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3 HEARING ON COMPREHENSIVE HEALTH REFORM DISCUSSION DRAFT

4 THURSDAY, JUNE 25, 2009

5 House of Representatives,

6 Subcommittee on Health

7 Committee on Energy and Commerce

8 Washington, D.C.

9       The Subcommittee met, pursuant to call, at 9:35 a.m., in  
10 Room 2123 of the Rayburn House Office Building, Hon. Frank  
11 Pallone, Jr. [Chairman of the Subcommittee] presiding.

12       Members present: Representatives Pallone, Dingell,  
13 Gordon, Eshoo, Green, DeGette, Capps, Schakowsky, Baldwin,  
14 Matheson, Harman, Gonzalez, Barrow, Christensen, Castor,  
15 Sarbanes, Murphy of Connecticut, Space, Braley, Deal,  
16 Whitfield, Shimkus, Shadegg, Buyer, Pitts, Murphy of  
17 Pennsylvania, Burgess, Blackburn, Gingrey, and Barton (ex  
18 officio).

19           Staff present: Karen Nelson, Deputy Committee Staff  
20 Director for Health; Any Schneider, Chief Health Counsel;  
21 Jack Ebeler, Senior Advisor on Health Policy; Brian Cohen,  
22 Senior Investigator and Policy Advisor; Robert Clark, Policy  
23 Advisor; Tim Gronniger, Professional Staff Member; Anne  
24 Morris, Professional Staff Member; Stephen Cha, Professional  
25 Staff Member; Allison Corr, Special Assistant; Alvin Banks,  
26 Special Assistant; Jon Donenberg, Fellow; Karen Lightfoot,  
27 Communications Director, Senior Policy Advisor; Caren  
28 Auchman, Communications Associate; Lindsay Vidal, Special  
29 Assistant; Earley Green, Chief Clerk; Mitchell Smiley,  
30 Special Assistant; Brandon Clark; Ryan Long; Marie Fishpaw;  
31 Aarti Shah; William Carty; Chad Grant; Abe Frohman; Melissa  
32 Bartlett; Clay Alspach, and Nathan Crow.

|

33           Mr. {Pallone.} The Subcommittee on Health will  
34 reconvene our hearing on comprehensive health care reform on  
35 the discussion draft, and we have actually four panels today,  
36 and we are going to get started. So our first panel is on  
37 Medicare payment, and let me introduce our two witnesses.  
38 First, on my left, is Glenn M. Hackbarth, who is the chair of  
39 the Medicare Payment Advisory Commission, better known as  
40 MedPAC. And then next to him is the Honorable Daniel R.  
41 Levinson, who is the Inspector General for the U.S.  
42 Department of Health and Human Services.

43           We are starting fresh today. If you had been here at  
44 seven o'clock last night, it wouldn't have been as--we would  
45 have all looked very tired, but now we are all fresh, so--you  
46 know the drill. We ask you to talk about 5 minutes, and your  
47 complete testimony becomes part of the record, and then we  
48 will have questions, and so we will start with Chairman  
49 Hackbarth.

|  
50 ^STATEMENTS OF GLENN M. HACKBARTH, CHAIR, MEDICARE PAYMENT  
51 ADVISORY COMMISSION; AND HON. DANIEL R. LEVINSON, INSPECTOR  
52 GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

|  
53 ^STATEMENT OF GLENN M. HACKBARTH

54 } Mr. {Hackbarth.} Thank you, Chairman Pallone, and  
55 Ranking Member Deal, members of the Subcommittee. I  
56 appreciate the opportunity to talk about the Medicare Payment  
57 Advisory Commission's recommendations for improving the  
58 Medicare program.

59 As you know, MedPAC is a non-partisan Congressional  
60 advisory body. Our mission is to support you, the Congress,  
61 in assuring Medicare beneficiaries have access to high  
62 quality care, while protecting the taxpayers from undue  
63 financial burden. MedPAC has 17 commissioners. Six of the  
64 Commissioners are trained as clinicians. Seven of the  
65 commissioners have experience either as executives or Board  
66 members of health care providers or health plants. Three  
67 commissioners have high level experience in Congressional  
68 support agencies, or CMS, and we have four researchers who  
69 add intellectual rigor to our work. And some commissioners  
70 have more than one of these credentials. In addition to

71 that, we have a terrific staff, headed by Mark Miller, the  
72 executive director.

73 I want to emphasize the credentials of the  
74 commissioners, to emphasize that we are from the health care  
75 system in no small measure. As such MedPAC commissioners  
76 recognize the talent and commitment of the professionals who  
77 serve within the health care system. We are not outsiders,  
78 critics who have no appreciation of the challenges of being  
79 on the front line. MedPAC recommendations may be right, they  
80 may be wrong. The issues are complex, and rarely are they  
81 clear cut. But if we are wrong, it isn't because we are  
82 inexperienced, or lack a stake in the success of the system.  
83 We also take pride in our ability to reach consensus on even  
84 complex and sensitive issues. For example, in our March 2009  
85 report, we voted on 22 different recommendations. On those  
86 22 recommendations, there were roughly 300 yes votes and only  
87 4 no votes, and 3 abstentions.

88 All of the MedPAC commissioners agree that Medicare is  
89 an indispensable part of our health care system. Not only is  
90 it financed care for many millions of senior citizens and  
91 disabled citizens, it has helped finance investments in  
92 health care delivery that have benefited all Americans. But  
93 we also know that Medicare is unsustainable in its current  
94 form. We must slow the increase in costs, even while

95 maintaining or improving quality of care and access. We  
96 believe accomplishing that task will in turn require both  
97 restraint and payment increases under Medicare's current  
98 payment systems and a major overhaul of those payment  
99 systems.

100 Medicare's payment systems, and, I would add, those used  
101 by most private payors, reward volume and complexity without  
102 regard to the value of the care for the patient. Moreover,  
103 those payment systems facilitate siloed or fragmented  
104 practice, whereby providers caring for the very same patient  
105 to often work independently of one another. When care is  
106 well integrated and coordinated, it is usually testimony to  
107 the professionalism of the clinicians involved. That  
108 coordination and integration is too rarely supported or  
109 rewarded by our payment systems.

110 The resulting fragmented approach to care is not only  
111 expensive, it is dangerous, especially for complex patients,  
112 of which there are many in the Medicare program. It is  
113 MedPAC's belief that we need payment reform that rewards the  
114 efficient use of precious resources and the integration and  
115 coordination of care. But it is not enough to simply change  
116 how we pay health care providers. We also must engage  
117 Medicare beneficiaries in making more cost-conscious choices,  
118 or being sensitive to the complex nature of the decisions

119 that must be made, and the limited financial means of many  
120 beneficiaries.

121         It is our belief that the cost challenge facing the  
122 Medicare program, and indeed the country, is so great that we  
123 need to engage everyone, patients, providers and insurers, in  
124 striving for a more efficient system. In the last several  
125 years, MedPAC has recommended a series of changes in the  
126 Medicare program that we believe would help improve the  
127 efficiency of the care delivered, while maintaining or  
128 improving quality. Let me just quickly mention a few of  
129 those recommendations.

130         First is increase payment for primary care services, and  
131 perhaps a different method of payment as well. Abundant  
132 research has shown that a strong system of primary care is a  
133 keystone of a well functioning health care system.

134         Second, we have recommended that the Congress take a  
135 number of steps to increase physician and hospital  
136 collaboration, including gain sharing, that would encourage  
137 collaboration between physicians and hospitals in reducing  
138 cost and improving quality.

139         Third, we have recommended reduced payment for hospitals  
140 experiencing high levels of potentially avoidable re-  
141 admissions. As you know, about 18 to 20 percent of all  
142 Medicare admissions are followed by a re-admission within 30

143 days, at a cost of roughly \$15 billion a year to the Medicare  
144 program.

145         Next, we have recommended a pilot of bundling, whereby  
146 payment for hospital and physician services provided during  
147 an admission would be combined into a single payment, and  
148 perhaps combined with payment for post-acute services as  
149 well.

150         Next, we have recommended reform of the Medicare  
151 advantage program so that participating private plans are  
152 engaged in promoting high performance in our health care  
153 system, instead of offering plants that mimic Medicare--

154         Mr. {Pallone.} Mr. Hackbarth, I want you to finish, but  
155 I just want you to know you are minute over, so--

156         Mr. {Hackbarth.} Okay. I am to the last step, Mr.  
157 Chairman. Let me just close with two cautionary statements.  
158 One is changing payment systems, and we must change them, and  
159 doing so with some speed is going to require more resources  
160 and broader discretion for CMS than it now has.

161         The second caution is that, while we need to reform  
162 payment, it is going to take some time, and in the meantime,  
163 we need to continue pressure on the prices under our existing  
164 payment systems in the Medicare program. Thank you.

165         [The prepared statement of Mr. Hackbarth follows:]

166 \*\*\*\*\* INSERT 1 \*\*\*\*\*

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167           Mr. {Pallone.} Thank you very much for what is really  
168 important in terms of what we are trying to accomplish here.  
169 I appreciate it.  
170           Mr. Levinson?

|  
171 ^STATEMENT OF HON. DANIEL R. LEVINSON

172 } Mr. {Levinson.} Good morning, Chairman Pallone, Ranking  
173 Member Deal, and members of the Subcommittee.

174 Mr. {Pallone.} Your mike may not be on, or maybe it is  
175 not close enough. Try to move it--no, I think you have got  
176 to press--you have to--when the green light is on, it--green  
177 light on?

