a Catamount Health policy at the following rates, with the remainder paid by the State:

Up to 200 percent FPL: $60 per month;
200–225 percent FPL: $110 per month;
225–250 percent FPL: $135 per month;
250–275 percent FPL: $160 per month;
275–300 percent FPL: $185 per month; and
Over 300 percent FPL: Full cost of the Catamount Health individual policy ($393/month).

Employer Sponsored Insurance (ESI) Premium Assistance Programs.—Vermont's health care reform is designed to support and build on our Nation's current health care system that primarily relies on employer-based coverage. As such, the new Catamount Health Plan and the associated premium assistance programs were constructed to minimize "crowd-out" from employer coverage, and the funding of the reforms include an assessment on employers that do not offer insurance.

[2] Uninsured means: (1) you have insurance which only covers hospital care OR doctor's visits (but not both); (2) you have not had private insurance for the past 12 months; (3) you had private insurance but lost it because you lost your job or your hours were reduced; got divorced; have or are finishing COBRA coverage; had insurance through someone else who died; are no longer a dependent on your parent's insurance; or graduated, took a leave of absence, or finished college or university and got your insurance through school; (4) you had VHAP or Medicaid but became ineligible for those programs; (5) you have been enrolled for at least 6 months in an individual health insurance plan with an annual deductible of $10,000 or more for single coverage or $20,000 or more for two-person or family coverage; or (6) you lost health insurance as a result of domestic violence.

The ESI Premium Assistance Program also makes health coverage more affordable for uninsured Vermonters who have incomes under 300 percent FPL and have access to approved employer-sponsored coverage.[3] If cost-effective for the State, adults currently enrolled in the Medicaid VHAP program and new VHAP applicants who have access to an approved employer-sponsored insurance (ESI) plan are required to enroll in their employer-sponsored plan as a condition of continued coverage under VHAP. The premium assistance program provides a subsidy of premiums or cost-sharing amounts based on the household income of the eligible individual to ensure that the individual's out-of-pocket obligations for premiums and cost-sharing amounts are substantially equivalent to or less than the annual premium and cost-sharing obligations under VHAP (ranging from $7 to $49 per month). In addition, supplemental benefits or "wrap-around" coverage is offered to ensure VHAP-eligible enrollees continue to receive the full scope of benefits available under VHAP.

Catamount Health Premium assistance applicants who have access to an approved employer-sponsored insurance (ESI) plan are required to enroll in their employer-sponsored plan as a condition of receiving premium assistance. Their cost sharing for their employer's plan is identical to those enrolled in the Catamount Health Premium Assistance program.

As of the end of March 2009, over 1,450 Vermonters were receiving premium assistance from the State to enroll in their employer's plan.

Seamless Transitions.—The statutes and State regulations governing the premium assistance programs and the already existing Medicaid-related programs are designed to create an integrated system of State assistance to better assure the continuity of health care to covered beneficiaries, so that individuals who fall out of one assistance category may transition into another when financial eligibility requirements are met.

Comprehensive, Integrated Marketing and Outreach.—The State has worked with the private carriers offering Catamount Health Plans and other Vermont stakeholders to develop a comprehensive marketing strategy across all the coverage and affordability initiatives. Through a contract with a national marketing firm, the State has implemented an aggressive outreach campaign, including television, radio, Internet, and print advertising; developed a new Green Mountain Care Web site with a high level screening tool; augmented an existing toll-free help-line to inform people about and assist them to enroll in Green Mountain Care programs; and conducted trainings around the State with over 2,500 participants. The State also works with the Department of Labor to conduct outreach to employers, including targeted efforts to companies following a layoff; has implemented targeted outreach to 18–34-year-olds where they live, work and play; and has recently gotten sponsorship by a major bank to promote Green Mountain care.

Private Insurance Market Reform.—A viable non-group market (where premiums are perceived as affordable and where enrollment is stable for all demographic groups without access to employer-sponsored insurance) is an essential component of a well-functioning, all-lines health insurance market. Like many other States, the Vermont non-group market is characterized by declining enrollment, adverse selection, increasing prices, enrollment in high deductible plans, and limited carrier participation. Act 191 of 2006 directed BISHCA to establish a non-group market security trust to reduce premiums in the non-group market by a minimum of 5 percent to make non-group products more affordable for individual Vermonters. Unfortunately, limited State funds have resulted in a lack of progress to lower the costs for Vermonters enrolled in these products.

Act 191 of 2006 also directed the State to study the non-group market and make recommendations to the General Assembly to improve this option for Vermonters. While the State has contracted with a national expert to conduct studies and make recommendations for reforms to this market the complexity of this type of reform has prohibited significant changes.

Healthy Lifestyles Insurance Discounts.—Vermont is a community-rated State, and therefore costs variations within a specific insurance product are not generally allowed for different populations. However, beginning in 2006, health care reform legislation has authorized the State to adopt regulations permitting health insurers to establish premium discounts (up to 15 percent of premiums) or other economic rewards for subscribers in Vermont's community-rated non-group and small group

[3] ESI plans must be comprehensive and affordable. Affordable is defined as a maximum individual in-network deductible of $500. Comprehensive is defined as including coverage for physician care, inpatient care, outpatient, for prescription drugs, emergency room, ambulance, mental health, substance abuse, medical equipment/supplies, and maternity care. Employers do not have to contribute to the plan for it to qualify.

markets, and to allow insurers in the small and large group markets to offer split benefit design plans, which would allow a healthy lifestyle differential in cost sharing for the same premium cost. Any discounts offered through these programs must be offered in a non-discriminatory manner and may not be limited by health status. Individuals committing to improve health through healthier lifestyle choices must be offered the discount. It is hoped that these new options will provide an incentive for choosing healthier lifestyles, help make insurance more affordable for individuals and businesses, improve the health of Vermonters enrolled in these plans, and thereby affect the overall growth in our health care costs in the long run.

Possible Individual Insurance Mandate.—In 2006, Vermont made a conscious decision to not require an individual mandate such as the Massachusetts approach. However, Act 191 of 2006 does require that if less than 96 percent of Vermont's population is insured by 2010, the legislature must "determine the needed analysis and criteria for implementing a health insurance requirement by January 1, 2011 . . . including methods of enforcement, providing proof of insurance to individuals, and any other criteria necessary for the requirement to be effective in achieving universal health care coverage." Actuaries for the Vermont Department of Banking Insurance and Health Care Administration have opined that an individual mandate can be an effective way of addressing adverse selection and pre-existing condition coverage challenges. However, learning from Massachusetts, it is clear that an individual mandate requires significant State investments to make affordable coverage available so residents can meet the mandate. Given the current economic environment, an individual mandate does not seem fiscally feasible for Vermont in the near future.

FINANCING FOR VERMONT'S COVERAGE REFORMS

Funding for the programs within Vermont's Health Care Reform is based on the principle that everybody is covered and everybody pays.

Catamount Health Fund.—Vermont's health care reform established a new fund in Fiscal Year 2007 primarily as a source of funding for the Catamount Health and ESI premium assistance programs. Sources of revenue include 17.5 percent of the new cigarette taxes (see below), the Employers' Health Care Premium Contribution (see below), Catamount Health premium assistance amounts paid by individuals to the State, and other revenues established by the General Assembly.

Increases In Tobacco Product Taxes.—The health care reform legislation included a $.60 per pack increase in the cigarette tax beginning July 1, 2006 and an additional $.20 per pack increase beginning July 1, 2008; a new tax on "little cigars" and roll-your-own tobacco as cigarettes; and changed the method of taxing moist snuff to a per-ounce basis and increases tax on July 1, 2008 by 17 cents.

Employers' Health Care Contribution Fund.—Act 191 of 2006 established an Employer Health Care Contribution Fund to contribute to the Catamount Fund.[4] Employers pay an assessment based on their number of "uncovered" employees, using the following guidelines:

- Employers without a plan that pays some part of the cost of health insurance of its workers must pay the health care assessment on all their employees.
- Employers who offer health insurance coverage must pay the assessment on workers who are ineligible to participate in the health care plan (unless the plan is offered to all full-time employees, and the employee is a seasonal or part-time worker with coverage elsewhere), and on workers who refuse the employer's health care coverage and do not have coverage from some other source.

The assessment is based on full-time equivalents at the rate of $91.25 per quarter ($365 per year), exempting eight FTEs in fiscal years 2007 and 2008, six FTEs in 2009, and four FTEs in and after 2010. The assessment rate increases annually indexed to Catamount Health Plan premium growth.

Medicaid Global Commitment to Health 1115 Demonstration Waiver.—In 2005, Vermont entered into a new 5-year comprehensive 1115 Federal Medicaid demonstration waiver designed to: (1) provide the State with financial and programmatic flexibility to help Vermont maintain its broad public health care coverage and provide more effective services; (2) continue to lead the Nation in exploring new ways to reduce the number of uninsured citizens; and (3) foster innovation in health care by focusing on health care outcomes. The Waiver program consolidates funding for all of the State's Medicaid programs, except for the new Choices for Care (long-term care) waiver and several small programs (SCHIP and DSH payments for hospitals). It also converts the State's Medicaid organization to a public Managed Care Organization (MCO). Under this new waiver, the MCO can invest

[4] More information can be found at: *www.labor.vermont.gov/Default.aspx?tabid=1164*.

in health services that typically would not be covered in our Medicaid program, and Vermont's Medicaid program has programmatic flexibility to implement creative programs and reimbursement mechanisms to help curb our health care costs.

In 2007, the State requested an amendment from CMS to include Catamount Health and the employer-sponsored insurance premium assistance programs under the financial umbrella of this waiver. However, CMS only approved use of Medicaid funds up to 200 percent of FPL. The Governor and the Legislature agreed to use State General Fund to subsidize the premium assistance for individual within the 200 percent to 300 percent FPL range, recognizing that many of these individuals cannot afford to purchase full cost insurance on their own.

State Fiscal Obligations Protected.—The health care reform legislation enables the State Emergency Board to establish caps on enrollment in the Premium Assistance Programs if sufficient funds are not available to sustain the programs. This has not been employed to date.

KEY LESSONS LEARNED AND HOW THEY INFORM NATIONAL COVERAGE REFORM

Plan Affordability.—Access to affordable health care plans is key to universal coverage. This is very evident in Vermont's reforms, as only 15 percent of the people who have enrolled in the new Catamount Health Plans have bought the plans at full cost ($393 per month for an individual). The remaining have enrolled with premium assistance, and 75 percent of those are individuals below 200 percent FPL who only pay $60 per month.

Any national coverage option must be made affordable to people in all income ranges, without compromising the comprehensiveness of benefits and without further shifting costs of care to the private sector or providers. Vermont tried to achieve this in the Catamount Plans by requiring the providers be reimbursed at Medicare rates plus 10 percent rather then the estimated 130 percent currently paid by private insurers. This would not be an option for a national plan, as providers could not absorb such a massive shift in their payer mix. Therefore, options for a federally offered plan must provide premium assistance based on income and have mechanisms such as a risk-pool to cover the costs for the most high needs beneficiaries. These provisions will have significant costs that cannot be absorbed by the States.

Collaboration.—Vermont's progress on health care reform has not come easily. Choosing a public-private partnership model for expanding coverage requires close collaboration amongst insurers, providers and government. Non-profit agencies have also contributed time and money to the effort to achieve universal access. At times, this degree of collaboration may seem duplicative, but is essential to success in the absence of an individual mandate.

Flexibility.—Even in a small State like Vermont it is clear that one-size-doesn't-fit-all. What works well in Burlington with its academic medical center may be very different than what will work in a rural community in the Northeast Kingdom. Reform efforts must allow for such grassroots change, building on existing local successes. The dictum of *primum non nocere* applies to reform as well as it does to health care itself.

VERMONT ELEMENTS THAT ARE CRITICAL TO NATIONAL REFORM

Benefit Design.—As previously mentioned, Vermont's Catamount Health plans offer very comprehensive coverage and low out-of-pocket costs. Vermont believes that providing comprehensive, affordable coverage with an emphasis on primary and preventive care, is key to successful reforms of our health care system. Coverage with high deductibles, high cost-sharing and/or minimal coverage does not promote accessing early and preventive care, which in turn, will not achieve the long-term goal of decreasing our system's health care costs. Vermont also believes that ensuring community rating and guaranteed issue is paramount for ensuring that all eligible people can access the coverage they need at an affordable and fair price.