178 Mr. {Levinson.} It is.

179 Mr. {Pallone.} Now you are fine.

180 Mr. {Levinson.} Okay. Thank you. Chairman Pallone,  
181 Ranking Member Deal, members of the Subcommittee, good  
182 morning. I thank you for the opportunity to discuss the  
183 Office of Inspector General's work at this very important  
184 time of deliberations over health care reform.

185 Based on our experience and expertise, our office has  
186 identified five principles that we believe should guide the  
187 development of any national health care integrity strategy.  
188 And consistent with these principles, OIG has developed  
189 specific recommendations to better safeguard Federal health  
190 care programs. My office has provided technical assistance,  
191 as requested, to staff from the Committee, and we welcome the  
192 fact that many of OIG's recommendations have been

193 incorporated into the House Tri-Committee health reform  
194 discussion draft.

195 Principle one, enrollment. Scrutinize those who want to  
196 participate as providers and suppliers prior to their  
197 enrollment in the Federal health care programs. Provider  
198 enrollment standards and screening should be strengthened,  
199 making participation in Federal health care programs a  
200 privilege, not a right.

201 As my written testimony describes, a lack of effective  
202 provider and supplier screening gives dishonest and unethical  
203 individuals access to a system that they can easily exploit.  
204 Heightened screening measures for high risk items and  
205 services could include requiring providers to meet  
206 accreditation standards, requiring proof of business  
207 integrity or surety bonds, periodically certification and on  
208 site verification that conditions of participation have been  
209 met, and full disclosure of ownership and controlled  
210 interests.

211 Principle two, payment. Establish payment methodologies  
212 that are reasonable and responsive to changes in the  
213 marketplace.

214 Through extensive audits and evaluations, our office has  
215 determined that Medicare and Medicaid pay too much for  
216 certain items and services. When pricing policies are not

217 aligned with the marketplace, the programs and their  
218 beneficiaries bear the additional cost.

219         In addition to wasting health care dollars, these  
220 excessive payments are a lucrative target for unethical and  
221 dishonest individuals. These criminals can re-invest some of  
222 their profit in kickbacks, thus using the program's funds to  
223 perpetuate the fraud schemes.

224         Medicare and Medicaid payments should be sufficient to  
225 ensure access to care without wasteful overspending. Payment  
226 methodology should also be responsive to changes in the  
227 marketplace, medical practice and technology. Although CMS  
228 has the authority to make certain adjustments to fee  
229 schedules and other payment methodologies, some changes  
230 require Congressional action.

231         Principle three, compliance. Assist health care  
232 providers in adopting practices that promote compliance with  
233 program requirements.

234         Health care providers can be our partners in ensuring  
235 the integrity of our health care programs by adopting  
236 measures that promote compliance with program requirements.  
237 The importance of health care compliance programs is well  
238 recognized. In some health care sectors, such as hospitals,  
239 compliance programs are widespread and often very  
240 sophisticated. New York requires provides and suppliers to

241 implement an effective compliance programs as a condition of  
242 participation in its Medicaid program. Medicare Part D  
243 prescription drug plan sponsors are also required to have  
244 compliance programs.

245 Compliance programs are an important component of a  
246 comprehensive integrity and strategy, and we recommend that  
247 providers and suppliers should be required to adopt  
248 compliance programs as a condition of participating in  
249 Medicare and Medicaid.

250 Principle four, oversight. Vigilantly monitor the  
251 programs for evidence of fraud, waste and abuse.

252 The health care system compiles an enormous amount of  
253 data on patients, providers and the delivery of health care  
254 items and services. However, Federal health care programs  
255 often fail to use data and technology effectively to identify  
256 improper claims before they are paid and to uncover fraud  
257 schemes. For example, Medicare should not pay a clinic for  
258 HIV infusion when the beneficiary has not been diagnosed with  
259 the illness, or pay twice for the same service.

260 Better collection, monitoring and coordination of data  
261 would allow Medicare and Medicaid to detect these problems  
262 earlier and avoid making improper payments. Moreover, this  
263 would enhance the government's ability to detect fraud  
264 schemes more quickly.

265           As fraud schemes evolve and migrate rapidly, access to  
266 real time data and the use of advance data analysis to  
267 monitor claims and provider characteristics are critically  
268 important. OIG is using innovative technology to detect and  
269 deter fraud, and we continue to develop our efforts to  
270 support a data driven anti-fraud approach. However, more  
271 must be done to ensure that we and other government agencies  
272 are able to access and utilize data effectively in the fight  
273 against health care fraud.

274           Final principle, response. Respond swiftly to detected  
275 fraud, impose sufficient punishment to deter others, and  
276 promptly remedy program vulnerabilities.

277           Health care fraud attracts criminals because the  
278 penalties are lower than those for other criminal offenses,  
279 there are low barriers to entry, schemes are easily  
280 replicated, and there is a perception of a low risk of  
281 detection. We need to alter the criminal's cost/benefit  
282 analysis by increasing the risk of swift detection and a  
283 certainty of punishment.

284           As part of this strategy, law enforcement is  
285 accelerating our response to fraud schemes. The HHS/DOG  
286 Medical Fraud Strike Force model describe in my written  
287 testimony is a power anti-fraud tool, and represents a  
288 tremendous return on investment. These strike forces have

289 proven highly effective in prosecuting criminals, recovering  
290 payments for fraudulent claims and preventing fraud through a  
291 powerful sentinel effect.

292         In conclusion, our experiences and results in protecting  
293 HHS programs and beneficiaries has applicability to the  
294 current discussions on health care reform. We believe that  
295 our five principle strategy provides the framework to  
296 identify new ways to protect the integrity of the programs,  
297 meet the needs of beneficiaries, and keep Federal health care  
298 programs solvent for future generations.

299         We appreciate the opportunity to work with the  
300 Committee, and welcome your questions. Thank you.

301         [The prepared statement of Mr. Levinson follows:]

302 \*\*\*\*\* INSERT 2 \*\*\*\*\*

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303           Mr. {Pallone.} Thank you. Thank you both. I am going  
304 to ask my questions of Mr. Hackbarth, but not because what  
305 you said is not important, Mr. Levinson. I think this whole  
306 issue of enforcement and fraud and abuse is really crucial.

307           But I--yesterday, Mr. Hackbarth, I asked basically the  
308 same question of Secretary Sebelius. In other words, you  
309 know, on the one hand we are talking about reductions in  
310 payments for certain Medicare and Medicaid programs. On the  
311 other hand, we are talking about enhancements and, you know,  
312 actually spending more on other aspects of Medicare and  
313 Medicaid, for example, Medicare Part D, filling up the  
314 doughnut hole, and you do both. In other words, my  
315 understanding is that, you know, your recommendations, which  
316 we--many of which are incorporated in this discussion draft,  
317 accomplish both purposes.

318           So--what I wanted to do, though, is--I think there is  
319 more media attention on cuts than there is on what you do to  
320 enhance programs, so I wanted you to talk a little bit about  
321 what motivates MedPAC to propose some of the reductions we  
322 are contemplating, you know, like the Medicare Advantage, the  
323 home health rebasing, productivity into payments updates and  
324 the rest. But why is it that MedPAC sees these as important  
325 policy proposals on their own terms, not because of, you

326 know, cost savings?

327           Mr. {Hackbarth.} Um-hum. Well, Mr. Chairman, we  
328 believe that pressure on the prices in the Medicare payment  
329 system is important to force the system towards more  
330 efficiency. As you and the other members of the Committee  
331 know, Medicare has administered price systems. They are set  
332 through a government process, as opposed to market prices.

333           We believe that what we have to do with that  
334 administered price system is mimic, so far as possible, the  
335 sort of pressure that exists in a competitive marketplace.  
336 The taxpayers who finance the Medicare program face  
337 relentless pressure, often from international competition,  
338 for example, forcing the firms that they work for to lower  
339 their costs, day in and day out. We think the health care  
340 system must experience the same sort of pressure.

341           Mr. {Pallone.} And then the solvency of the trust fund  
342 is extended, and premiums are reduced, and the program is  
343 maintained for future generations, so that is the ultimate  
344 goal?

345           Mr. {Hackbarth.} Absolutely.

346           Mr. {Pallone.} And let me ask you another question  
347 about--you know, we get this argument from some--not too  
348 many, but some employers and providers complain about alleged  
349 cost shifting from Medicare to the private sector. The

350 argument is, like--something like if Medicare would pay more,  
351 private plans could pay less, and so health care would be  
352 cheaper for employers and others. I don't understand how  
353 increasing Medicare payment rates would lead a private  
354 hospital to decrease the prices it charges private insurers,  
355 and--can you explain this to me? You know--I mean, I know I  
356 am asking you the opposite of what you believe, but--

357 Mr. {Hackbarth.} Yeah.

358 Mr. {Pallone.} --I mean, what--

359 Mr. {Hackbarth.} Yeah. Well, let me start by saying  
360 that we believe that Medicare payment rates are adequate. We  
361 don't believe that they are too low. We don't believe that  
362 they should be increased. And we--let me focus on hospital  
363 services as an example of that. We look at the data in  
364 several different ways. We have looked at time series data,  
365 and you see there is a pretty consistent relationship in  
366 periods where private payments are generous, Medicare margins  
367 become negative. And it is our belief that that is because  
368 when the private payments are generous, hospitals have more  
369 money to spend, and they spend it. It is a largely not-for-  
370 profit industry. If they get revenue, they will spend it.

371 And--then we see the same pattern when we look at  
372 individual hospitals, so what we have identified is a group  
373 of hospitals that don't have a lot of generous payment from

374 private payers. They have constrained resources. Those  
375 institutions lower their costs and actually have a positive  
376 margin on Medicare business. They don't have the luxury of  
377 additional private money flowing into their institutions.  
378 They are forced to control costs, and they do control costs  
379 as a result.

380 Mr. {Pallone.} And so you disagree with claims that  
381 Medicare is responsible for high health insurance premiums?

382 Mr. {Hackbarth.} No. I--if institutions--clearly the  
383 rates paid by Medicare and private payers are different.  
384 Private payers pay higher rates. It does not follow from  
385 that, however, if you increase Medicare rates that the  
386 private rates would fall.

387 Mr. {Pallone.} Okay. Now, let me just--one more thing  
388 about access. You know, we hear about, in some parts of the  
389 country that, you know, Medicare enrollees say that they  
390 can't find a doctor willing to accept new patients. Based on  
391 your research, do you have any reason to believe that we have  
392 a crisis of access in Medicare, that--basically providers not  
393 taking Medicare in a significant way?

394 Mr. {Hackbarth.} Each year we do a careful study of  
395 access for Medicare beneficiaries, asking both patients and  
396 physicians. Our most recent patient survey, which was done  
397 in the Fall of 2008, found that Medicare beneficiaries are

398 most satisfied with their access to care than private  
399 patients, privately insured patients, in the 50-64 age group.

400       The one area of concern that we do have is around access  
401 to primary care services, especially for Medicare  
402 beneficiaries looking for a new physician, for example,  
403 because they have moved. That is the area where we see  
404 Medicare beneficiaries reporting the most problem, but we  
405 also see privately insured patients in the same circumstance  
406 reporting problems as well. So we don't think the issue is a  
407 function of Medicare payment rates, but rather too few  
408 primary care physicians.

409       Mr. {Pallone.} Which was one of the things we were  
410 trying to address in this discussion draft. Thank you.

411       Mr. Deal?

412       Mr. {Deal.} Mr. Hackbarth, let me follow up on one of  
413 your comments about your look at those hospitals that have  
414 higher ratios of Medicare patients and lower ratios of  
415 private paying patients.

416       Mr. {Hackbarth.} Um-hum.

417       Mr. {Deal.} And I believe your statement was that they  
418 are able to make a profit and, in fact, be more profitable  
419 than some of the ones who have lower volume of Medicare  
420 patients. Don't those hospitals receive dish payments, as a  
421 general rule?

422 Mr. {Hackbarth.} Some of them may, yeah.

423 Mr. {Deal.} Does your recommendation in any way address  
424 whether dish payments should continue or be abolished?

425 Mr. {Hackbarth.} We have had some discussion, Mr. Deal,  
426 about refocusing dish payments. We have not recommended  
427 abolishing them.

428 Mr. {Deal.} Okay. Mr. Levinson, the draft talks about  
429 expanding Medicaid coverage and providing Federal payment of  
430 100 percent for some of this expansion of new populations so  
431 that the states don't have to pick up even their matching  
432 share in their Medicaid formula. If that is the case, if the  
433 Federal government picks up 100 percent of this cost, are you  
434 concerned that states will no longer have the incentive to  
435 look for the waste and the fraud and the abuse because they  
436 don't really have any stake dollars in that pot? Is that a  
437 concern, from your standpoint?

438 Mr. {Levinson.} Well, it is certainly always a concern  
439 about what is occurring with the Federal share of Medicaid,  
440 and indeed, as we look for a larger share of that on the  
441 Federal side, it becomes of greater interest to us at the  
442 Federal level. It is an issue, actually, that I, as a member  
443 of the Recovery Act Accountability and Transparency Board, is  
444 already dealing with, with my colleagues on the Board,  
445 because the ARA does include a significant increase in the

446 Federal share funding to alleviate states of some of the  
447 Medicaid burden. And in some of the states, particularly in  
448 the south central part of the United States, we are  
449 approaching a level where states give little, if any,  
450 contribution to Medicaid. So we are focusing on ensuring  
451 that there are controls in place to make sure that the, you  
452 know, the Medicaid dollar is protected, but as the Federal  
453 involvement becomes greater, the need for more Federal  
454 monitoring of those dollars also becomes greater.

455 Mr. {Deal.} Because the states have been the primary  
456 enforcement--first line of enforcement against fraud and  
457 abuse, with oversight from the Federal. So you are saying  
458 that there may be a need for more Federal oversight?

459 Mr. {Levinson.} That is correct. Historically the  
460 Medicaid Fraud Control Units, which exist in nearly every  
461 state of the union, have been really the first protectors, as  
462 it is, of the Medicaid program. We have provided oversight.  
463 In the last several years, though, Congress has provided  
464 additional funding to be more involved in the monitoring of  
465 those Medicaid dollars as the Federal share has increased.

466 Mr. {Deal.} Mr. Hackbarth, in your testimony, you make  
467 reference, I think, to the fact that about 60 percent of  
468 beneficiaries now buy supplemental policies to cover part of  
469 their Medicare cost. That seems, to me, a little bit

470 inconsistent with your conclusion that the Medicare  
471 reimbursement rates are adequate. I know one is from the  
472 provider standpoint and the other being from the patient  
473 standpoint.

474 Do you foresee, from the patient standpoint, that if we  
475 model everything after the Medicare reimbursement rates and  
476 the Medicare model, that there is going to be a need for even  
477 more purchasing of supplemental insurance by the individual  
478 patients?

479 Mr. {Hackbarth.} Well, as you say, Mr. Deal, there are  
480 two distinct issues. One is the adequacy of payments rates  
481 to providers, and we believe those payment rates are  
482 adequate. The Medicare benefit package is probably not  
483 designed the way any of us would design it if we were  
484 starting with a clean piece of paper. The design could be  
485 streamlined, and that process may reduce the need for  
486 beneficiaries to buy supplemental coverage. For example, if  
487 we were to add catastrophic coverage, a key missing component  
488 on Medicare, that might reduce the perceived need for  
489 supplemental coverage.

490 Mr. {Deal.} Okay.

491 Mr. {Hackbarth.} We have begun looking at that redesign  
492 issue.

493 Mr. {Deal.} Real quickly, you were going through your

494 principles that you have recommended, and you got through  
495 most of them, I think. In the very short time that I have  
496 left, are there any of those principles that you are  
497 concerned that are not being addressed in this discussion  
498 draft, in particular any that you have great concern about?

499 Mr. {Hackbarth.} Off the top of my head, Mr. Deal, I  
500 can't think of one.

501 Mr. {Deal.} Okay. Thank you, Mr. Chairman.

502 Mrs. {Capps.} The chair now recognizes Mr. Murphy for  
503 his questions.

504 Mr. {Murphy of Connecticut.} Thank you very much, Madam  
505 Chair, and Mr. Hackbarth, thank you so much for all the work  
506 that you have done guiding this Congress on this issue of  
507 moving away from a volume based system to a system that  
508 attempts to really reward outcome and performance.

509 And I think--I, for one, am worried that if don't take  
510 advantage of this moment in time, with this health care  
511 reform debate, to make those changes, that we may never be  
512 able to make them. And so--I know Mr. Deal just asked you a  
513 general question about whether there were points of reform  
514 that you have pushed that aren't in this bill, but I wanted  
515 to ask specifically on this issue of payment reform.

516 Mr. {Hackbarth.} Um-hum.

517 Mr. {Murphy of Connecticut.} Have you taken a look at

518 this bill with regard to payment reform, and how do you think  
519 it measures up versus what you think could be potentially  
520 done through this Reform Act, with regard to transforming our  
521 payment system?

522 Mr. {Hackbarth.} Yeah. As I indicated to Mr. Deal, I  
523 think that the bill's provisions on Medicare are pretty  
524 comprehensive, and address the major issues that MedPAC has  
525 raised about the Medicare program. Having said that, some of  
526 the provisions--let me take an example, accountable care  
527 organizations rebuttalling. You know, the bill provides for  
528 pilots of these new ideas, and, in fact, that is what MedPAC  
529 has recommended. These are complex ideas that will take time  
530 to develop and refine. So, the bill includes provisions. We  
531 shouldn't assume from that that, oh, it is a done deal.  
532 There is lots of work that needs to be done in CMS, in  
533 particular, to make these things a reality.

534 Mr. {Murphy of Connecticut.} Well--and that was going  
535 to be my second question. You have had a lot of experience  
536 in pilot programs, and I think one of the things that some of  
537 us worry about is that it is--that there has been a lot of  
538 research done on, for instance, the issue of accountable care  
539 organizations and bundling, and I think the majority of  
540 evidence is that they work. That they get good outcomes, and  
541 they can reduce costs. And so if we are going to go into a

542 bill that pilots these, how do we make sure that if the  
543 pilots turn up with the outcomes that pretty much every  
544 other--all other work on these payment reforms have done, how  
545 do we make sure that then that becomes a system-wide reform?

546 Mr. {Hackbarth.} Yes. This is an issue that I think we  
547 discussed last time I was with the Committee. The pace at  
548 which we make changes, reform the Medicare payment systems,  
549 is way too slow, and one of the things that we have  
550 recommended is broader use of pilots, as opposed to  
551 demonstrations. And the difference, in our mind, is that  
552 under a pilot, the Secretary has the authority to move to  
553 implementation if the pilot achieves stated objectives. It  
554 doesn't have to come back through the legislative process.  
555 We think that is a very important step.

556 And again, I would emphasize CMS needs more resources to  
557 do these things both quickly and effectively. They are  
558 operating on a shoestring, and the work is too important, too  
559 complex, to allow that to continue.

560 Mr. {Murphy of Connecticut.} And let me ask  
561 specifically about this issue of accountable care  
562 organizations. And--it seems to me that one of the ways that  
563 you expand out to a system of outcome based performance is  
564 that you try to encourage physicians to join in and  
565 collaborate.