Crowd-Out Protections.—Vermont's reforms included several mechanisms that were designed to support the existing employer-sponsored insurance system, through which 56 percent of Vermonters get their primary health care coverage. Catamount Health Plans and the premium assistance programs require that individuals must be uninsured for 12 months before becoming eligible (with exceptions due to life-changing events). In addition, Vermont provides premium assistance for people to enroll in their employer's plan (if it is affordable and comprehensive). Finally, employers who do not offer coverage to their employees must pay into the Employer Health Care Contribution Fund to help support the State-sponsored programs. As such, over the past 3 years, Vermont has not seen a large drop in the number of insured Vermonters who have employer-sponsored insurance even in

times of economic downturn (decrease of only .5 percent). Any national reform efforts built on the employer-based health care system will need to include similar provisions that protect from its erosion.

Connector Mechanisms and Insurance Regulation.—Vermont did not use the Massachusetts Connector approach, but instead developed a unified marketing and enrollment process between State government and the private insurers offering the new Catamount Plan. While national reforms that involve a coverage mandate or new Federal coverage options may necessitate formal mechanisms to connect individuals with their coverage options, Federal legislation should allow for program design and implementation at the State level. Most States have specific rules and regulations in place to regulate coverage and provide consumer protections based on State values, such as community rating and guaranteed issue provisions enacted in Vermont. Unless the national reform includes standards that adhere to this level of access, a national connector will not meet States' needs.

Establishing a national floor with flexibility for a State-based approach would allow States to preserve consumer protections valued by their citizens and implement innovative strategies to contain costs while improving access and quality. States would also greatly benefit from the creation of multi-state pooling of risk (information only exchanges are not as useful), as long as minimum standards are applicable. Benefit plans should be comprehensive in services covered including mental health parity; should be subject to State consumer appeals and remedies; and should be subject to State system reform initiatives such as chronic care management and treatment standards. Utilized in this way, national standards establishing a floor may be an effective way to establish minimum coverage requirements while maintaining State-based regulation and preventing a set-back for State reform efforts already underway.

System Delivery Reform.—Although not the specific focus of this Roundtable, strong evidence is emerging that coverage expansions will not be successful if there are not simultaneous and significant efforts to reform the care delivery system. Lack of access to primary care physicians is a major concern as many existing physicians are reaching retirement age and fewer medical school graduates are going into this field. Better support (such as multi-payer payment reforms, electronic information systems, and additional care condition staff) must be provided to primary care providers to enable them to deliver evidence-based preventive care and to attend to patients with chronic conditions. Incentives to attract and retain primary care providers and other needed allied health care providers should include educational scholarships, loan forgiveness and reformed payment systems. Additional improvements in administrative systems such as common formularies, pre-authorization requirements, and common claims systems would help to secure a primary care base and necessary access for patients. These supports may also help turn the tide on waning interest in this type of practice. Vermont has put significant efforts into transforming its care delivery system though the Blueprint for Health multi-payer integrated medical home and community care team projects, along with the development of a statewide health information exchange. National emphasis on these types of initiatives will be key to controlling the cost of health care in the long-run and making coverage both affordable and accessible.

MOST DIFFICULT ASPECTS OF VERMONT'S COVERAGE REFORMS AND EFFORTS TO ADDRESS THEM

Balancing Fiscal Resources.—Even though Vermont currently offers premium assistance for people up to 300 percent FPL, it has done so without full Federal assistance that was initially expected when the reforms were designed. As noted above, Vermont requested an amendment from CMS to include Catamount Health and the employer-sponsored insurance premium assistance programs under the financial umbrella of its 1115 demonstration waiver, which operates under a negotiated cap for total State and Federal expenditures. However, CMS only approved use of Medicaid funds up to 200 percent of FPL, necessitating that State funds be used over the past 2 years to support premium assistance programs between 200 and 300 percent FPL. This has been a significant drain on State resources, and as the economy continues to decline, this may put the program in jeopardy. In order to help reforms succeed, the Federal Government must support States that believe they can fiscally support expansions under already existing Federal spending agreements.

Vermont, like other States, is facing large budget deficits over the next few years, even after factoring in the assistance provided in the American Recovery and Reinvestment Act. Just this past Friday, Vermont's revenues were down-graded another 1.3 percent for this State fiscal year ending on June 30, and by 4.1 percent for State fiscal year 2010. This is the third revenue downgrade in the past 6 months. As such,

Vermont is now experiencing significant pressures on its budget to support the already existing Medicaid programs.

Medicare.—The fiscal resource dilemma faced by Vermont and other States is compounded by the fact that State Medicaid programs are being required to cover growing percentages of the costs for long-term care and people who are dual-eligibles for Medicaid and Medicare. These budgetary pressures are putting our coverage initiatives at risk, thereby possibly undermining our successes to date and into the future. Any new requirements within national reform for Medicaid expansions and/or mandated coverages will need full Federal financial support, and Federal payment changes for Medicare must be a part of the fiscal plan.

The fact that Medicare is an isolated federally administered program that often has conflicting payment structures and benefit design elements with Medicaid also impedes States' ability to deliver coordinated and effective care for its citizens who have dual coverages. In addition, the lack of State-level flexibility to integrate Medicare with State reforms significantly impedes reform efforts. While Federal policymakers have rightly focused on how Medicare can drive change in the health care system, valuable partnerships can be formed between Medicare and States that have already been leading the way in reform. However, this requires the Federal Government transform the Medicare program to permit such collaboration and partnerships with States. One possible solution would be to allow CMS to establish a system where State-led reform efforts could be considered outside of the current Medicare demonstration project methodology (e.g., CMS set up a review panel to consider State-led proposals *as they are developed*). This approach is well established in other Federal agencies, such as the National Institutes for Health.

Complexity of Medicaid Rules.—Vermont has tried to develop a seamless system of State-sponsored coverage options. However, the complexity of Medicaid rules and eligibility categories has made this extremely difficult to design and administer. Medicaid rule simplification and the latitude to better align eligibility categories and rules across programs (e.g., food stamps) would be extremely helpful.

Old Eligibility and IT Systems.—Many States, including Vermont, are relying on antiquated eligibility systems that are difficult to program and make it hard to access data and reports for guiding policy and budgetary decisions. Vermont's eligibility determination system was put in place in 1983. There has been recognition for a number of years that system replacement is important; however, this requires considerable State fiscal investments which have been prioritized for beneficiary coverage instead. As such, it has taken significant staff and fiscal resources to implement all of the eligibility changes created with the addition of the Catamount and ESI premium assistance programs. In addition, in some cases new policies that would benefit beneficiaries or create fiscal savings have not been implemented due to eligibility system capacities. The American Recovery and Reinvestment Act contains significant funds for health information technology, but these funds cannot be used to assist States to replace their eligibility systems. Since these systems will be key to any new coverage expansions, this decision should be revisited at the national level.

ERISA.—The Employee Retirement Income Security Act (ERISA) has been a problem for Vermont's reform efforts in several ways. For example, the inability to gather data on self-insured benefit plans limits targeted outreach to uninsureds and the ability to monitor employer-based benefit changes over time. In addition, Vermont has had to work around the fact that self-insured employers do not have to be at the table for State reforms, whether focused on health care quality, cost containment, or improving access. The ERISA also poses implementation dilemmas for ESI premium assistance programs. A possible Federal solution would be to write an exemption to allow States to apply for a waiver of ERISA pre-emption, provided the State reform effort is aimed at reducing the uninsured or achieving other federally approved policy goals.

CONCLUSION

A key to Vermont's health reform has been the inclusion of all stakeholders all the time—in development, design and implementation. As we move forward with national reform, individuals, providers, the private sector and government—at the State and Federal levels—must work collaboratively to realize our shared goals of improving access and quality and containing costs.

Many States have taken the lead and have implemented incremental and comprehensive reforms that can and should inform national health care reform, but these State reforms also should not be dismantled in the process. There are a range of issues where State variability matters, especially given the unique conditions of

State and local insurance markets, different perspectives on health care services, and options for creating effective health care delivery systems.

States strongly support services that provide for the health and well-being of their citizens. While there is a very important role for the Federal Government in paying for and shaping the type of health coverage available, overly proscriptive requirements will impede States' ability to design programs, benefit packages, and coordinate services in a way that meets the needs of our citizens.

In conclusion, we want to express our appreciation for the leadership by your committee to move forward on the national agenda for health care reform. We in Vermont believe it is essential to the overall physical and fiscal health of our State and our Nation, and we look forward to partnering with you in this crucial and exciting endeavor.

Senator BINGAMAN. Thank you very much.

Dr. Chen.

STATEMENT OF HARRY CHEN, M.D., EMERGENCY ROOM PHYSICIAN AND BOARD OF VERMONT PROGRAM FOR QUALITY IN HEALTH CARE, BURLINGTON, VT

Dr. CHEN. Thank you, Senator Bingaman and other Senators and Senator Sanders.

As a practicing emergency physician, I can speak directly to the human toll of being uninsured. All of these are all of the more compelling when they look you right in the eyes.

I've been privileged for the past 4 years to play a role in shaping healthcare reform in Vermont, and I'm proud of our results of some of the lowest uninsured rates in the Nation. Again, we discussed arduously the mandate and came up with our answer of not to do the mandate in Vermont, but I certainly could understand how it helped Massachusetts.

We haven't reached our goal, but we're hopeful that we'll get there. Coverage initiatives as a part of healthcare reform must be comprehensive. A high-deductible plan is not healthcare reform, it's asset protection, and it's important—for our goal—to get the right care to the right person, at the right time.

Coverage initiatives must be a part of comprehensive healthcare reform, that simultaneously address quality, efficiency and cost. We won't succeed without an adequate workforce, without more emphasis on prevention, delivery system reform, and payment reform. Affordability is the problem that can unravel our efforts at real healthcare reform.

As you move forward, please be careful that your efforts don't undermine what we've done in the States. It's clear from Vermont's efforts that one-size-does-not-fit-all, and I would encourage the committee—as I do in my practice of medicine—to first, do no harm.

I'm sure this committee will wrestle with some of the same issues that we did in Vermont in terms of the individual mandate. We opted not to have a mandate, but with the proviso that we could go back to it at a later time. We also wrestled with the issue of public or private, and in Vermont we—as you might expect—in politics, came up with what was possible, which was a mixture of both.

In closing, I'm delighted that this committee is taking on this important issue. I'm sure that most of us in this room consider universal access to healthcare a moral imperative. I'm proud of our

progress in Vermont, and hope our experiences can help inform other States in this committee, as we move forward.

Thank you.

Senator BINGAMAN. Thank you very much.

Representative Clark, I mistakenly tried to demote you to the job of Majority Leader, I understand you're the Speaker.

We are very glad to have you here. Please, go right ahead.

STATEMENT OF THE HON. DAVID CLARK, SPEAKER OF THE UTAH HOUSE OF REPRESENTATIVE, SALT LAKE CITY, UT

Speaker CLARK. Thank you very much, I appreciate the opportunity to be here, and especially want to extend a thanks to Senator Kennedy, and to you, Senator Bingaman, for the invitation to testify on a number of issues that are related to health system reform.

It's interesting to note that if two States as widely differing culturally, politically, and systemic backgrounds as Utah and Massachusetts can pursue similar reforms, then other States can do the same, provided they're given the ability and the tools necessary to make those adjustments, and the adaptations to the same basic model that fits each one of their own States' unique circumstances.

As we proceed to developing a national health system policy, we would propose that the best way for the Federal Government to be involved is to respect the starting points of each individual State—their distinct systems, their institutions, their values, their attitudes—by allowing significant flexibility to implement reforms and systemic changes consistent with all of our own local circumstances.

I appreciate the recognition of looking at what's going on in the States, or we wouldn't have the invitation to be here today, but I would like to challenge the Federal Government that they should take no action that should further reduce the ability of States to develop creative solutions by reducing healthcare spending, and expanding coverage. The willingness of States to experiment should be encouraged, and their ability enhanced by allowing reasonable exemptions, or waivers, from some of the Federal laws and regulations that constrain innovations right now on the State level.

Our reform efforts have included several elements, such as creating affordable plans, developing data transparency, creation of private marketplace, or an exchange, and also look to creating incentives that will enhance consumerism and enable the private market to come up with solutions. We suggest that a similar focus on market-oriented solutions is the basis for any action that should be taken on the Federal level.

In the State of Utah, we feel confident that the invisible hand of the marketplace, rather than the heavy hand of government, is the effective means whereby reforms should take place.