566 Mr. {Hackbarth.} Right.

567 Mr. {Murphy of Connecticut.} We have put an enormous  
568 amount of money in the stimulus bill into giving physicians  
569 and hospitals the information technology to create those  
570 interaction and that coordination. And I guess I would ask  
571 you what are the ways that we need to be looking at in order  
572 to try to provide some real incentives for physicians to  
573 coordinate, become part of multi-specialty groups, enter into  
574 cooperative agreements? And then should we be looking at  
575 only incentives, or should we be looking at something tougher  
576 than incentives to try to move more quickly to a system by  
577 which physicians aren't operating in their own independent  
578 silos?

579 Mr. {Hackbarth.} Yeah. Well, the fact that we have a  
580 fragmented delivery system, I believe, is the result of how  
581 we have paid for medical care not just in Medicare, but also  
582 in private insurance programs for so many years. We  
583 basically enabled a sort of siloed, independent practice  
584 without coordination. The most important step we can take is  
585 change the payment systems so that services are bundled  
586 together, and physicians of various specialties and the  
587 various types of providers must work together. And there is  
588 abundant evidence that when they do that, we not only get  
589 lower costs, we get better quality.

590 Mr. {Murphy of Connecticut.} Thank you very much, Madam  
591 Chair.

592 Mrs. {Capps.} [Presiding] Thank you. The Chair now  
593 recognizes Congressman Burgess for his questions.

594 Mr. {Burgess.} Thank you, Madam Chair. Mr. Hackbarth,  
595 always good to see you, and I have several questions that I  
596 am going to submit in writing because time is so short during  
597 these Q&As, and I was going to reserve all my questions, in  
598 fact, for the Inspector General, but I just have to pick up  
599 on a point that we just expressed.

600 And under accountable care organization within Medicare,  
601 just within the Medicare system, with Medicare being an  
602 entirely Federal system--it is not a state system, it is a  
603 Federal system, so we don't have state mandates in Medicare.  
604 It functions across state lines.

605 If we were to provide an incentive, that is a backstop  
606 on liability under the Federal Tort Claims Act for doctors  
607 practicing within the Medicare system who practice under the  
608 guidelines of whatever we decide the accountable care  
609 organization--the proper accountable care organization should  
610 be, would that not be the types of incentive that we could  
611 offer to physicians that would not require increase in  
612 payments, but yet would bring doctors--increase their  
613 interest in practicing within these accountable care

614 organizations?

615           Mr. {Hackbarth.} Yeah. Dr. Burgess, MedPAC has not  
616 looked specifically at the malpractice issue. We principally  
617 focus on Federal issues. You know, that is our--

618           Mr. {Burgess.} But, if I could, we could make liability  
619 a Federal issue within the Medicare system because defensive  
620 medicine does cost the Federal system additional dollars, as  
621 Dr. McClellan's great article from 1996 showed.

622           Mr. {Hackbarth.} Right. And my point is that there's  
623 no MedPAC position on malpractice issues. As you know,  
624 though, I am formerly a CEO of a very large medical group, so  
625 I have lot of experience working with physicians, and I know  
626 how large malpractice looms in the minds of physicians.  
627 Because I have not studied the issue in detail, I don't have  
628 a specific recommendation, but I think addressing physician  
629 concerns about malpractice is a reasonable thing to do.

630           Mr. {Burgess.} Well, one of the things that really  
631 bothers me about these discussion in this Committee, you have  
632 so many people here who have never run a medical practice, as  
633 you have, and as some of us have. Doctors tend to be very  
634 goal directed individuals. That is why the fee for service  
635 system has worked for so long, because you tell us what to do  
636 and what the rules are, and we make a living at it. I am not  
637 a big fan of bundling. I don't trust hospital

638 administrators, as a general rule, and I would not trust them  
639 to appropriately apportion out the payments, so not a big fan  
640 there. But are there--there ought to be other ways to tap  
641 into the goal directed nature of America's physicians to  
642 achieve the goals that you are trying to get, and right now I  
643 don't think, at least from what I have seen, we are quite  
644 there.

645 I am going to actually go to Mr. Levinson, because what  
646 you have talked about is so terribly important, and--let me  
647 just ask a question. Right now, within the discussion draft  
648 we are talking about, I don't think the numbers are filled in  
649 as far as the budget, the numbers--the dollar numbers that  
650 are going to be there. What do you need today in order to do  
651 your job more effectively?

652 Mr. {Levinson.} Well, we certainly need the resources  
653 that we have been given by the Congress and by the Executive,  
654 and it is certainly being used, I think, in an optimum way.  
655 But as the mission gets larger, the need for greater  
656 resources also is there.

657 Mr. {Burgess.} And I am going to interrupt you, that is  
658 an extremely important point, because we have increased the  
659 FMAP on--in the stimulus bill and some of the other things  
660 that we are talking about doing. Is that not going to  
661 increase the burden, the pressure, that is placed on you and

662 your organization in order to provide the proper oversight?

663 Mr. {Levinson.} Certainly our mission has been heading  
664 north for the last few years, and we are really pressed to  
665 enlist really the best investigators, evaluators, lawyers and  
666 auditors we can find to handle, you know, a much larger  
667 budget than historically we ever have had before.

668 Mr. {Burgess.} And it is not just you, because my  
669 understanding, from talking to folks back home in the  
670 Dallas/Fort Worth area, from--within the HHS Inspector  
671 General's shop, and within the Department of Justice's  
672 jurisdiction, there is actually a deficit of prosecutorial  
673 assets, or, actually, assets have been--been had to use for  
674 other things, Homeland Security, narcotics trafficking, and  
675 there is not the prosecutors to devote to the cases that you  
676 all develop, to bring those cases to trial.

677 Mr. {Levinson.} That is a very important point, and  
678 sometimes it is overlooked how key it is to understand that  
679 the resources that are used to fight health care fraud really  
680 require a collaborative effort across several different  
681 government entities. And if you have the Justice Department  
682 personnel, but don't have the IG personnel--

683 Mr. {Burgess.} Right.

684 Mr. {Levinson.} --and vice versa, you really have a  
685 significant problem.

686           Mr. {Burgess.} And just one last point--I will submit  
687 several questions in writing--on the issue that we are  
688 hearing so much about in McAllen, Texas, where the--McAllen  
689 appears to be an outlier. Many physicians from the Texas  
690 border area were in town yesterday. I don't represent the  
691 border area, but they discussed it with me. They are  
692 concerned, obviously, about the negative press that they have  
693 been getting over the report by Dr. Guande in the New Yorker  
694 magazine. Is there any special focus that you are putting on  
695 that area because of the possibility of diversion of  
696 Medicare/Medicaid dollars within other ancillary agencies,  
697 imaging, drugs, home health? Are--is the possibility that  
698 this number is skewed not because of practitioners in the  
699 area, but because, in fact, the--we don't have the resources  
700 to devote to the investigation of fraud, the prosecution of  
701 fraud when it is uncovered?

702           Mr. {Levinson.} Well, there are a number of high  
703 profile areas that we oversee that we do need to concentrate  
704 on, because they do tend to be areas where fraud, waste and  
705 abuse tends to become a lot more serious than perhaps others.  
706 The durable medical equipment area, for example, especially  
707 in South Florida, has triggered our need to develop a strike  
708 force that is specifically devoted to trying to uncover and,  
709 to the extent possible, eliminate DME fraud in South Florida.

710 We have had very good results there, actually, in being able  
711 to clean up many of the problems areas. I can point to other  
712 parts of the country where other kinds of issues have arisen  
713 that really require a concentrated effort by us, working with  
714 our law enforcement partners. I can't speak specifically to  
715 McAllen, Texas.

716 Mr. {Burgess.} Are--is that on your radar screen to  
717 pull that into the investigative process?

718 Mr. {Levinson.} I can only say that the entire nation  
719 is on our screen, because we have such an extensive  
720 jurisdictional requirement.

721 Mr. {Burgess.} All right. Thank you, Mr. Chairman.

722 Mrs. {Capps.} The Chair now recognizes Mr. Green for  
723 his questions.

724 Mr. {Green.} Thank you.

725 Mr. Hackbarth, in your testimony, you cited lack of care  
726 coordination and lack of incentive of providers to actually  
727 coordinate care as a cost burden, and I agree, and we have  
728 several coordination bills pending before our committee. One  
729 is the Realigning Care Act, which focuses on geriatric care  
730 coordination. Your testimony cites geriatrics as an area in  
731 which care coordination is especially necessary. Can you  
732 elaborate on how geriatric care coordination could help lower  
733 health care costs? And again, we are dealing with Medicare,

734 but maybe we could also deal with whatever we create as a--in  
735 the national health care.

736 Mr. {Hackbarth.} Yeah. Geriatricians, as you know,  
737 tend to focus on elderly patients who have very complex  
738 multiple illnesses. And for those patients, not only is the  
739 potential for inappropriate, unnecessary care large, the risk  
740 to the patient of uncoordinated care is very large indeed.  
741 And so such patients really need somebody who is going to  
742 follow them at each step, not hand them off to specialists,  
743 and then they are handed to another specialist and another.  
744 They need somebody as that home base to integrate and  
745 coordinate the services.

746 Mr. {Green.} And I know that is our goal, is to talk  
747 about a medical home, you know, where someone could--any of  
748 us--a number of us had elderly parents who we have had to  
749 monitor the number of doctor's visits simply because they  
750 also take lots of different medications, and there is nobody  
751 coordinating that, except maybe a family member.

752 Mr. {Hackbarth.} And the problem, as you well know, Mr.  
753 Green, is that Medicare really doesn't pay for that activity,  
754 outside of the patient visit, the phone calls that need to be  
755 made to pull together the services of the well integrated.  
756 So we have made a series of recommendations to increase  
757 payment for primary care and the medical home, which in

758 addition to the fee based payments, has a per patient sum to  
759 support that sort of activity.

760 Mr. {Green.} And since we are all so concerned about  
761 the scoring, did MedPAC look at--by creating this benefit of  
762 coordinated care, could we save on the back end? Is there  
763 something we could quantify, say, to CBO, or someone could  
764 say, we--over a period of time, let us-- we think we can save  
765 ultimately?

766 Mr. {Hackbarth.} Yeah. Well, it is our hope, and  
767 perhaps even our expectation, that there would be savings.  
768 But what we have recommended, and what the Congress has done,  
769 is a large scale pilot, so that, in fact, we can hopefully  
770 document those savings and to have a resulting CBO score from  
771 it.

772 Mr. {Green.} Okay. And I know we have your--under  
773 current law we have your welcome to Medicare exam. That--do  
774 you think that could fit in there with what we would call a  
775 geriatric assessment initially, and then build on using that  
776 primary care?

777 Mr. {Hackbarth.} Well, potentially, because it gives  
778 the physician, hopefully a strong primary care physician, an  
779 introductory assessment of all of the patient's problems  
780 right from the outset.

781 Mr. {Green.} Okay. And again, I know there is a

782 provision in the bill, and a lot of us have that interest,  
783 and that is one of the good things about this bill that we  
784 are dealing with, but, again, since we are looking at  
785 scoring, say, you know--and it is hard to get CBO to say at  
786 the end we can save money. Not only save money, but almost--  
787 much more humane dealing Medicare, or any patient, in all  
788 honesty.

789 Mr. {Hackbarth.} Well, what I can say, Mr. Green, is  
790 that--as I said in my opening comment, there is abundant  
791 evidence that systems that have strong primary care have  
792 lower costs and higher quality than systems that don't have  
793 strong primary care. You see that in international  
794 comparisons. You see that in studies within the United  
795 States that compare regions with one another. You see that  
796 within health systems. So there is lots of evidence of that  
797 sort. Whether CBO considers that strong enough to score is--

798 Mr. {Green.} Well--

799 Mr. {Hackbarth.} --a CBO issue, not a--

800 Mr. {Green.} --maybe by your testimony we can encourage  
801 CBO to look at other countries that have a primary care  
802 emphasis, and how that can reduce the cost. So maybe the  
803 bean counters can actually say, this works, and so--I  
804 appreciate your testimony, and hopefully we will get that in  
805 our response when we are--when we get that score, so--thank

806 you.

807 Chairman--Madam Chairman, I yield back my time.

808 Mrs. {Capps.} Congressman Gingrey is now recognized.

809 Mr. {Gingrey.} Madam Chairman, thank you. And I am  
810 going to direct my questions to Mr. Hackbarth.

811 Mr. Hackbarth, one of the barriers to achieving value in  
812 Medicare cited in your testimony--you state that Medicare  
813 payment policies ``ought to exert physical pressure on  
814 providers.''

815 Mr. {Hackbarth.} Um-hum.

816 Mr. {Gingrey.} You go on to state that in a fully  
817 competitive market, which I am guessing infers that Medicare  
818 does not compete in a fully competitive market, that this  
819 physical pressure happens automatically in a fully  
820 competitive market. In the absence of such a competitive  
821 market, you suggest that Congress must exert this pressure by  
822 limiting payment updates to Medicare physician updates.

823 When created Medicare Part D, Congress considered  
824 instituting a set payment rate in lieu of creating a  
825 competitive market, where competition among the pharmacy  
826 benefit plans might automatically keep the cost down. In the  
827 end, this Congress elected to go with that competitive model  
828 and forego payment rates set in statute, some of those that  
829 exist under current Medicare fee for service. The results,

830 as we all now know, is that, due to the private market  
831 pressure, rather than government price setting, Part D  
832 premiums are much lower than anticipated, and drug prices  
833 have gone down.

834         So, instead of exerting the physical pressure on  
835 providers that you suggest must be exerted due to the lack of  
836 a competitive market to do it automatically, I am curious as  
837 to your thoughts on how using a competitive bidding process,  
838 like what we did in Medicare Part D, might achieve the same  
839 sort of efficiencies you suggest are required in traditional  
840 Medicare, but without having to resort to restricting of  
841 payments.

842         Mr. {Hackbarth.} Um-hum. Well, let me approach it from  
843 two directions, Dr. Gingrey. If we look at private insurers,  
844 and the private insurance marketplace, and we compare the  
845 costs of those programs with Medicare costs, what we see is  
846 that, on average, and my evidence here is from the Medicare  
847 Advantage Program, is that the bids submitted by the private  
848 plans are higher than Medicare's costs, they are not lower.  
849 Now, there are some plans that bid lower, but on average, the  
850 private bids are higher.

851         So that is an opportunity for private plans to come in  
852 and compete and show that they can reduce costs, and by their  
853 own bids, they have not done that.

854 Mr. {Gingrey.} You are talking Medicare Advantage?

855 Mr. {Hackbarth.} Medicare Advantage.

856 Mr. {Gingrey.} But, of course, they--Mr. Hackbarth,  
857 they do provide something that these three committees that  
858 have come up with this draft legislation, if you will, really  
859 want, and that is, of course, emphasis on things other than  
860 just episodic care, treatment of pain and suffering, but also  
861 wellness prevention and that sort of thing.

862 Mr. {Hackbarth.} Yeah. Some do, some don't. The  
863 private plans are quite variable in their structure, how they  
864 deal with providers, what sort of care coordination programs  
865 they have, and most importantly, they are quite variable in  
866 their bottom line results. Some are outstanding, some are  
867 not.

868 Mr. {Gingrey.} Yeah. Let me go on to another question.  
869 I thank you for that response. One of the foundations of  
870 your testimony today is that the American health care system  
871 has serious quality problems. You--``At the same time that  
872 Americans are not receiving enough of the recommended care,  
873 the care they are receiving may not be appropriate.'' And  
874 then you go on to cite the Dartmouth Center for the  
875 Evaluative Clinical Services as proof of a wide variation in  
876 Medicare spending and rates of service used.

877 Just to be clear, when you say the American system, Mr.

878 Hackbarth, are you referring to the American Medicare system,  
879 and not the entire American health care system? Am I correct  
880 in that assumption, given that the Dartmouth study used only  
881 Medicare data for its findings? We are talking about the  
882 American Medicare system and not the entire health care  
883 system?

884 Mr. {Hackbarth.} Well, in fact, the Dartmouth study is  
885 done using Medicare data because it is the most readily  
886 available comprehensive database. I don't think there is any  
887 reason to believe that physicians are practicing different  
888 for Medicare patients and private patients, but my personal  
889 experience in working closely with physicians is that it is a  
890 matter of principle that they don't vary their care based on  
891 the insurance coverage of the patient. They treat the  
892 patient based on what the patient needs.

893 So I think it is a reasonable inference, if you see this  
894 variation of Medicare, likely you have the same variation--

895 Mr. {Green.} Well, I know my time is up, Madam  
896 Chairman, but I--the reason I ask you this question, Mr.  
897 Hackbarth, because we are going to have another panel,  
898 probably several more panels today, but I think there are  
899 going to be some physicians that are practicing in the  
900 private market that might want to dispute what you just said.  
901 But thank you so much for your response, and I yield back,

902 Madam Chairman.

903 Mrs. {Capps.} Thank you. I now yield myself my time  
904 for questions, and I thank you both for your testimony today.  
905 Mr. Hackbarth, we are sort of picking on you, I think, but  
906 you can tell from the questions that Medicare payment reform  
907 seems to be a very pressing issue for many of us. And one of  
908 the Medicare payment reforms that we are suggesting in this  
909 legislation is a change to the Gypsy formula in California so  
910 that it is now based on MSAs, Metropolitan Statistical Area.

911 Two of the counties I represent in California are  
912 negatively impacted by the current payment formula.  
913 Physicians in both San Luis Obispo and Santa Barbara Counties  
914 are paid less, much less they would say, than the actual cost  
915 of practicing medicine. My question to you is in general,  
916 but also specifically toward California. Will the Gypsy  
917 provisions improve the accuracy of payments in the new fee  
918 schedule areas that you--across the country, as you have  
919 envisioned them?

920 Mr. {Hackbarth.} Yeah. The provision related to  
921 California in the bill is based on one of two options that  
922 MedPAC developed for CMS back in--I think it was 2007. So  
923 approach in the bill is consistent with the advice that we  
924 have given CMS.

925 Mrs. {Capps.} Excellent. And then maybe you could

926 elaborate a little bit on the benefit, obviously, that you  
927 are seeing from having physician payment areas aligned with  
928 hospital payment areas, and is that, again, consistent around  
929 the nation, once we get our alignment correct in California?

930 Mr. {Hackbarth.} Well, the issue that we focused on was  
931 specific to California. As you know, the Gypsies work  
932 differently in different states, and so our recommendation  
933 wasn't that this approach be applied everywhere, but we saw  
934 it as a reasonable solution to the California issues that you  
935 and other members have raised.

936 Mrs. {Capps.} Now, we have seen that other area of the  
937 country have this disparity as well, but you think those are  
938 best resolved on a regional basis?

939 Mr. {Hackbarth.} Yeah. Different states have elected  
940 to resolve it differently, and we think the problems are not  
941 national in scope, but more isolated, and more tailored  
942 approaches are the best way to go.

943 Mrs. {Capps.} And that would be a pattern that you  
944 might suggest in other areas as well, that we look at  
945 regional issues, particularly--at least in the payment  
946 schedules?