Thank you.

[The prepared statement of Speaker Clark follows:]

PREPARED STATEMENT OF THE HON. DAVID CLARK

My name is David Clark and I am Speaker of the Utah House of Representatives. Senator Kennedy and Senator Bingaman, thank you for inviting me to testify before you today on a number of issues related to State health system reform.

Utah is arguably the healthiest State in the union and is often recognized as having the most efficient health care delivery system. Not coincidentally, Utah also enjoys the lowest per-capita health spending in the Nation.[1] However, in spite of our enviable circumstances, Utah State officials recognized the dysfunction of our health system and, in 2005, began serious efforts aimed at reform. Lawmakers in both parties agreed that the status quo was unacceptable and that the current system, characterized by misplaced competition and misaligned incentives, could no longer be tolerated and should be replaced by one characterized by efficiency and value.

In 2008 and 2009, the Utah State Legislature passed landmark legislation setting into motion dramatic changes in the health system. The legislative Health System Reform Task Force met numerous times in 2008 and relied heavily on input and ideas from a broad base of Utah stakeholders, including health care providers, insurers, businesses, and community members. Through a process involving extensive research, public input, and consensus building, the Task Force advanced a number of measures representing critical steps in moving our health system reform efforts forward.

Utah's reform efforts have been and will continue to be designed to address our State's unique circumstances; however, there are certainly elements of our approach that may be broadly applied.

For instance, Utah and Massachusetts both pursued consumer focused health reforms, albeit in different fashion and with a different priority order for the common components. Both States also achieved a broad, bipartisan consensus supporting the basic reform elements. Dissimilarly, however, Utah began by implementing private market reforms first—creating a defined contribution health insurance option for employers and their workers, with public sector reforms likely to follow. Massachusetts, on the other hand, acted first on the public sector reform piece, shifting tax dollars from paying hospitals for treating the uninsured to buying insurance coverage for the low-income uninsured, and is now rolling out private insurance market reforms.

If two States with such widely differing cultural, political, and systemic backgrounds as Utah and Massachusetts can pursue similar reforms, then other States can do the same, provided they are given the ability and the tools necessary to make adjustments and adaptations to the same basic model in order to accommodate unique circumstances. As we proceed in developing a national health reform policy, we would propose that the best way for the Federal Government to be involved is to respect the starting points of individual States—their distinct systems, institutions, values, and attitudes—by allowing significant flexibility to implement reforms and systemic changes consistent with local circumstances.

A key lesson in our experience was the importance of cultivating awareness and understanding of the issues at hand. State officials engaged in a multi-year process of discussion and education among lawmakers and stakeholders leading up to enactment of reform. That process resulted in near unanimous approval of the reform legislation in both houses of the Utah State Legislature. An up-front investment in education and consensus building is essential to achieving truly transformative health system changes. While that requires more time and effort, the results are more satisfactory than the alternatives of simply trying to carve out a niche with special rules for some favored product, or patch or expand the current, sub-optimal system.

Effective communication with stakeholders is essential. In Utah, we made it clear at the onset that the status quo simply wouldn't do and that we were committed to enacting meaningful reform. "Real change requires real change" was our clarion call. We also made a decisive effort to clearly define our expectations to stakeholders, making them aware that our vision of reform would require serious engagement and an element of sacrifice by all involved. We encouraged providers, insurers, business leaders, and members of the community to be innovative, and even courageous, in thinking about health system reform. Early and often, my message to stakeholders was, "I don't want to hear 'No, because . . .' I want to hear, 'Yes, if . . .'"

While all of the Utah reform provisions (see Appendix for detailed list) are critical, perhaps the two with the most immediate impact on the health system is the establishment of a new defined contribution market for health insurance and the creation of the Utah Health Exchange. A defined contribution approach to health insurance puts the consumer directly in control of their health benefit, while preserving all of the Federal tax advantages that are currently only available through an employer-sponsored arrangement. This approach is analogous to the movement from a

[1] This and other comparative state-level data may be found at *http://www.statehealthfacts.org/*.

defined benefit pension program for retirement to employer's defined contributions to an employee's retirement through contributions to a 401(k) or similar retirement account.

Instead of promising or providing a certain level of health benefit, the employer provides a pre-determined level of funding that the employee then controls and uses to purchase their choice of health insurance. The advantage to the employer is that in this simplified system, their only decision is how much to contribute toward the employee's health benefit each year. They are no longer responsible for choosing the benefit structure, insurance company, or provider network. However, the employer is still required to have 75 percent employee participation in the defined contribution market. This feature is designed to encourage appropriate funding of the employees' benefit plan. Both the choice and the accountability are moved from the employer side of the equation to the employee.

Employees benefit because they now can choose the health benefit that meets their needs, adding additional funding of their own if they so desire. This could have a major impact on the health care system. As consumers are given the opportunity to engage in informed choices, competition will increase. Health plans will have to respond directly to consumer needs and demands. Ultimately, having consumers more engaged in the process will lead to more efficient health care and better health.

The Utah Health Exchange is another critical component. In order for a defined contribution system to function efficiently, consumers need a single shopping point where they can evaluate their options and execute an informed purchasing decision. For a consumer-based market to succeed, individuals must have access to reliable information to allow consumers to make side-by-side comparisons of their options.

The Utah Health Exchange is an internet-based information portal with three core functions: (1) provide consumers with helpful information about their health care and health care financing, (2) provide a mechanism for consumers to compare and choose a health insurance policy that meets their needs, and (3) provide a standardized electronic application and enrollment system. In addition, a feature completely unique to the Utah Health Exchange will allow for premium aggregation from multiple sources (for example, premiums from multiple employers for an individual, from multiple employers for different family members, or from State premium assistance programs) for a single policy.

In addition to these two key operational features, a critical component of the Utah approach was the underlying reliance on market-based principles. We feel confident that the invisible hand of the marketplace, rather than the heavy hand of government, is the most effective means whereby reform may take place. The State must be involved in shaping reform, but the government's role should be limited to simply facilitating the necessary changes.

Perhaps the most difficult aspect of our reform efforts involved overcoming Federal regulatory barriers including the Employee Retirement Income Security Act of 1974 (ERISA), the Consolidated Omnibus Budget Reconciliation Act (COBRA) and the Health Insurance Portability and Accountability Act (HIPAA). These Federal regulations seriously limit the scope of the market affected by State reforms. Moreover, States are unable to aggressively pursue a number of programs, such as many of those involving wellness initiatives or personal responsibility elements. This issue might be largely overcome if States were granted broad authority to initiate demonstration projects determined to promote the intended objectives of the Federal statute.

This concludes my prepared remarks. I will be glad to answer any questions you may have. Thank you.

APPENDIX.—UTAH'S APPROACH TO HEALTH SYSTEM REFORM

2008 LEGISLATION

The 2008 legislative session was the proving ground for the innovation and determination of State leaders in reforming our health system. Their efforts resulted in a number of measures that established a foundation for health system reform in several ways.

- **Provider Transparency.**—The All Payer Database (APD) was created to provide statewide quality and cost measures for episodes of care.
- **Patient Transparency.**—The Utah Department of Health was authorized to adopt standards for the electronic exchange of medical records by the creation of the Clinical Health Information Exchange (CHIE).

• **Internet Portal.**—Legislation created the Office of Consumer Health Services (OCHS) to be housed under the control of the Governor's Office of Economic Development. This office was charged with the task of creating an Internet portal that promotes a consumer-oriented health care system by making information available to consumers, allowing them to make more informed decisions.

• **CHIP open enrollment and outreach.**—Legislation ensured that Utah's Children's Health Insurance Program (CHIP) will cover all eligible children who apply. It also required the State departments of Education, Health and Workforce Services to promote enrollment of eligible children in CHIP and Medicaid.

• **State Tax Credit.**—The legislation established a nonrefundable State income tax credit of up to 5 percent for individuals paying for health insurance with post-tax dollars.

• **Waiver Amendments.**—Required State programs to work with the U.S. Department of Health and Human Services to help more people get insurance through private programs and to make public programs and subsidies available to more people in difficult circumstances.

• **Legislative Task Force.**—Legislation also provided for an 11-member Task Force to study health system reform. Members of the Task Force formed five working groups representing various stakeholders who dedicated immeasurable time and effort discussing and exploring reform options and strategies.

2009 LEGISLATION

Through a process of extensive research, public input, and consensus building, the Task Force advanced four bills in the 2009 session. These bills represent critical steps in moving Utah's Health System Reform forward. Among the many ambitious and bold accomplishments in these bills:

H.B. 188: Representative David Clark, House Speaker; Sponsor, Health System Reform—Insurance Market

• **Creation of a Defined Contribution Market.**—This legislation increases the availability of consumer information, choice, and power in the health insurance market. The defined contribution system will be operational for the small group market by January 1, 2010. In this market, employees will be able to choose any plan in the market on a guaranteed issue basis using pre-tax dollars. Rating and underwriting in this market will be based only on the employee's age and their employer's group risk factor. The newly established Risk Adjuster Board will guide technical issues related to keeping the market vibrant and functional. Furthermore, the defined contribution system allows individuals and families to aggregate premium payments from multiple employer or government sources.

• **Expanding the Role of the Internet Portal.**—This bill clarifies and expands the role of the Internet portal in making information available to consumers to make informed decisions in the small group and individual markets, as well as the new defined contribution market. The Internet portal will be a one-stop information, shopping and comparison tool for health care consumers. The portal will provide the technology backbone where the defined contribution market can operate.

• **Enhanced Transparency.**—While several efforts to enhance transparency were initiated by the 2008 legislation, this bill contains several additional provisions to increase the transparency of the marketplace and to allow consumers improved access to information so they can make better choices. The bill also requires insurance producers to disclose commissions and compensation to their clients.

• **Lower Cost Products.**—The bill creates new, lower cost alternatives in several markets. The bill establishes the new lower cost NetCare health benefit plan, allowing the exclusion of certain State-mandated benefits. NetCare will be available as an alternative to employees in the Utah mini-COBRA, COBRA, and conversion markets. This bill also establishes a new product that blends PPO and HMO products and eliminates some of the mandates related to insurer networks.

• **Task Force Re-authorization.**—This bill reauthorized the Health System Reform Task Force for an additional year and further required stakeholders to continue efforts for State health system reform.

H.B. 331: Representative James A. Dunnigan; Sponsor, Health Reform—Health Insurance Coverage In State Contracts

• **Level Playing Field for Contractors.**—Contractors bidding for State projects will no longer be advantaged if they do not provide health insurance for their employees. This legislation establishes a requirement that companies contracting with the State for projects exceeding a specified dollar amount provide a basic level of health insurance for their employees. The legislation establishes enforcement and

penalties for a contractor who does not maintain an offer of qualified health insurance coverage for employees during the duration of the contract.

H.B. 165: Representative Merlynn T. Newbold; Sponsor, Health Reform—Administrative Simplification

• **Administrative Simplification.**—This bill requires providers and insurers to work together to simplify the billing, coordination of benefits, prior authorization, notification, and eligibility determination processes. This bill also moves the State toward card swipe technology for insurance cards so that a health care provider and patient can determine eligibility and what insurance requirements must be met for services such as deductibles, copayments and insurance status in real time.

• **Demonstration Projects.**—The legislation starts the process for health care payment and delivery reform to realign incentives in the health care system. The bill creates a systemwide, broad-based demonstration project involving health care payers and health care providers for innovating the payment and delivery of health care in the State.

S.B. 79: Senator Peter C. Knudson; Sponsor, Health System Reform—Medical Malpractice Amendments

• **Tort Reform.**—This legislation addresses the unique circumstances of receiving health care in an emergency room where health care providers are required, under Federal law, to treat any person who comes into an emergency room. Most times, emergency room physicians must treat with no knowledge of the patient and sometimes with an inability to communicate with a patient to determine past medical history. The legislation establishes a standard of proof for emergency room care in medical malpractice actions based on clear and convincing evidence.

Senator BINGAMAN. Thank you very much.

Mr. James, go right ahead.

STATEMENT OF BRENT JAMES, M.D., M.STAT., EXECUTIVE DIRECTOR, IHC INSTITUTE FOR HEALTH CARE DELIVERY RESEARCH, INTERMOUNTAIN HEALTH CARE, INC., SALT LAKE CITY, UT

Dr. JAMES. Thank you.

I first need to apologize, Senator Bingaman, Senator Kennedy. I run a big training program that teaches clinical quality to physicians and nurses—I have about 45 senior physicians and executives sitting in my classroom in Salt Lake right now, so this, for me, is a day trip. I have to hit the 4:30 flight to be home, I'm on the spot tomorrow, so I'm going to quietly slip out of here in a few minutes, I hope.

Senator Kennedy, I have to mention that quite a number of those folks are from Massachusetts General Hospital and Brigham and Women's at the moment, so we're having a delightful discussion in my old home State, some years ago. Saturday I'll be there to deliver a keynote at a lecture on electronic medical records to maintain my faculty appointment at Harvard School of Public Health.

The CHAIRMAN. Badly needed.

Dr. JAMES. It's essential, to say the least. It's good to be going home, at least for a visit.

The CHAIRMAN. Good.

Dr. JAMES. Short version, the key to universal access is controlling the rate of increasing healthcare costs. The key to controlling healthcare costs is something called utilization rates. It's not how much we pay per unit, it's the number of units.

We've just completed a study that will soon appear in a major journal, where we estimated that, approaching 50 percent of all healthcare expenditures in the United States, they are technically

waste, using a quality model. That's almost 50 percent of a $2.4 trillion budget. I think that's where the real solution to this lies.

Senator BINGAMAN. Could you just pull the microphone a little closer?

Dr. JAMES. There we go.

Senator BINGAMAN. That helps.

Dr. JAMES. Is that better?

Senator BINGAMAN. Thank you, yes.

Dr. JAMES. Yes, about 50 percent, we estimated, using a rigorous model that leads directly to action of current healthcare expenditures are waste from a patient's perspective, nonvalue adding, and represents a huge opportunity.

We think one of the ways to approach that, which we're starting to experiment with in support of Representative Clark's initiatives is bundled payment through accountable care organizations. Quality measurement and accountability are essential parts of that, we know an awful lot about that today, know how to do it, and there are a series of well-established principles by which we could build effective quality measurements in the country; we're not following them very well today.

[The prepared statement of Dr. James follows:]

PREPARED STATEMENT OF BRENT C. JAMES, M.D., M.STAT.

Mr. Chairman, thank you very much for the opportunity to share some of our experience as we have studied, then attempted, health reform within the State of Utah. I join the Honorable David Clark, Speaker of Utah House of Representatives, in this hearing. Speaker Clark has very ably led a joint Utah Senate-House task force studying health care delivery reform for the last 2 years. The task force report anticipates a coordinated series of legislative initiatives, that will roll out over the next several years. The first installment of that legislation was passed and signed into law earlier this year.

Speaker Clark is obviously better positioned to describe the task force, the results of its investigations, and the resulting Utah State health reform legislative agenda than am I. I therefore plan to focus my remarks on the implementation of health care reform within the State of Utah. I am the Chief Quality Officer at Intermountain Healthcare. Intermountain is a not-for-profit system of 23 hospitals, almost 120 outpatient clinics, and a health insurance plan. We supply more than half of all care delivered within the State of Utah. The short version of our mission statement is "the best medical result at the lowest necessary cost." We provide that care to all people in our service area, regardless of insurance status. As a result, we are the source of much of the charitable care currently delivered in the State. We have been identified by external evaluators as one of the highest quality, most efficient care delivery organizations in the United States—or, for that matter, in the world. For example, the Dartmouth Atlas has asserted that if the rest of the country delivered the same care that is found within Intermountain, national Medicare costs would fall by more than 30 percent while clinical outcomes would significantly improve.

The key to health reform is payment reform. We believe that the evidence clearly shows that efforts to extend health insurance to all citizens, whether at a State or national level, will rapidly fail unless we are able to control the rapidly rising costs of health care delivery.

We recently completed a study, currently under review for publication, that applied quality improvement (sometimes also called process management) principles to estimate waste within current care delivery. The advantage of using a process management approach is that such quality-based waste is, by definition, actionable waste. The same tools that identify the opportunities can be used to reduce operating costs by improving patient outcomes. Our model identified five nested categories. We were able to obtain synthetic national estimates for two of those categories. The three categories for which we could not generate robust estimates, at this time, were of a size roughly comparable to the two that we could estimate. Even then, we judged that almost half of all current expenditures in health care delivery

are non-value adding from a patient's perspective. (Unfortunately, one person's waste may be another person's income.)

Our analysis distinguished between two important factors that determine health care costs. The first is "unit costs"—the actual cost of a single procedure, service, or other item used in health care delivery. The term is fractal, in the sense that it can evaluate granular items such as a single blood test, an imaging exam, a dose of a drug, an hour of acuity-adjusted nursing care, or a minute in surgery. It can also "bundle up" individual, granular, items into cases, such as a total hip arthroplasty (artificial hip joint replacement), a hospitalization for congestive heart failure, or the total cost of an outpatient visit to a specialist, with testing and imaging. The second factor is utilization—the "number of units" used to deliver care to a patient or to a defined population. Total cost is "number of units" multiplied by "cost per unit."

In the past, most governmental efforts to control the rate of growth of health care expenditures centered around unit costs alone. Typically, payment rates in government-related health care delivery programs are not negotiated with care providers. The controlling agency set payment rates, then care providers chose whether they would participate. However, such price control mechanisms do not address utilization rates—how many cases are performed, each paid at the mandated payment rate.

Our analysis addressed both unit costs and utilization rates. However, the largest opportunities for savings came through utilization rates, by better matching care delivery to patients' true needs and desires (patient-centered care).

To illustrate, over the past 3 years we have been working closely with government-run care delivery systems in western Canada. Clinical leaders of those systems report that, despite universal insurance coverage, as many as one-third of the individual citizens for whom they are responsible have difficulty in obtaining timely access to primary care physicians. The patients with the most difficulty in getting access are those who need it the most—patients with chronic disease. The root of the problem appears to be unit-based payment structure: Physicians can make more by seeing a large number of relatively healthy, simple, patients (the "worried well") than by spending the necessary time with a smaller number of complex patients. This has had a secondary effect of increasing waiting lines for already overburdened, and more expensive, specialists. The "payment per unit" was set by government policy within a province. Physicians have a strong financial incentive to increase the "number of units" (visits), but shortening the time spent per unit.

To support State-level health reform, for patients with chronic diseases we are structuring bundled payments to groups of allied primary care physicians, specialists, and hospitals. This approach relies upon coordinated care. It centers around (a) physician-led primary care clinics; (b) with embedded nurse care managers; (c) supported by evidence-based best practice protocols, built into clinical work flows; (d) tightly linked to an effective network of specialists and, when necessary, hospitals. An electronic medical record is essential. It helps implement evidence-based best practice, and greatly enhances communication among all members of the team (patients, care management nurses, primary care physicians, and specialists). A series of careful studies have shown that this structure produces very significant improvements in both patient outcomes and patient experience of care, while significantly reducing costs. Some call this approach a "medical home." (We were a little slow in coming to the catchy title, but have had such care in place, in some clinics, for more than 6 years.)

In conjunction with the Mayo Clinic, we have assessed the contributions of this coordinated practice style as compared to financial incentives to patients built into insurance plans (e.g., copayments). While both factors contributed to cheaper care, the level of practice organization dominated insurance design.

While about one-third of the physicians practicing in Intermountain's networks are employed by the system, the majority are community-based, independent physicians. This reflects a sea-change that is currently underway within the healing professions: We are moving away from a care delivery model based on a chaotic mixture of individual expert clinicians, to one that recognizes that most modern care is delivered by teams of clinicians, and that coordination among clinical teams is essential for good care. While such coordination does not require that physicians enter employment with some specific group (a common emerging model), it does require a local consolidator (sometimes called an Accountable Care Organization).

We are presently moving to bundled payment in support of coordinated care delivery. Under bundled payment, an accountable care delivery group is given a fixed annual payment for all services for patients with chronic diseases (clinic visits; testing; imaging; hospitalization; end-of-life care). The payments are risk-adjusted based upon the number, type, and level of intensity of the chronic diseases involved. This

payment structure directly addresses a major defect in current unit-based payment systems: Under current governmental payment systems, care providers are paid more when patients suffer complications (in sound byte form, "we are paid to harm our patients"). Such circumstances require more care, which means more utilization (the consumption of more units of service). For example, a care delivery group can make much more money by hospitalizing a patient who has congestive heart failure, than by managing that patient so well in an outpatient setting that hospitalization is not necessary. Under a bundled payment system, the care delivery group has strong financial incentives to prevent complications, avoid preventable procedures and hospitalizations, to reduce operating costs, and increase operating margins (sometimes called "shared savings" payment models).

Quality measurement is essential. Over the past 20 years, our ability to measure care outcomes has improved dramatically. This primarily came about by using quality improvement (process management) theory. The resulting evidence demonstrated that quality is very highly "process specific." That is, the fact that a care delivery group does well on one process (e.g., open heart surgery), does not mean that the same group will necessarily do well on any other process (e.g., management of congestive heart failure). It is now possible to (a) prioritize care delivery processes; then (b) generate measurement systems biggest to smallest, one at a time, specific to each condition. (Each of the individual measurement systems are unique—there's some, but not a lot, of overlap among them.)

A prioritized approach helps get the most benefit to the most patients, in the face of limited resources. Care delivery concentrates massively. For example, within Intermountain, 104 of about 1,400 clinical care processes accounts for about 95 percent of all the care that we deliver.

Even with major advancements in measurement, for most clinical conditions quality measurement is not sufficiently precise to accurately rank physicians, hospitals, or practice groups (references available on request). That fundamental truth has another face: It is easy to scientifically demonstrate that, for most clinicals conditions it is impossible to build an evidence-based best practice guideline that perfectly fits any patient. As a result, achieving 100 percent performance on most quality measures means that a subset of patients received substandard care. On that foundation, a set of key principles for the appropriate design of quality measurement systems has emerged:

• Methods exist that build quality measurement and accountability in ways that don't depend on ranking providers.

• Measurement systems must contain a feed-back loop (called "gauge theory" in the quality sciences). At a technical level, when quality measurement finds a performance outlier, it (precisely) means that: "If I carefully analyze this outlier, I will (with high probability) be able to find its true cause." With new data systems—even carefully constructed clinical measurement—many of the initial outliers track back to the measurement system (the gauge). This provides opportunity to "fix" the measurement system over time, and is the method by which reliable measurement systems emerge.

• Measurement must blend into clinical workflows:

(a) The things most needed for solid quality measurement and accountability tend to be those elements that front-line clinicians need to deliver good individual patient care;

(b) Embedded data tends to be much more timely and accurate (clinicians use the data, and so help produce both timeliness and accuracy);

(c) If accountability measurement is not embedded in work flow, then the measurement system will compete for resources (time and people) at the front line, potentially damaging clinical performance (quality);

(d) Embedded measures lend themselves directly to change—they lead to improvement (in other words, use of "after-the-fact" measurement not only competes for resources with care delivery, it also competes for resources with improvement).

To support State-level health reform, Intermountain is building embedded quality measures as an entry "gateway" for groups to receive bundled payment. We place thresholds at a high enough level that any participating group must put in place effective process management systems, but not so high that compliance with an external standard will damage some patients (as is clearly happening within the current CMS measures).

As a result, Intermountain's evidence-based best practice protocols, and the quality measurement systems that are part of them, are the opposite of "cook book" medicine. Under the reality of current "state-of-the-art" quality measurement, where "it is almost always impossible to generate a guideline that perfectly fits any patient," being too high (a statistical outlier) on a performance measure is just as con-

cerning as being too low on the same measure (a statistical outlier on the other side). Both require the same sort of follow-up, learning, and adjustment.

In summary, health care reform is advancing rapidly within Utah. Key lessons learned include:

- The key to universal access is controlling the rate of increase of health care costs.
- The key to controlling health care costs is managing utilization rates.
- Bundled payment for chronic disease, through Accountable Care Organizations, provides a very attractive mechanism to match utilization to patient needs, as seen by the patient.
- Quality measurement and accountability is an essential part of bundled payment.
- A series of well-established principles form the foundation for effective quality measurement.

Thank you for your time and attention.