947 Mr. {Hackbarth.} Yeah. Well, you know, that is a big  
948 statement, and I--

949 Mrs. {Capps.} Well, I am just wanting to see how far

950 you want to go--

951 Mr. {Hackbarth.} Yeah. I would like to take a look  
952 at--consider the issues one by one, as opposed to make that  
953 as a broad policy statement.

954 Mrs. {Capps.} Well, I know our--my California colleague  
955 said this has been a real serious detriment to Medicare, and  
956 the practice of Medicare in our state. In many of the  
957 regions that the cost of living has been--

958 Mr. {Hackbarth.} Right.

959 Mrs. {Capps.} --very different from what the allotment  
960 has been, so this becomes, for us, a really vital component  
961 of Medicare reform--

962 Mr. {Hackbarth.} Yes.

963 Mrs. {Capps.} --under this bill.

964 Mr. {Hackbarth.} Yeah. And to say we think the  
965 approach in the bill is a reasonable one, and it is one of  
966 the options that we recommended to see in this.

967 Mrs. {Capps.} Okay. I am going to yield back my time,  
968 and recognize Mr. Buyer for his questions.

969 Mr. {Buyer.} I see a company in Tampa just shut their  
970 doors to 500 jobs due to the S-CHIP bill. They are going to  
971 send the tobacco--those cigars to be made offshore. Just  
972 thought I would let everybody know who really cares, I guess.

973 This has been a challenge to get my arms around this in

974 a short period of time, just to be very honest with you, so--  
975 I am trying to understand--I just went through that tobacco  
976 bill, where the majority froze the market, so they are--now  
977 they love this talk about competition, and they love to  
978 freeze the market in place, and I am getting a sense that  
979 that is what you are doing in this bill also, freezing the  
980 market. So those of whom had existing plans, you freeze it,  
981 grandfather it, and then you have got to figure out how you  
982 move people into the exchange, and if you--and when we freeze  
983 that market--so help me here with my logic, because I am  
984 trying to figure out what you are trying to do. We freeze  
985 that market, and you want to move a population into an  
986 exchange. You can--we will grandfather, so people can keep  
987 their existing coverage, but if, at some point in time, that  
988 employee chooses to move to a government plan, then the  
989 employer has to be an eight percent tax on it. Is that  
990 right?

991 Mr. {Hackbarth.} Is that--

992 Mr. {Buyer.} Yes.

993 Mr. {Hackbarth.} --Mr. Buyer?

994 Mr. {Buyer.} Congressman Buyer

995 Mr. {Hackbarth.} Buyer, I am sorry.

996 Mr. {Buyer.} Okay.

997 Mr. {Hackbarth.} Our focus is on the Medicare

998 provisions of the bill, and the bill is not our bill. We--  
999 our advisory--

1000 Mr. {Buyer.} Okay. So you--

1001 Mr. {Hackbarth.} --our body--

1002 Mr. {Buyer.} --can't answer that question?

1003 Mr. {Hackbarth.} Absolutely--

1004 Mr. {Buyer.} Right

1005 Mr. {Hackbarth.} --not. That is beyond our  
1006 jurisdiction.

1007 Mr. {Buyer.} No, that is okay. Well, let me ask a  
1008 question, then, that is within your jurisdiction. You had--  
1009 sir, you had suggested that encouraging the use of  
1010 comparative effectiveness information would facilitate  
1011 informed decisions by providers and patients about  
1012 alternative services for diagnosing and treatment of most  
1013 common clinical conditions, is that correct?

1014 Mr. {Hackbarth.} Um-hum.

1015 Mr. {Buyer.} Uh-huh means yes?

1016 Mr. {Hackbarth.} Yes, sir.

1017 Mr. {Buyer.} Thank you. Following your line of  
1018 reasoning, could the Medicare program also use this research  
1019 to exert fiscal pressure on drug and device makers, or even  
1020 restrict certain procedures based solely on price?

1021 Mr. {Hackbarth.} What MedPAC has recommended is that

1022 the Federal government invest in comparative effectiveness  
1023 research, make it available to physicians, patients,  
1024 insurers, for them to make their own decisions about how to  
1025 use the information.

1026 Mr. {Buyer.} Then how best do we, i.e. Congress--how  
1027 best do we make sure that this research is used to inform the  
1028 consumer and providers without being an excuse to exclude or  
1029 ration certain types of care? How do we best do that?

1030 Mr. {Hackbarth.} Well, decisions about how Medicare  
1031 would use the information are issues on which Congress can  
1032 legislate. What MedPAC has recommended is investment in  
1033 information to be used in a de-centralized way by all of the  
1034 participants in the system.

1035 Mr. {Buyer.} All right. Mr. Levinson, the--one of the  
1036 great concerns I have is--can you--would you be able to  
1037 address a comparison or an analogy on Medicaid? I know you  
1038 are Medicare--you guys are claiming lanes of jurisdiction  
1039 here.

1040 Mr. {Levinson.} Mr. Buyer, we actually--as an Office of  
1041 Inspector General, we oversee all 300 programs of--

1042 Mr. {Buyer.} Okay.

1043 Mr. {Levinson.} --of the Department, so--

1044 Mr. {Buyer.} All right.

1045 Mr. {Levinson.} --we also have--

1046 Mr. {Buyer.} Most of the--

1047 Mr. {Levinson.} --side of Medicaid.

1048 Mr. {Buyer.} All right, thank you. So most of the  
1049 fraud cases, with regard to Medicaid, are they discovered by  
1050 the states or are they discovered by the Federal government?

1051 Mr. {Levinson.} Medicaid cases can be developed along a  
1052 very wide spectrum of possible sources.

1053 Mr. {Buyer.} I understand, but are most cases  
1054 discovered in the states or by the Federal government?

1055 Mr. {Levinson.} I would have to find out those numbers  
1056 for you. I suspect it would be mostly states in terms of  
1057 absolute number. But in terms of dollars, because some of  
1058 the biggest--

1059 Mr. {Buyer.} All right. Don't do it by dollars, do it  
1060 by cases.

1061 Mr. {Levinson.} By the number of cases--

1062 Mr. {Buyer.} I think common sense tells us--let me jump  
1063 ahead.

1064 Mr. {Levinson.} Given the Medicaid fraud--

1065 Mr. {Buyer.} I think common sense is going to tell us  
1066 that if states had a stake in the game, that they have an  
1067 incentive, then, to make sure they go after fraud cases. If  
1068 the Federal government picks that up at 100 percent, my  
1069 concern is are we disincentivizing states with this oversight

1070 responsibility, which places more on you, and is that a  
1071 concern to you?

1072 Mr. {Levinson.} It is a--certainly a very important  
1073 concern that we make sure that every Medicaid dollar--and we,  
1074 of course, have responsibility for the Federal share of that  
1075 Medicaid--is accounted for as much as possible. And as the  
1076 Federal share, as the FMAP goes north, goes up, obviously our  
1077 reach needs to be greater, our concern needs to be elevated  
1078 on the Medicaid side, absolutely.

1079 Mr. {Pallone.} Thank you. The gentleman from Iowa, Mr.  
1080 Braley.

1081 Mr. {Braley.} Thank you, Mr. Chairman.

1082 Mr. Levinson, to follow up on that point, all of us on  
1083 this Subcommittee are strongly opposed to fraud in any health  
1084 care delivery system, so let us start with that premise. I  
1085 think the real elephant in the room is that fraud is a small  
1086 component of what the real obstacle is to meeting full health  
1087 care reform, and that is waste. Because, according to many  
1088 reliable projections, there are \$700 billion annually of  
1089 waste in Medicare delivery, which is a much greater problem.  
1090 Because if you take that number and multiply it over the 10  
1091 year period of this health care bill we are talking about,  
1092 you are talking about \$7 trillion of cost savings that would  
1093 more than pay for the entire cost of the program we are

1094 talking about. So isn't it waste that is really the problem  
1095 here?

1096 Mr. {Levinson.} Mr. Braley, we try to identify and  
1097 correct issues of fraud, waste and abuse, and we do not have  
1098 solid figures in which to share with you exactly how that pie  
1099 may be divided specifically. But all of those kinds of  
1100 issues are of great concern to the office, and we have work  
1101 that supports recommendations on--in all of those areas.

1102 Mr. {Braley.} And they should be of concern to American  
1103 taxpayers also?

1104 Mr. {Levinson.} Absolutely.

1105 Mr. {Braley.} Okay. Mr. Hackbarth, I really appreciate  
1106 the effort that you and MedPAC have put into this. You  
1107 mentioned the objectives of health care reform being high  
1108 quality care and protecting taxpayers from undue financial  
1109 burdens, and getting back to my point that I just made, under  
1110 the current health care delivery system and reimbursement  
1111 model, we are wasting billions of dollars every year, aren't  
1112 we?

1113 Mr. {Hackbarth.} It is our belief that, yeah, we can do  
1114 better with less, and there is lots of research to support  
1115 that.

1116 Mr. {Braley.} Well--and one of the problems that my  
1117 health care providers and I will have is that for years they

1118 consistently rank in the top five in every objective quality  
1119 measurement, and at the very bottom of Medicare  
1120 reimbursement. Isn't that a summary of what is wrong with  
1121 our health care model today?

1122 Mr. {Hackbarth.} Well, my home state of Oregon is also-  
1123 -

1124 Mr. {Braley.} Exactly.

1125 Mr. {Hackbarth.} --with you in Iowa, and--so that is a  
1126 type of evidence that we can do better for less in Medicare.  
1127 You know, I think it is good for Iowa, good for Oregon, that  
1128 we have got low health care costs and high quality. Not only  
1129 does it hold down Medicare expenditures, it is good for our  
1130 beneficiaries. It holds down their out of pocket expenses,  
1131 the Medigap premiums. So I don't want to increase Iowa and  
1132 Oregon to be more like some of the high cost states.