ATTACHMENT.—PRINCIPLES FOR EFFECTIVE MEASUREMENT OF QUALITY FOR THE PURPOSES OF ACCOUNTABILITY

BACKGROUND INFORMATION

Quality measurement has improved significantly over the past three decades:

- W. Edwards Deming linked quality to underlying work processes. He suggested that every process produces three parallel classes of outcomes: quality, cost, and service. This provided a robust structure for quality measurement, in context.
- Health services researchers (Nelson, James) further broke medical quality into four major subdivisions, which greatly simplified measurement within much more consistent categories. Those four major subdivisions are:

1. appropriateness (indications),
2. complications,
3. therapeutic goals (biologic performance as seen by a health professional), and
4. patient functional status (biologic performance as seen by a patient).

- These advances have led to validated quality measures within well-defined patient populations.

Despite those advances, quality measurement still has major limitations:

- There are widespread problems with incomplete science, incomplete assessment, incomplete documentation, and incomplete data extraction from fragmented, dispersed medical records.
- "Availability bias."
- Problems with attribution (most care is delivered by teams, so clinician-to-clinician comparisons tend to fail).

Any quality measurement system itself contains variability, which can obscure underlying care delivery performance:

- There is a clear need for feedback and follow up on the data system itself, using well-established methods found in industrial quality control theory (gauge theory);
- No national groups currently employ this critical element; and
- Example of how it works: condition-specific measurement within Intermountain Healthcare.

As a result, it is currently impossible for quality measures to accurately rank providers in most circumstances:

- A very robust scientific literature supports this conclusion (will supply on request); and
- Good quality accountability therefore needs to use approaches that do not rely on ranking—effective non-ranking approaches do exist, primarily derived from quality improvement theory.

Provider quality performance is highly condition specific:

- Three decades of investigation have found no reliable general quality indicators (the fact that a provider does well or poorly on one condition does not imply that the same provider will do well or poorly on other conditions);
- However, care delivery concentrates massively. About 10 percent of clinical conditions account for over 90 percent of all care delivery; and
- Therefore, build in measures by condition, in size order, to address the most good for the most patients.

Poorly-constructed quality measurement systems often lead to "data gaming" (principle: it is easier to look good than to be good):

• There are three ways to get a better number (Deming):

1. Improve the underlying process,
2. Shift resources to the area under the measurement spotlight, at the expense of areas not under the measurement spotlight (very often, the peripheral damage outweighs the focused gain), and
3. Game the number.

• Deming: "as one attaches greater rewards or punishments to achieving a number, one gets increasing proportions of (2) and (3)";
• Extrinsic rewards tend to destroy intrinsic motivation, damaging professional oversight; and
• It is very clear that type (2) and (3) activities are becoming common among U.S. hospitals, relative to the CMS measures.

Transparency is not the same as accountability:

• High-quality care delivery usually involves a series of decisions around sequential care delivery choices;
• Patients usually make those decisions in the context of a caring relationship, with a physician or nurse advisor;
• "Transparency" means that all participants—the clinician advisors as well as the patients—have sufficiently accurate, detailed information to make wise choices at each step in the chain; and
• Accountability measures, that reduce the problem to a single patient choice of a hospital or a physician, can directly undermine the true transparency that is essential to high quality care.

There are 2 primary approaches to quality—(1) measurement for selection (accountability) versus (2) measurement for improvement:

• measurement for improvement contains measurement for selection/accountability—the opposite is not true (measures for accountability, mandated from above, do not create capacity for actual quality management and improvement at the front line);
• measurement systems designed for accountability often consume limited front-line resources and actively damage quality of care (Casalino; *NEJM*; 1999; Wachter et al.; *Ann Int Med*; 2008); and
• there are rigorous methods for generating reliable front-line, embedded data systems that minimize burden and maximize data quality (NQF SFB report). These methods stand in contrast to the political methods currently used by most national reporting groups.

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Senator BINGAMAN. OK, thank you very, very much. Thank all of you for your presentation, and let me see if Senator Kennedy—did you have?

The CHAIRMAN. I'll join in——

Senator BINGAMAN. OK. Let me ask a question or two, just to get started.

One of the issues that, obviously, we have to grapple with, and I guess each of your States has grappled with it in a different way, is this issue of whether or not to mandate coverage, or mandate

that people go out and obtain insurance if they're not covered by a plan.

Massachusetts has chosen to do that, and believes that that has been a key factor in the success that they've had. The other States have not—the other States represented here—and I guess in Vermont, Dr. Chen, you were indicating, Ms. Besio, you were indicating that this is a decision that was consciously made the other way, in Vermont.

Let me just ask those of you from Vermont to explain your decision a little more, as to why you think it wasn't the right thing to do in Vermont and what you recommend we consider doing here.

Dr. CHEN. Sure. In terms of the mandate, I was on the Conference Committee when we were negotiating the healthcare reform bill, and we really found that people—I'll use the euphemism—on the right of us and on the left of us, both of them, really, were opposed to the mandate. Some of the concern was, could we afford it, and I think, that really came down to the issue of affordability. If we had mandated, and everybody had taken advantage of it, we wouldn't have enough money. From a fiscal point of view, we couldn't implement a mandate.

Now, as we develop our products, as we work toward our goal of 96 percent insured, we put in our bill a chance, an opportunity, to re-look at that mandate. If we didn't make enough progress, that's certainly something we would consider, I believe, in this upcoming year, 2010.

Senator BINGAMAN. Have you been able to implement some of the insurance market reforms? I mean, in an earlier roundtable discussion that we had, the strong message that I picked up from some of the representatives of the insurance industry was that they would support a mandate—or they would support insurance market reforms such as prohibiting them from excluding people for preexisting conditions, requiring guaranteed coverage, or guaranteed coverage—but they would only support that if it was in the context of a mandate, where everybody had to sign up. Have you been able to implement any of these insurance market reforms? And, if so, how does that work?

Ms. BESIO. We actually have, in Vermont, guaranteed issue, and we also have community rating, meaning that we don't differentiate, in terms of the cost of products, according to age, or geographic location, or any other thing that's out of an individual's control. We have a very high standard in terms of our market, and the standards behind it.

The dilemma—in terms of affordability for the individual mandate—is that you have to provide products that are affordable for everyone. If you have a standard that we, in Vermont, believe is very important, that you want to have low out-of-pocket cost in your benefit design to encourage people to actually access care early and use that insurance in the way that it was initially designed, and not just be catastrophic coverage, then you've got a relatively expensive product, or products, that are going to be offered on the market.

The way to make those affordable are either to have a high-risk pool that helps cover those high-risk cases, or to offer premium as-

sistance. Either of those options costs money to bring down the cost of the coverage.

I think that's the dilemma, from our perspective, really around the mandate, and can we provide affordable, comprehensive coverage that people would have access to, and can we afford that?

Senator BINGAMAN. And you determined that you can not afford it?

Ms. BESIO. We can not afford it at this point in time, and in the foreseeable future, given the current state of our economy.

Senator BINGAMAN. Let me ask Mr. Kingsdale if he had any comment on this issue, this set of issues?

Mr. KINGSDALE. Just that, actually, I think that Ms. Besio articulated the issue quite well. In Massachusetts, we also had adjusted community rating, guaranteed issue, guaranteed renewal, prior to the individual mandate—I believe there are five States in the country that do. We in Massachusetts—and I believe this is true of the other four—without the mandate and some other reforms, experienced what any economist or underwriter would predict, which is, a shrinking market for—made up largely of older, sicker people—buying a product that nobody who wasn't pretty sure they were going to use a lot of it would buy voluntarily on their own part.

The thing about the individual mandate is—definitely expensive, because you're trying to get everybody insured, and that's expensive. You have to subsidize people of lower income.

It does create what an underwriter or an actuary would call a statewide credible risk pool. It brings in the young invincibles and others, so that actually the premium rate for the cost of coverage for people who were previously buying nongroup insurance actually fell as a result of reform, and as a result, we have a lot more product, we have more than doubled the size of our non-group market in just the first year of reform.

It's expensive, I think you've described the challenge very, very aptly, but that's the challenge of getting universal coverage.

Senator BINGAMAN. Senator Kennedy, did you want to ask a question? Or Senator Enzi? What's your preference? Senator Enzi? Mike, why don't you go ahead.

Senator ENZI. OK.

I thank everybody for the brevity of their statements so that we can have questions. And I want you to know, that from each of you, I learned something that will help us on healthcare reform, and I think it's because you kept your statements very succinct, but I do have a few questions, and one of them will be for Ms Liu. What do you attribute to California not being able to pass their bill? There probably were a lot of roadblocks, but what ones could you share with us?

Ms. LIU. Certainly there were a number of roadblocks, as you said, one of them actually was a lot of controversy around a number of the policy issues that we were trying to pursue, one of them being the individual mandate, frankly.

We were able to take a lot of the stakeholders who normally would not support an individual mandate, and discuss with them the reason that it was required in order to get universal coverage. That's really what the Governor had asked us to do.

Absolutely, there needed to be a number of market reforms that were in place in order to achieve guaranteed issue under an individual mandate, and we took a lot of precautions in trying to move those forward.

Why didn't it pass in California? You know, there are a number of reasons. We built a very large stakeholder coalition, but obviously not quite large enough. I think a lot of it also had to do with the timing of the proposal. It did pass, the Governor signed it, and it did pass the Assembly Health Committee, but by the time it got to the Senate Health Committee, a few days prior to that, notice had come out that California had a budget deficit of $14.5 billion. At the time, that, frankly, was the cost of the new reform proposal, which would have been $14.5 billion.

Now, we had financed that completely separate from the State budget, so there wouldn't have been an impact on State revenues, but that made it difficult for us to get that message across.

I could go into a number of other reasons, but I'll leave it there, for now.

Senator ENZI. Well, as you think of others, you could write them down for us, and we'd appreciate that.

Ms. LIU. Certainly.

Senator ENZI. But, I just want to mention that our budget deficit dwarfs yours.

Ms. LIU. Fair enough. That's the only place that does, actually, dwarf California's budget deficit.

[Laughter.]

Senator ENZI. For the other States, one of the things I keep—I'm very proud of the Wyoming legislature and the volume of bills that they're able to pass. One of the things I always watch is to see how many correction bills they have to do. Any time you pass something major, there's usually something that got left out. Could one person from each of the States kind of mention some things that they're still mulling over that probably need to be fixed?

If you don't have anything, that's OK, too.

Mr. KINGSDALE. I'll take a crack at it.

Obviously, as I said in the opening statement, I think it's often—it's generally recognized—we took on access with a nod toward cost containment, but I think the real battle over cost is still to be fought in Massachusetts.

I would point out that our reforms did not exacerbate the cost issues in Massachusetts, or any of the other, sort of, national problems that characterize healthcare delivery in the United States. Everybody now recognizes that, in Massachusetts, that near-universal coverage is simply not sustainable, financially, unless we do address healthcare costs.

I think we now, sort of, confront that issue from the moral high ground of a commitment—a moral commitment—to universal access and maintaining and protecting that. That's clearly a major piece still to be dealt with.

There have been a number of other, sort of, smaller issues that—all the way from technical corrections to recognizing, for example, that the already growing national problem of inadequate, or shrinking, primary care supply is an issue that—if we're going to deal with finances, we ought to deal with labor supply, as well.

There's legislation that passed last August, Chapter 305 of the Acts of 2008, which build on some private efforts to fund retention and recruitment of primary care physicians and nurse practitioners in Massachusetts, and I understand that 92 such physicians and nurse practitioners have been recruited and retained as a result of that program.

Massachusetts——

Senator ENZI. I don't want to cut you off.

Mr. KINGSDALE. Sure, OK.

Senator ENZI. I do want to hear from others, and my time is running out. If you think of some more, let us know, because you're the laboratory for us to work from.

Vermont, do you have any corrections?

Ms. BESIO. Let me just say that our reforms were very comprehensive, and we didn't set up a lot of study groups. Actually, in our legislation, we created things like loan forgiveness funds, loan repayment funds, to help with our primary care workforce, and workforce area, in rural areas.

However, the two things that have continued to be discussed over the last two legislative sessions—and there have been, actually, bills that have been passed to augment on the first bill, 2006 reform legislation—primarily dealt with increasing our Blueprint for Health, which is our effort to change the way care is delivered at the local level. That includes payment reform, community care teams, it's a multipayer approach, to support primary care practices, both in terms of prevention and managing chronic conditions better.

On the coverage side, there's been a lot of discussion about expanding access to our new product, the Catamount Health product, and the premium assistance programs, and honestly, the roadblock there has been money. Can we afford to do any more expansions, allow more people into that premium assistance program, and access that product that's subsidized by the State? That has been a roadblock for us, consistently, over the past 2 years.

Senator ENZI. Thank you.

Utah?

Speaker CLARK. Thank you very much.

Utah's on a—well, I'm just a Southern Utah banker by profession, so I try and make things simple. Numbers are what I'm more comfortable with, so I've taken our healthcare and said it's a 1–3–6–10 as our formula. Our first year of effort, a 3-year path, we identified six major areas of which we think we need to implement reform, including insurance modernization, which we're talking about here, but we anticipate that it'll take us a decade to fully implement that. This is a long and major process.

We are beginning to take, what I call, the old carpenter rule. We have a good health system in the State of Utah—high quality, low cost. We are attempting to do the carpenter rule where you measure twice and cut once, before you do anything. So, we're having a very measured process, and one which we continually look back in the rear view mirror to make sure that our course correction is providing us where we thought we'd be, and not the unintended consequences.

Now, let me take and put my legislative hat on. What I want, when I'm sitting in this chair, is somebody sitting at this microphone, giving me succinct answers on what I need to know about what the problems are. What you've heard across here is, in fact, that it's dollars. It is, truly, a very, very costly process to go through this. Massachusetts was approaching some serious problems with a large Medicaid retraction, and they needed to make some alternative direction, so they began looking at finding what they can do to retain that money, and still work within the system.

In Utah, we never got the deposit slip—we never got to the bank to get that money. Dish payments, according to different States—I don't know if there's anyone here from New Hampshire, I was told there was $8,300 for every man, woman, and child.

Wyoming, I don't think, receives any, they're 50th—49th is Utah. We get less than $100 per person. The tools we have to solve these problems that are flowing from Washington are entirely different. That's what allows—and I think why it's so important for each State to retain its own autonomy, to try and have some maneuverability in this process—it is really critical.

I would hope that if nothing else, perhaps a 5-year partnership—give us a demonstration project. The opportunity, the flexibility to come back and report—I think it's going to take a partnership between all 50 States, and the Federal Government to find the right solution. But the bottom half of those solutions might be as independent as all 50 States.

Very simple, let me tell you one of the challenges we have and why it's important we work in partnership. Right now, ERISA, in the State of Utah, covers the large employers, States off Federal mandate, Federal guidelines, we have no say, whatsoever. That's one-third of my market, completely gone.

Government, Medicare, Medicaid, CHP—while we do have some influence, statewide—most of the guidance and direction and the—what we do comes from the Federal Government, the State maneuvers slightly through there, but we've got just this much movement in our wrist, and the Federal Government controls most of it.

I have a 30 to 32 percent of the market that I'm trying to influence and control with a limited source of resources, and you start taking and putting mandates and guarantees—I have these whole other markets I don't impact, but all of the adverse selection and the narrow trouble it comes to, gets funneled down right directly onto that 30 to 32 percent—the small businesses around the country that are carrying the burden on this.

In my State, 70 cents out of every dollar paid for insurance comes from an employer-based program. I have to be careful and be mindful of the business community and their efforts, and make sure that we're responsive to those needs, and not continue to layer back on top of them. That work is just beginning.

Senator ENZI. Thank you very much.

I apologize for running over so dramatically. I usually don't do that, but I hope this——

Senator BINGAMAN. No, no, this was very useful, I think.

Senator ENZI. I hope those were questions that were in a general spirit, rather than to make a point.

Senator BINGAMAN. They're very good questions, and answers, too.

Senator Kennedy, did you want to——

The CHAIRMAN. Just very quickly, Mr. Chairman, one thing that I've been thinking on as we've gone through these excellent questions and that is, what we know is that an enormous fraction of our healthcare costs are generated by the very small proportion of patients with serious illness. How can we reduce that, through better care and coordination?

We have all of these pressures that we find out, and in particular, as we listen to so many of those who have testified and have done so well today. I think we're going to hear from some of those who have been dealing with healthcare challenges, that all of us are going to be faced with—those on this committee and those who aren't on this committee—and we're going to have the macrocosts that are going to come in there.

We are also going to be faced with these enormous amount of costs that are going to be coming our way, and we're all going to be asked how we're going to be able to deal with those.

We have also seen the situation where some of the costs of these individuals that we've heard about, go through a rather small window, and yet they have a large window that they're going to have to pay out through, that's going to come through in terms of expenditures.

How general is your sense about these costs that we are going to be facing over a period of time? There's nothing new in this comment, but what I think is something we all ought to be reminded about, and that is what we can do to try and help the States to constantly work so that the States themselves have a reasonable opportunity for success.

Senator BINGAMAN. Mr. James, go right ahead.

Dr. JAMES. I first ought to correct that—I'm trained originally in surgical oncology, so——

Senator BINGAMAN. Speak up.

Dr. JAMES. I trained originally in surgical oncology, so I make the second physician on the group.

In my specialty area, the first is, that higher quality care usually costs less. I think we did the first clinical demonstration of that in Utah way back in 1986. We've shown it consistently since. That's why my colleagues, partners in Boston are spending so much time out in Utah right now.

The second part is, that we understand which parts of it really doesn't serve patient needs, and really need to be modified. Just as one example, about 30 percent of all Medicare expenditures go into end-of-life care. We measure it different ways—6 months of life, the last 6 months, the last year, occasionally you can actually identify the actual episode. There are significant differences across the States in terms of how much that spend is. Dartmouth Atlas currently identifies Utah—specifically inter-mountain—as the most efficient. We spend about $12,000 for a Medicare enrollee who dies. Los Angeles is actually the highest right now—$58,000. For the same course of care—interestingly, the same group shows that the quality of care in Utah is higher. Five times more expense, worse medical outcome.

My favorite term for that is "rescue care." We're understanding it fairly fully—when I talk about approaching 50 percent waste in the system, that's what I mean. Right there. It's not care delivered in good service to patients.

Very often this care—if they were given a fair choice—is not what they would have selected or chosen. We need to get it right, frankly, within the healthcare professions.

Senator BINGAMAN. Dr. Chen did you want to comment?

Dr. CHEN. Sure. I think Dr. James raised a very good point about the variation in the healthcare spending in medicine, and there's been some wonderful work done by Elliot Fisher using the Dartmouth Atlas.

I think there's certainly a lot of opportunity to deal with some of the waste in medicine there. I think I would also turn our attention to another part of medical care, and that's what I will call effective care. Those are the things that we know that people need with their chronic diseases, so when you have diabetes, we know you need that eye exam, we know you need that urinalysis, we know you need that foot exam.

It is very important that these people get that care, because that prevents more expensive complications down the line. What Vermont has done is created this—what was originally a chronic disease management program, the Blueprint for Health—we've enhanced it, we've put the, as we say, the Blueprint's on steroids and we put it into medical home projects, in demonstration projects throughout Vermont. Where people will be tied together by information technology, and following standard protocols where there is a unified payer, reimbursement based on a per member, per month to provide this kind of case management. And where there's a community care team that makes sure they deal with all of the other patient needs, whether it be mental health needs, whether it be making sure the patient has transportation to get to the doctor's appointment, or to make sure that the patient has enough money to pay for nutritious food.

That's all of, I think, what you're going to have to address, when you try to deal with those very costly people that end up having the chronic disease, and that's where we spend 70 percent of the healthcare dollars, on those 20 percent of the people.

Senator BINGAMAN. Go right ahead.

Ms. MCANNENY. There is a growing focus in Massachusetts among employers on workplace wellness initiatives. I think we're increasingly of the sentiment that the best way to control cost is not to incur them at all. Folks are trying to keep their employees healthy—large employers can use a very holistic approach—they change the food offerings in the cafeteria, they set up walking paths and so forth.

For smaller businesses that don't have those resources, they're collaborating with our State's Department of Public Health, trying to give them the toolkit they need to make some changes into focus on wellness

Ms. LIU. If I could just add, very briefly, that what this really revolves around is over-utilization in care, and what we need in place is changes in our care delivery system and our payment sys-

tem, so that we're incenting value-based care, as opposed to volume of care delivered.

Certainly, at Kaiser Permanente, that is what we focus on, about giving people the right care at the right time, in the right place. We have some of those tools in place to be able to allow us to do that. So, when you're thinking about affordability, that's what I would focus on.

The CHAIRMAN. Thank you very much.

Senator COBURN. Can I jump in?

Senator BINGAMAN. It's your turn, so why don't you just go ahead and ask your question.

Senator COBURN. All right, well, we've heard about payment reform. The classic study is at Duke, where they opened a congestive heart failure clinic, and they lowered hospitalizations by 25 percent but, they had to shut it down, because they couldn't get recognized for the payments. Under our payment system under Medicare and Medicaid to drop this magnificent amount of money by putting people back in the hospital, rather than going to a managed, accountable care organization or medical home where we're actually having performance for pay, rather than pay for performance—where you perform and you get paid.

Duke modeled this and they said, "We've got a plan that works," but the payment reform is key on this. The payment reform is key on retention of primary care. We have a payment system that is broken, and it's broken in the government's payment system, and it's broken in the private insurance model.

I'm interested to ask the folks from Vermont, how are you—without an individual mandate, you've moved 2 percentage points in terms of coverage—most of the people we've had testify before this committee and in the study groups that are going around here is you can't have guaranteed coverage if you don't have an individual mandate.

How have you done that? Have you incentivized so well, in terms of the co-payments, or the subsidization? Is that how you've moved people?

Ms. BESIO. I think it's to—that is part of it. The premium assistance program has been very powerful in terms of getting people enrolled. Actually, when we did our initial reforms—prior to doing our reforms, we did a statewide survey that indicated that half of the people who were uninsured were already eligible for our existing Medicaid programs and expansion programs but had not enrolled. Seventy-seven percent of those folks, of all of our uninsured said it was because of cost. Well, Medicaid's free.

Part of what we did as a strategy, when we developed our new Catamount Health Plan and our Premium Assistance Programs, we did integrated marketing with the private carriers that offered the new Catamount Health Plan. Our message to Vermonters was, "Every Vermonter needs insurance." That was it. "Every Vermonter needs insurance," here's the 800 number, and we asked people to call that number and we would help them—help determine which program they might be eligible for. And we think that that message actually got out.

We have an employer contribution component to help finance our healthcare system, so that's also helped, I think. But our most re-

cent survey, that gave us our new numbers, which just happened this fall, showed us that only about .5 percent of Vermonters have experienced a loss of employer-based insurance.

Our employers, while they may be increasing cost sharing, they are still continuing to offer that insurance, and we think it's because we've put that message out there and people have taken it to heart.

Senator COBURN. A couple of questions for Massachusetts, in looking at your own administrative budget and reading all the press reports we hear about the difficulties. You have a mandate and you have guaranteed issue, and yet we see the cost rise. One of the statements I think you said earlier, is that it didn't have anything to do with the plan, in terms of the cost increases. I wrote it down, exactly what you said. You said, the plan didn't affect the cost, the costs were there anyway. You also said the most impossible challenge that we have is cost.

How are you all going to address the cost? As I read what's published about the Massachusetts plan, that's a big issue for you, and where do you go? Since you've got coverage, but now it looks like you can't afford the coverage because you've got cost. How are you going to handle that challenge?

Dr. KINGSDALE. That's a great question, it's the question of the hour in Massachusetts, I believe.

I would point out that the major new coverage program we have, Commonwealth Care, that comes out of the connector, we actually had a premium reduction from this year to the——

Senator COBURN. I'm talking about your administrative budget, I'm not talking about those—my question was related to your total cost—you've got a 33 percent increase in your administration of it this year, over 2008.

Dr. KINGSDALE. Actually we're going to come in at just about flat, but we also have a lot more members this year.

I think your real—as I hear it——

Senator COBURN. The real question is cost.

Dr. KINGSDALE [continuing]. The real question is about underlying cost of healthcare, yes. I actually have—I am very enthusiastic, I spent 30 years trying to design coordinated care systems and endorse some of the comments made earlier about systems and your own comments about payment reform and payment systems being broken. But I do believe that all that stuff takes a long, long time to develop, and these systems, you don't just change them overnight.

This is a long struggle. Frankly, part of it is putting less money out. We have extremely, extremely smart doctors and health plan administrators and hospital administrators, and if we give them the right incentives, I believe it's much better for them to figure out than for government to micro-manage changes in the delivery system. But that is going to take time.

We have one cost containment policy in this country, we have only one that I'm aware of. We ration access to health insurance, so we have 50 million people who don't get care because of that, and I think we need a better cost containment policy than that.