1133 Mr. {Braley.} Exactly.

1134 Mr. {Hackbarth.} I want to bring the high cost states  
1135 down to Iowa and Oregon.

1136 Mr. {Braley.} And isn't that the problem? Because  
1137 under Medicare's proposed pay for performance system, the  
1138 modeling is based upon improvement in efficiency. So if you  
1139 are a state like Oregon and Iowa, who is already delivering  
1140 efficient, low cost, high quality health care, you get no  
1141 incentive from a model of reimbursement that is based only on

1142 improvement, isn't that true?

1143           Mr. {Hackbarth.} Well, as we move to new payment  
1144 systems, move away from our siloed fee for service system to  
1145 bundle payment systems or ACOs, one of the critical decisions  
1146 that is going to have to be addressed is how to set those  
1147 initial rates for these new types--

1148           Mr. {Braley.} Right.

1149           Mr. {Hackbarth.} --of payment systems. And in that is  
1150 an opportunity to address some of these regional inequity  
1151 issues that have come up in the program.

1152           Mr. {Braley.} But if you are going to base a public  
1153 health insurance option on a Medicare model that already has  
1154 built-in inefficiencies and inequities in reimbursement, what  
1155 reform hope does that give to this country?

1156           Mr. {Hackbarth.} Yeah. We need to change the Medicare  
1157 model. Independent of the public plan issue, for Medicare's  
1158 own sake, for the taxpayers' sake, for the beneficiaries'  
1159 sake, we have to change the Medicare model.

1160           Mr. {Braley.} Well--and I am glad you mentioned that,  
1161 because Congressman Ron Kind and I have introduced the  
1162 Medicare Payment Improvement Act of 2009, H.R. 2844, that  
1163 attempts to do just that by identifying clear, objective  
1164 quality measurements that are highly recommended by a number  
1165 of health care organizations that are looking to improve

1166 efficiencies and increase quality. It examines things like  
1167 health outcomes and health status of the Medicare population,  
1168 patient safety, patient satisfaction, hospital readmission  
1169 rates, hospital emergency department utilization, hospital  
1170 admissions for conditions, mortality related to health care,  
1171 and other items determined by HHS.

1172       Isn't it true that until we move to some  
1173 transformational type of health care reimbursement we are  
1174 ignoring the real cost opportunities to transform health care  
1175 and provide expanded access to coverage?

1176       Mr. {Hackbarth.} Yes. We believe that we need to  
1177 adjust payment to reflect the quality of care. That is one  
1178 type of change. But we also believe that we need to move  
1179 away from fragmented fee for service payment to paying for  
1180 larger bundles, paying for populations of Medicare patients.

1181       The big difference between Iowa and the high cost states  
1182 is on the utilization of services. How many hospital days  
1183 per 1,000, how many referrals to specialists and the like.  
1184 Iowa tends to be low on those things, and the high cost  
1185 states tend to be high on those things. If we move towards a  
1186 payment system that advantages places with lower utilization,  
1187 like Iowa, that will begin to address these regional inequity  
1188 issues that you are focused on.

1189       Mr. {Braley.} Thank you.

1190 Mr. {Pallone.} Thank you, Mr. Braley. Mr. Shimkus?

1191 Mr. {Shimkus.} Thank you, Mr. Chairman, and I  
1192 appreciated the little comments we had before my questioning.

1193 I am going to follow up on something I addressed last  
1194 night, and--addressing just the basic FMAP formula, which has  
1195 been a bone of contention for me for many years, because I  
1196 believe it has been flawed, and does not accurately reflect a  
1197 given state's need to meet its Medicaid obligations. So that  
1198 is kind of where I am coming from.

1199 The formula does not accurately reflect the difference  
1200 between a state's fiscal earnings, low income citizens, or  
1201 cost of delivery of service. This results in states like  
1202 mine, and I think other states, if my colleagues would do  
1203 some research, which--only having a match of around 50  
1204 percent. We know in the testimony yesterday we had New  
1205 Jersey here, we had California. They are also 50 percent  
1206 match states, and I have got the list here where every state  
1207 falls. But it falls short of its needs, yet other states  
1208 have matches as high as 75 percent.

1209 Overall, the FMAP formula has resulted in the Federal  
1210 government's financing remaining around 57 percent across the  
1211 board, yet the discussion draft seeks to have states enroll  
1212 childless adults ages 19 to 64, up to 137 of poverty line,  
1213 and have the Federal government finance 100 percent of this

1214 new Medicaid population. That was part of the discussion we  
1215 were having offline. Do you think it is fair that we  
1216 continue to have these inequities among states when it comes  
1217 to FMAP, given we aren't meeting the needs of many states,  
1218 especially those with low matches?

1219 Mr. {Levinson.} Mr. Shimkus, would you like me to  
1220 respond to that--

1221 Mr. {Shimkus.} Both.

1222 Mr. {Levinson.} --question?

1223 Mr. {Shimkus.} It is a question to both.

1224 Mr. {Levinson.} Because I would have to say that our  
1225 office, not being a policy office, we don't actually  
1226 establish the FMAP rates. We certainly audit those among our  
1227 auditors, but we are not a program office. We oversee that.  
1228 So I can't--

1229 Mr. {Shimkus.} So as an auditing office, you wouldn't  
1230 disagree with that analysis that I have given?

1231 Mr. {Levinson.} Well, actually, the rate is higher now  
1232 in some of the states as a result of the American--

1233 Mr. {Shimkus.} Yeah, and that is--

1234 Mr. {Levinson.} --Recovery--

1235 Mr. {Shimkus.} That is--yeah, that is true, but there  
1236 are still percentage inequities. So you have a 75 percent  
1237 state that is now up to 83 percent. You have a 50 percent

1238 state that is up to maybe 60 percent, but, of course, there  
1239 is no assumption--I mean, depending upon what we do on a  
1240 bill, there is no assumption that those amounts remain,  
1241 because the stimulus bill was a short term bill, and there is  
1242 no certainty that that input of money will remain.

1243 Mr. {Levinson.} Mr. Shimkus, we work with the numbers  
1244 that we are given, as opposed to--

1245 Mr. {Shimkus.} Okay. That is--

1246 Mr. {Levinson.} --the numbers ourselves.

1247 Mr. {Shimkus.} Mr. Hackbarth?

1248 Mr. {Hackbarth.} Mr. Shimkus, we focus exclusively on  
1249 Medicare issues, not Medicaid. That is our jurisdiction  
1250 under the statute.

1251 Mr. {Shimkus.} Okay. Let me just--then let me go with  
1252 a few other questions, just to put it--you know, our  
1253 frustration with this process of rushing through and having a  
1254 draft is we have got to ask these questions when we have--and  
1255 I want to get these out. Would it be appropriate, in the  
1256 context of health reform, to address the inequity of FMAP by  
1257 recalculating the FMAP to accurately reflect needs, or, at  
1258 the very least, level the playing field for every state? Mr.  
1259 Levinson, do you want to--

1260 Mr. {Levinson.} Mr. Shimkus, that is really beyond my  
1261 charter.

1262 Mr. {Shimkus.} Good. Okay. Mr. Hackbarth, same  
1263 answer?

1264 Mr. {Hackbarth.} Yeah.

1265 Mr. {Shimkus.} Okay. So what I am trying to establish  
1266 is this. Illinois is a 50/50 match state, which means that  
1267 for every dollar spent on Medicaid, we will write a check to  
1268 the state for 50 cents, okay? There are states out there  
1269 that for every dollar they spend on Medicaid, the Federal  
1270 government sends them 75 cents. If we are doing health care  
1271 reform, and the premise of this bill is when we add people to  
1272 Medicaid, 100 percent of that will be spent, but it still  
1273 does not affect the basic fundamental inequity of the FMAP.  
1274 So what states have to do is they have to game the system.  
1275 They have to go to HHS, they have to find past additional tax  
1276 incentives to get additional rebates. We have the tax  
1277 increase on beds in hospitals that we passed, so they pass a  
1278 tax. They remit the tax back to the Federal government, the  
1279 Federal government gives the tax back to them, plus some  
1280 additional revenue.

1281 So I would encourage folks to look--my colleagues to  
1282 look at their FMAP percentage. And if we are going to move  
1283 on streamlining health care and reimbursement that--even as  
1284 we increase the amount for the new Medicaid people we bring  
1285 on, we really bring some clarity and equality across the

1286 state lines and FMAP.

1287 And Mr. Chairman, thank you for letting me go 13 seconds  
1288 over, and I yield back my time.

1289 Mr. {Pallone.} Thank you. The gentlewoman from  
1290 Florida, Ms. Castor.

1291 Ms. {Castor.} Thank you, Mr. Chairman. Good morning.  
1292 Mr. Hackbarth, you state in your testimony that the payment  
1293 system for Medicare Advantage plans needs reform. Medicare  
1294 Advantage--the Medicare Advantage program continues to be  
1295 more costly than traditional Medicare health services. The  
1296 Medicare Advantage government payments per enrollee are  
1297 projected to be 114 percent of comparable fee for service  
1298 spending in 2009. It is up from 2008. The high Medicare  
1299 Advantage payments provide a signal to plans that the  
1300 Medicare program is willing to pay more for the same services  
1301 in Medicare Advantage than it does in traditional Medicare  
1302 and fee for service.