Senator COBURN. Yes, you all don't have that option in Massachusetts right now, so what you do is going to be a great model for

us to look at, in terms of how you handle it. Do you have the flexibility, being a single State, to modify some of the things you need to, to get to the cost issue?

Dr. KINGSDALE. Well, you know, Medicare is the biggest payer, it's 18, 19 percent of the healthcare sector, and we are—there's a payment reform commission set up by the—Chapter 305, I mentioned, was passed in August. They are actively considering, they've already sort of voted to recommend movement over the next 5 years to global budgets, as a way of paying and away from fee-for-service. And we probably would, if we can legislate that, seek something like a Medicare waiver to try to involve the biggest payer in the country in that. It is a challenge when you're at the State level.

Senator COBURN. One short follow-up—is everybody looking at accountable care organizations?

Ms. BESIO. Yes.

Senator COBURN. Everybody?

Ms. BESIO. Yes.

Senator COBURN. OK, thank you.

Senator BINGAMAN. Senator Sanders.

Senator SANDERS. Thank you, Mr. Chairman.

Welcome to all of our guests. This is, in fact, an important hearing, because as Representative Clark and Orrin Hatch and others have pointed out, a lot of interesting things are happening at the statewide level and we want to include those experiences and any ideas that we have for national legislation.

In fact, in that regard, while I suspect my ideas may be different than Speaker Clark's, we have introduced legislation that would provide five States of the country, who want to go forward with universal healthcare, waivers to do it their way. You may do it in Utah one way, Vermont may choose to go a single-payer route, but let's analyze the results of those and see how it's applicable to national legislation. Does that make sense to you?

Dr. JAMES. Absolutely, I think the incubation—what we're talking about—I mean, I look at Utah and Massachusetts. Massachusetts began this process of their reform by going to the public sector first, doing that reforming, and now they're beginning to look at the private sector.

Senator SANDERS. Let me just jump in, but the idea of giving States the freedom to have support from the Federal Government, do the waivers you mentioned, ERISA, so you can have those waivers to go forward in the way that you think makes sense. Make sense to you?

Dr. JAMES. It does if I can add COBRA, HIPAA, Department of Labor, and the tax code, yes.

Senator SANDERS. Yes, OK. And that's, Mr. Chairman, what we have introduced, and I think we can learn from those experiences. I think what States will do will be very different. I think Utah will be different than Vermont, let's look at those results.

No. 2, we have—obviously the theme of the hour is cost all over the country. I want to say some good news here, which is that in the Stimulus Package, we have put $2 billion more, we've doubled the funding for community health centers, a program that Senator Kennedy developed some 40 years ago.

We have tripled the funding for the National Health Service Corps to provide debt relief for those physicians who want to go into primary healthcare, and dentists and nurses as well. The beauty of that, is that what the studies tell us is that if you have strong primary healthcare in a medical home, you save money at the end of the day. Does anybody not think that we should continue that effort in strengthening primary healthcare and the National Health Service Corps? Is that a good idea? Anyone think it's not a sensible idea?

Mr. Speaker.

Speaker CLARK. Well, the devil's always in the detail. The 30,000-foot view you said right there, I think we're all in complete agreement.

Senator SANDERS. OK, great.

The one issue, when we talk about the cost healthcare that has not come up, and it amazes me that it hasn't, is that we spend almost twice as much per person on healthcare as any other industrialized Nation, and yet we have 46 million Americans without any health insurance, and we're the only industrialized country in the world without a national healthcare program.

I know it will shock people to hear this, but the one program, as I understand it, that has more support from physicians than any other program in the country, is called single-payer. At least 15,000 physicians, a number of State legislators have come on board. The single-payer concept and the strength of the single-payer concept is that it eliminates all of the waste, administrative costs, bureaucracy, profiteering, that currently takes place within private insurance companies.

So we talk about saving money, I wonder how we do not talk about the fact that there are private insurance companies who take 25, 30 percent or more of every healthcare dollar for administration, rather than putting that money into doctors, nurses, medicine, etc. Does anyone want to comment on whether or not we think we have a good system if some private insurance company is making 30 cents of every dollar in bureaucracy and billing and every other thing, driving everybody nuts, in terms of the billing process? We don't talk—are we not allowed to talk about that issue? Are the private insurance companies quite so strong that we're not allowed to raise it? Jesus, OK.

Dr. KINGSDALE. I'll address it if you want.

Senator SANDERS. OK.

Dr. KINGSDALE. We run two exchanges. One of them, the largest one, run about 8 percent administrative costs and the exchanges can function, I think, to take that part of our health insurance industry, which has the highest administrative cost, the highest cost of distribution and no—on the order of 15, 20 percent, and I'm talking about the nongroup market—and introduce substantial efficiencies into the distribution of insurance. When you have guaranteed issue, guaranteed renewal, community adjusted rating, and we get 80 percent of our applications in our private market online, you can actually take 10, 12 percent out of the cost of nongroup insurance.

I'm not going to address your larger question, I know there are issues about waste and billing and claims and so forth, but there is a concrete way to take a substantial chunk out of that.

Senator SANDERS. I think it was Dr. Chen who made the point, maybe I'm paraphrasing him, that coverage is not coverage. We have to get into the specifics. You can have a catastrophic plan which really doesn't mean much, huge deductibles, co-payments, so what. You're on a statistic that's covered, but it's not a good plan.

Now, let me ask Dr. Kingsdale, I have a statistic, tell me if I'm right. This is on the Massachusetts plan. As I understand it, and I know you don't have the figures in front of you, but tell me if this sounds right. As of December 29, 2008, fairly recently, a 56-year-old—why we selected 56, I don't know—56-year-old middle income person, man, would spend $4,872, that's the cheapest plan available to that person. The policy has a $2,000 deductible, it has a 20 percent co-payment of up to $3,000. That means if a guy has a bad year, breaks his leg, he could be spending $10,000, has exposure of $10,000 for a middle income guy. Is that what is true for the Massachusetts plan?

Dr. KINGSDALE. You're right, I don't have the numbers in front of me, but I think—for an individual, that would be $5,000 not $10,000. And yes, healthcare is God-awful expensive.

Senator SANDERS. No——

Dr. KINGSDALE. In that example——

Senator SANDERS [continuing]. That's not $5,000. Under the Massachusetts plan, an individual is $4,800, is that correct for an individual?

Dr. KINGSDALE. I don't want to argue with the numbers, I think it's $5,000. But your point, nevertheless, whether it's 5 or 10, is a huge amount of money. Somebody else made the observation that that's really financial protection.

Now, that bill could well be $100,000, of which the insurance only covers $95,000. And yes, $5,000 is outrageously expensive, but that's medical care in this country.

Senator SANDERS. No I understand that, my only point was, before we look at Massachusetts as some kind of Utopian solution, to understand that a middle income person who breaks his leg could be spending $10,000 a year. That is not a solution, frankly, that is just far too much money. That's all.

Senator BINGAMAN. Senator Alexander.

Senator Alexander. Thank you very much.

I wonder if any of you looked at the Tennessee experience with TennCare in trying to see what mistakes you could avoid.

You know, back in the 1990's I remember riding along and hearing on the radio after I was Governor of the State that we were going to cover twice as many people for the same amount of money, and I thought, "That probably won't work" and for a while it seemed to, because there were a high level of children insured at a relatively low cost, but a few years later it was threatening to consume 40 percent of the State budget. The current governor has had to—even recommend taking 170,000 people off the rolls, which is a very painful experience.

I wonder if that provided any lessons that you were able to avoid in developing your plans or it wasn't relevant to your plans?

Yes, sir.

Dr. CHEN. Yes, I think that we did actually learn about the TennCare lesson in Vermont. I would say that throughout our expansions, both in Medicaid and also in the Catamount Health Program, we've put in what we'll call circuit breakers. There was always an ability to stop enrollment when we thought that enrollment was going too strong and costs were going to overwhelm the system itself, so that was a lesson we did learn from TennCare.

Senator ALEXANDER. Mr. Clark, you talked about Federal regulatory barriers preventing States from pursuing wellness initiatives or personal responsibility elements of a health reform program. Do you want to specify some examples of that?

Speaker CLARK. Right now there are—as I carved out—there is about two-thirds of the market that we have no impact on whatsoever or very, very little when it comes to the government program. It's always a matter of asking them for a waiver for direction. The ERISA plans are out of bounds, so we have our small commercial burr, so right around, the funnel starts to come down.

When it comes to incentives, a lot of regulatory issues that deal with how we do incentives. What would be wrong with incentivizing an individual, a diabetic, 5 years down the road, to receive back a portion of their premium if they were able to drop or share it with a physician that is able to improve the quality of health? You've got a baseline medical, you drop that down, they show the improvement, here you are.

Right now, IRS code—there's all kinds of challenges out there that are almost insurmountable to try and move forward.

I'll answer that question, if I can take 10 seconds—I know the Senator left, but we don't have 37 percent administrative costs in the State of Utah. The companies that we deal with—if they did, I would give them about 24 months and they would be in Chapter 7. I am a little bit disturbed sometimes at the abstract numbers that get pulled out. There may be those around here, but they are the outliers, they are not the mainstream performers that have viability and substance over the term.

Senator ALEXANDER. Thank you, Mr. Chairman.

Senator BINGAMAN. Thank you.

Senator Hagan.

Senator HAGAN. Thank you, Mr. Chairman.

One of the challenges I think we face in passing a healthcare reform bill this year, is convincing the 250 million people in our country who currently have health insurance and convincing them that reform will be as good for them as it will be for the 50 million people who don't have insurance.

With the uninsured, our goal is fairly straightforward, even if accomplishing it is not. We want to get them into an affordable, reasonable plan. For the people who have insurance now, the challenge isn't quite as clear. Of course, we need to make sure that the people who are happy with their insurance can keep it, but we also need to improve the system in such a way that even the people who are already covered see the benefits.

For example, I think it's generally true that health insurance is a source of stress even to the people who currently have it. I believe Kaiser conducted a poll late last year that showed that 29

percent of the people who have health insurance are worried, are very worried about losing it, and another 20 percent are somewhat worried about losing it. As we're trying to get more people covered, half the people who are already covered are worried about losing their insurance.

With that background, can those of you who have been a part of the efforts in Massachusetts and California, address the reactions of the insured population to the plans that were proposed in those States and any lessons we can learn at the national level, on how to best ensure the buy-in of those who have health insurance?

Ms. MCANNENY. Thank you. I think in Massachusetts, for those that had insurance prior to healthcare reform, I would put, at least for the employer community, I would categorize them in three different buckets, if you will.

The first would be the large self-insured that were mentioned. I think through healthcare reform, they were largely unaffected. There certainly were some implications for them, but they continued to purchase as before.

I think for the very small employers, those with 11 or fewer full-time equivalents, they too were unaffected because we chose to exempt them from healthcare reform, or at least any responsibility.

For that smaller employer community, with more than 11, but still in the fully insured market, it has been a challenge. Those are the folks who have faced the greatest new responsibilities under healthcare reform. I think for all employees who get their KIA through the employer-sponsored system, as healthcare costs continue to rise, it is a growing concern, because there has been more of a cost sharing with employees. I think that in this down economy, that will probably only exacerbate.

I think that it is a critical point and I think, from the employer community, one that we're watching very closely, in Massachusetts we chose to expand coverage first. The employer community's preference would have been to tackle the cost containment issue. We do have payment reform efforts underway, we're watching them closely and we do think that that's absolutely necessary if we are going to contain costs. I agree that for those who do get their insurance through their employer, cost is important and I think they are very concerned.

One of the issues with the individual mandate that I would like to raise has to do with—if you do have a mandate, it begs the question, how much insurance is enough to satisfy that? In Massachusetts the term is minimum credible coverage. That was a very contentious issue because what we did not want to do in Massachusetts was disturb the employer base. For those people who had insurance, most people are satisfied with their employer-sponsored coverage and wanted to keep it. We didn't want to make employers have to significantly amend the insurance that they offered.

At the same time, we wanted to make sure it was more than just catastrophic and provided coverage for a whole host of things, like inpatient, outpatient, prescription drugs and the like. That was one of the biggest challenges, in my opinion, for Massachusetts. I think that that's still a work in progress.

There are folks who want minimum credible coverage to be more expansive than it is. The employer community continues to push

back, but you don't want it to be overly generous so that it disturbs the market. So there is tension there.

Ms. LIU. Yes, in California, you're absolutely correct that one of the lessons we learned and one of the things we focused on is that we had to think about how the health reform proposal was useful for people who currently do have insurance. One of the things that we took a look at, No. 1, there was the issue, as you said, of people being afraid of losing their coverage, especially in these kind of economic times.

We were moving, in California, from an underwritten market to a market of guaranteed issue, so that people would be sure they could get products when they needed it. We also put in some market reforms that would lower the cost of care for people who had health conditions. We are going to phase out health status rating. That's the kind of things that the public wanted.

Now, in order to make that work, we needed to have in place, because we have such a highly underwritten market, an individual mandate to make sure that you could offer guaranteed issue at an affordable rate.

One of the other things that we looked at in terms of cost containment, for people who currently do have insurance, is tackling something that we called the hidden tax, and that's how we talked about it with people. What we really meant by that is that today, if you purchase through the commercial market, you're paying for your premium, but you are also paying for those who are uninsured, and you are paying for the underpayment, frankly, of public programs, especially in California, the Medi-Cal program significantly has very low reimbursement rates.

As part of our health reform process, we increased Medi-Cal reimbursement rates by over $4 billion, and that really—the focus there was to say we want to lessen the cost shift on the people who are currently purchasing coverage, as well as make sure for people who might lose that coverage, that they have that security that you were talking about.

Senator BINGAMAN. Senator Merkley.

Senator MERKLEY. Thank you very much, Mr. Chair.

Very quickly, in Massachusetts when folks do not comply with the individual mandate, how do you address that, what is the combination of incentives or punishments, if you will, that create the framework for that?

Dr. KINGSDALE. I mentioned earlier that health reform is a campaign and first of all, we compliment the individual mandate with an assessment on employers to make—if they don't make a fair and reasonable contribution with significant subsidies for low-income uninsured, and I think Susan referred to the cost of that. Beyond that, we implement the individual mandate with sort of a—we phased it in, we made additional coverage programs available before it went in effect. It didn't have any penalties attached to it for the first 6 months less 1 day. It had a modest penalty in the first year, 2007, that goes up in 2008 and 2009. We have a very robust appeals process, which the connector runs.

We basically try to run it and we compliment it with this campaign of shared responsibility. We use the Red Sox, the No. 1 brand name in New England, as Connector day, has a whole Connect to

Health. We tried to message that health insurance is good for you and administer the mandate from that perspective rather than a sort of got 'cha perspective, we're going to bend over backwards to try to penalize you. We try to bend over backwards not to penalize people.

Senator MERKLEY. Thank you very much, Doctor.

I have a number of questions, so I'm going to just keep it moving quickly here.

One of the questions on cost containment is how you create incentives, and there's been a lot of observation in various forms that when you have fee-for-service, you incentivize doctors to do lots of services, lots of tests, and so forth.

It has also been pointed out that the Mayo Clinic has one of the least expensive but highest quality services, and that one of the components of that is that the doctors are paid on salary, thereby eliminating incentives for them to do, additional tests. Is that part of the discussion in any of your States?

Ms. LIU. Briefly, I'm actually with Kaiser Permanente, and we agree with you because that's how we pay our doctors as well, is on salary, and that makes the financial incentives work for people, so that you do have the incentive to give the member appropriate treatment since you're getting a capitated payment and you're salaried, but you don't have the incentive to over treat.

At the State level, it's really hard to implement a lot of strategies.

Senator MERKLEY. Do you have the reverse problem, by the way, in which doctors receive more reimbursement if they provide less services or is it just the same regardless. Is the salary fixed?

Ms. LIU. The salary is fixed.

Senator MERKLEY. It is fixed.

Ms. LIU. Yes, absolutely. The doctors make the decisions about what care is appropriate. It's not the health plan making the decisions. What I'm saying is the incentives are in place because obviously you need to manage that members' care as effectively as possible because they are your member and you're getting paid a capitated fee on that.

I think, at the national level, you have a much broader opportunity to make those changes in care delivery and payment reforms that States are a little bit in a bind in terms of making, but I don't know if any of the other colleagues want to chime in.

Senator MERKLEY. Dr. Chen.

Dr. CHEN. In Vermont a significant proportion of the physicians, actually probably half, are employed by hospitals or hospital systems, so to the extent that we already have some of that in place, we can tailor some of the reform, whether it be the blueprint—enhanced medical home toward that using—taking advantage of that.

I think the rest of the physicians are small, very small practices of individual practitioners, but really would be hard to change that culture, in terms of trying to contain cost.

Senator MERKLEY. I see I'm starting to run out of time, so I'm going to throw one more question in and, Mr. Speaker, I'd be happy to get your follow up to that afterwards. You're, in fact—it is Speaker isn't it? Speaker Clark.

I think if I captured it right, doesn't it make sense for someone to get compensated for managing their diabetes, was that the comment? There's also been—the CEO of Safeway was here saying,

> "Hey, we and our self-managed health plan have a number of incentives we've incorporated, combined with real opportunity and encouragement to address disease management regarding diabetes, regarding heart conditions, certainly regarding smoking and smoking cessation."

Have any of your States succeeded in overcoming the bureaucratic obstacles or the cultural issues? Has it been a useful application of these sort of incentives to encourage people to make themselves healthier and help lower the cost of healthcare in the process for all?

Mr. Speaker.

Speaker CLARK. The wellness aspect of this, I think is one that's been probably the deepest richest vein, but hasn't been tapped as much as it needs to be. In Utah, part of our health system reform is involving a number of demonstration projects with large models that will allow them, both to do bundle pricing so that the entire product now—the physician, the hospital—is all one price and they have to manage to that price for the quality that they deliver. We're looking at other demonstration projects where we can enhance just what we talked about here, let us find out what it is we can do to try and find proper incentives.

We spent a considerable amount with a task force this last summer and tried to drill down what the different insurance that are in our State, what they do for incentives. Some have gathered the vision, some call an incentive a gift card, if you'll do certain things, we'll mail you a gift card to Target. Now those might be a—I think they're falling short of what I would call a wellness program. We need to do a more holistic program and we're trying to do some demonstration projects of a large enough scale that we can find out statistically and try and move forward in a major process.

Ms. BESIO. In Vermont, we have just passed legislation that allows our carriers, even though we do have community rating, to offer incentives, monetary incentives in their different products for people adhering to wellness initiatives. That's just getting underway, so we don't have any data.

I do want to make the point that we do have these integrated medical home pilots that are incentivizing practitioners, primary care providers, as well as their patients to adhere to better practices by using evidence-based care, having community care teams to support those patients that the doctors don't have time to support in 15-minute visits, giving them health information technology to know how many people on their panel need foot exams this year, I mean this month. Most providers don't have that kind of information, getting the lab test in so that when you go to a specialist, they don't have to be repeated, another unnecessary cost and concern for patients themselves.

But Medicare is not at the table. We can not get Medicare at the table. So we've got Medicaid and our three primary insurers all agreeing to provide the same monetary incentive to providers for evidence-based care, agreeing to support the same community care teams, they're all paying for this community care team, and agree-

ment to, in the future, in a year from now, if those show that they're cost-effective, to take the money that's currently being invested in their 1–800 disease management program and support moving this integrated model statewide. We can't afford to do it without Medicare's involvement, and because Medicare is so rigid in their demonstration programs and their approaches to States, we can't get their involvement because we need to apply to be part of a singular Medicare demonstration project, which makes no sense when you're at the provider level trying to manage care for your entire patient panel.

Senator BINGAMAN. Thank you.

Senator Enzi.

Senator ENZI. Mr. Chairman, this has been tremendously helpful. I always feel that roundtables are the best way to get the information if we're all working toward a common goal. Of course our common goal is to get everybody covered, and hopefully not to put States in particular constraint either.

I've got pages of notes here, but I'm also curious as to what the benefit packages are in each of these States and how you derive that and how you change it and how long it takes to make changes.

What we've gotten is just valuable beyond calculation, so I hope that you'll answer questions from myself and others that—maybe even some that weren't here—but I'll be sharing my notes with a number of people.

Thank you very much.

Senator BINGAMAN. Thank you.

Senator Merkley, did you have any other questions that you need to ask at this point?

Senator MERKLEY. I do have a couple if it would be appropriate.

Senator BINGAMAN. Why don't you go ahead.

Senator MERKLEY. Senator Coburn mentioned pay-for-performance as a reform. I'm not sure that I understand that exactly, but rather than just pay for tests, I assume it's the outcome or a successful treatment of a disease. Have any of you incorporated pay-for-performance, exactly how have you applied it, and what are the results?

Dr. CHEN. I think that it's fairly common, in the insurers in Vermont at least, that following well described evidence-based metrics, if you do X, Y, and Z on your patient, you get an enhanced payment. That happens with Blue Cross/Blue Shield and MVP, the two nonprofit insurers.

One of the things that we tried to stress, so that providers and physicians aren't really going crazy with all these different metrics, is that the blueprint says everyone will use the same metrics. Whether you're a Blue Cross, whether you're MVP, or whether you're Medicaid, we're going to follow the same thing, but we'll come to agreement on what they look like in the beginning. So we are doing it. It is certainly a part of healthcare in Vermont at this time.

Senator MERKLEY. When you talk about evidence-based practices, you've applied and determined that here are the best cost-effective steps for addressing a particular situation. If the medical practitioner follows those steps, they get an incentive payment or a bonus or a reward. It's not based on the outcome or the effective-

ness, that the person is healed, if you will, it's based on following the process.

Dr. CHEN. Right, it's a process-based measure, at least the classic pay-for-performance is process-based.

Ms. BESIO. I just want to point out that incentives can also take other forms. Giving those practitioners the kind of information technology tools that they need, that will help guide them in their care delivery, is also a form of incentive to help them provide that better care.

We've used a tool called DocSite that we're starting to provide to any practitioner in Vermont—we're starting with primary care practices—that literally has in it, embedded, the evidence-based practices that we are trying to promote, that also has in it preventive care—evidence-based practices for preventive care—not only to chronic disease management. It gives doctors reminders of the preventive care that people need when they show up. When people come to their office, you can get a printout on how they compare to the national norms or to the State norms or regional norms on different indices to show what they're at risk for, etc.

There's not only payment incentive, but also giving practitioners the tools and resources that they need in order to better manage care.

Senator MERKLEY. Have you all extended the best practices into the formulary world?

Speaker CLARK. That's a very interesting question. I think the formulary has probably been more focused on cost rather than best practice. I think it's been more driven by the dollars, but there has been some effort to try and do that. I just want to emphasize that—I wish Dr. James were here. What he has done has been recognized worldwide, in those particular efforts that you talked about here and best practices, quality measurements. In fact, I've heard him speak numerous times where he says that the cost, access, and quality, typically the three-legged stool is not a three-legged stool, but is a linear equation, and that if you want to have lower costs, then you need to make sure you have the quality. You get that and you will then solve the axis question accordingly.

Dr. CHEN. I think in terms of the formulary, there are some certain items, like an ace inhibitor if you're diabetic and you're spilling protein, that are recommended, and those are part of, in some areas, the evidence-based guidelines, but as Speaker Clark mentioned, a lot of the other best practices and formulas come down to, is there a better, equally effective drug that costs a lot less? It's really a cost issue, which is important.

Senator MERKLEY. I'll just wrap this up here. In Oregon we had a lot of discussion of formulary, and essentially the strategy was to lay out the recommendation to the physician that they adopt this drug first because of the evidence that it's been most cost-effective. If they wished, they could waive that recommendation. They had to fill out a form and say, "I'm waiving it." So a little bit of a hurdle, but there was no, sort of, bonus involved. I found that quite interesting. It was extremely controversial to have any sort of embodied advice, if you will, or this is the best idea. Not an easy discussion to hold as we were attempting to reduce costs.

Ms. BESIO. We actually use formularies in our Medicaid program. We don't provide incentives for it, but we actually require that people go through a formulary process.

Speaker CLARK. I think in many States, it is assumptive that it's the formulary, and if you want to do something outside of that, then it requires that additional effort on behalf of the physician.

Senator MERKLEY. Thank you all very much, I appreciated your responses.

Thank you, Mr. Chairman.

Senator BINGAMAN. Yes, let me just thank everyone as well. I think it's been very useful, as Senator Enzi indicated. This helps us to figure out what we ought to be trying to get consensus on around here. Thank you very much.

That will conclude our roundtable discussion.

[Whereupon, at 4:09 p.m. the hearing was adjourned.]

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