1303 Our discussion draft tackles the overpayment issue, but  
1304 what would happen if we did not do this?

1305 Mr. {Hackbarth.} Well, let me begin by saying that  
1306 MedPAC very much supports giving Medicare beneficiaries the  
1307 option to enroll in private plans, so we are enthusiastic  
1308 about that. Our objections are to the current payment  
1309 system, which, as you say, pays significantly more on average

1310 for private plans that it would cost traditional Medicare to  
1311 pay for the same patients. If we were to lower the rate, one  
1312 of the effects of that would be to send a marked signal to  
1313 private plans about what we want to buy as a Medicare  
1314 program, and we reward plans that take steps to be more  
1315 efficient, more effective in the care that they provide.

1316 So long as we continue to pay more, the signal that we  
1317 are sending is mimicking Medicare, traditional Medicare, just  
1318 at a higher cost, is okay with us. And so long as we send  
1319 that signal, we will get more of that. We have got to change  
1320 the signal to get the market response that we desire.

1321 Ms. {Castor.} And ultimately help us control costs  
1322 across the board?

1323 Mr. {Hackbarth.} Absolutely. Even control costs for  
1324 the beneficiaries as well--

1325 Ms. {Castor.} Um-hum.

1326 Mr. {Hackbarth.} --because all beneficiaries, even  
1327 those who aren't enrolled in private plans, are paying part  
1328 of the additional costs for Medicare Advantage.

1329 Ms. {Castor.} And I am afraid these overpayments have  
1330 created incentives for extensive unethical behavior by  
1331 insurance companies. Three-fourths of the states report  
1332 marketing abuses in Medicare, and I have some firsthand  
1333 experience with this, talking to seniors at retirement

1334 centers in my hometown, where insurance salesmen have come  
1335 in, targeted seniors with dementia, who have--were on  
1336 traditional Medicare and signed them up for Medical  
1337 Advantage, sometimes under the guise of coming in and selling  
1338 their Medicare Part D policies, and then switching them out.

1339         And what happens is that senior, who has a longtime  
1340 relationship with their doctor, oftentimes they lose access  
1341 to that doctor they had under traditional Medicare because  
1342 their Medicare Advantage plan doesn't have the same doctor.  
1343 There have been cases that--where cash incentives have been  
1344 provided to insurance salesmen, and this shouldn't be--we  
1345 shouldn't have these incentives for fraudulent behavior.  
1346 They--I think it has gotten out of hand, and unfortunately,  
1347 CMS has all but abdicated its oversight role.

1348         The Congress, some years ago, took the states' ability  
1349 away, their ability to regulate and oversee these terrible  
1350 marketing abuses. Now, our discussion draft, it makes some  
1351 very subtle change in--with enhanced penalties for Medicare  
1352 Advantage and Part D marketing violations, but don't you  
1353 think we need to go back to having as robust a strike force  
1354 as we possibly can so--and give the states the ability--you  
1355 know, they are closer to the ground--the ability they had  
1356 before to tackle the marketing abuses? The National  
1357 Associations on Insurance Commissioner supports such a move.

1358           Without it--unless we do this, we will continue to have  
1359 this huge regulatory gap, but what is your view?

1360           Mr. {Levinson.} Ms. Castor, we certainly work with the  
1361 states to--as much as possible to protect the Medicare and  
1362 the Medicaid programs. We have a very good collaborative  
1363 relationship with our state auditors and state and local law  
1364 enforcement. There are jurisdictional divides, and we try to  
1365 respect those. But to the extent that we can actually  
1366 understand schemes that are broader than just one particular  
1367 matter, that really allows us to do our work more effectively  
1368 because the fact of the matter is, although we are one of the  
1369 larger Inspector General offices in government, given the  
1370 size of our programs, we are very stretched. We only have a  
1371 few hundred criminal investigators to handle, you know,  
1372 billions and billions of dollars stretched across the country  
1373 in a variety of health care contexts.

1374           But I certainly would underscore the importance of being  
1375 able to work very much hand in glove with our state and local  
1376 partners.

1377           Mr. {Pallone.} Thank you. Gentleman from Pennsylvania,  
1378 Mr. Murphy.

1379           Mr. {Murphy of Pennsylvania.} Thank you, Mr. Chairman.  
1380 I thank the panelists for being here.

1381           Some questions about Medicare. It was founded in 1965.

1382 In the ensuing years, has there ever been a time when any  
1383 president or any Congress has really gone back and overhauled  
1384 the program, and--this program being established back in  
1385 pre-CT scan and MRI days. Has there ever been a  
1386 comprehensive overhaul of the system to modernize it, reform  
1387 it, make it work more effectively?

1388 Mr. {Hackbarth.} Well, the payment systems have  
1389 changed. Medicare began with payment systems--

1390 Mr. {Murphy of Pennsylvania.} Right.

1391 Mr. {Hackbarth.} --were based on cost reimbursement.

1392 Mr. {Murphy of Pennsylvania.} And in terms of how it--  
1393 because today you are talking about a number of interesting  
1394 reforms, and has that ever been attempted before?

1395 Mr. {Hackbarth.} Well, the payment systems have been  
1396 reformed. They have changed substantially over the life of  
1397 the program.

1398 Mr. {Murphy of Pennsylvania.} But I mean--

1399 Mr. {Hackbarth.} We think more changes are warranted.

1400 Mr. {Murphy of Pennsylvania.} You are talking about the  
1401 delivery--like, care coordination and preventing re-  
1402 admissions and things like that. That has never been  
1403 attempted, right? I mean, in terms of overall reforms in the  
1404 system.

1405 Mr. {Hackbarth.} In terms--there has not been payment

1406 reforms focused on re-admissions, no.

1407           Mr. {Murphy of Pennsylvania.} Okay. I am assuming you  
1408 are talking about more than just payment reforms today,  
1409 because your report has a lot more than just how the money  
1410 gets spent. Okay. And in that--I mean, I noted in the 110<sup>th</sup>  
1411 Congress there was 452 bills put in by members of Congress to  
1412 make some reforms to Medicare and Medicaid, I think 12  
1413 passed, and some 13,000 co-sponsors of these bills came  
1414 through members of Congress. So I look upon this--and  
1415 members of Congress themselves recognize there needs to be  
1416 some changes in Medicare and Medicaid, but it seems to come  
1417 slow.

1418           I am wondering in this process, where--some of the  
1419 changes you recommend here--and I applaud them, because they  
1420 are things I have been asking for for a long time too. Care  
1421 coordination, I mean, we will pay to amputate the legs of a  
1422 diabetic, won't pay to have some nurse call them with these  
1423 cases. We will--we recognize one in five chronic illnesses  
1424 gets re-admitted to the hospital, but we haven't been working  
1425 at keeping them out. Those are major changes to make here.

1426           Mr. {Hackbarth.} Yes.

1427           Mr. {Murphy of Pennsylvania.} My concern is the speed  
1428 at which the Federal government moves to make changes, number  
1429 one, and two, does the Federal government have to run its own

1430 insurance plan, given its track record of not being very good  
1431 at coming up with timely changes? Can we come up with some  
1432 of these changes with the Federal government pushing for and  
1433 mandating some of these changes in the private market--

1434 Mr. {Hackbarth.} Yes.

1435 Mr. {Murphy of Pennsylvania.} --and in the meantime  
1436 Medicare pushing some within itself? Is that possible to do  
1437 that?

1438 Mr. {Hackbarth.} Well, I think we need to do some of  
1439 each. The potential for Medicare Advantage is to invite  
1440 private plans to enroll Medicare beneficiaries, do things  
1441 differently to get better results for both the beneficiaries  
1442 and the program. Because of the way Medicare Advantage  
1443 works, the way the prices are set, it has not fulfilled that  
1444 potential. It has allowed private plans to enroll Medicare  
1445 beneficiaries, essentially mimic traditional Medicare, with  
1446 all the same problems. So one of the reasons we believe  
1447 Medicare Advantage reform is so important is to reward  
1448 private plans that do it better.

1449 Mr. {Murphy of Pennsylvania.} Okay. So that is--so, in  
1450 other words, you know, they can just continue on with  
1451 business as usual, but Medicare Advantage, they should really  
1452 be using these things for what it was designed to be, and  
1453 that is really work at prevention, really working at care

1454 coordination, am I correct on that?

1455           There was something else mentioned, or you--a point that  
1456 was made earlier, encouraging use of comparative  
1457 effectiveness information, public reporting, provider  
1458 quality, et cetera. This also relates to the issue of  
1459 evidence based medicine and evidence based treatments that  
1460 many people referred to. Throughout medicine, there are many  
1461 branches that have their own standards and protocols, College  
1462 of Surgeons, American Academy of Pediatrics. Would those be  
1463 things that Congress or the FDA or HHS could look towards in  
1464 terms of what these standards might be, in terms of what is  
1465 the best practices and what would be the standards and  
1466 protocols to use?

1467           Mr. {Hackbarth.} Well, specialties are quite variable  
1468 in how they develop those standards, those protocols. It is  
1469 difficult to generalize about them. Let me focus on the area  
1470 of imaging as one example. We had as a witness before the  
1471 MedPAC the president of College of Cardiology to talk about  
1472 imaging issues, and one of the things that she called for was  
1473 more information so they can move from just consensus based  
1474 guidelines to evidence based guidelines.

1475           The potential in comparative effectiveness research is  
1476 that we give physicians and societies the raw material to do  
1477 a better job at what they want to do.

1478 Mr. {Murphy of Pennsylvania.} So--and this is a  
1479 critically important point, and one that we should not rush,  
1480 because it is going to have long term implications. So the  
1481 College of Cardiologists or Radiologists or whatever that is,  
1482 we have to make sure it isn't just they have all sat down and  
1483 voted that--best thing, but there really needs to be a  
1484 demand, and this is where a valuable role of government--the  
1485 HHS or FDA to have oversight to say, we want to see evidence  
1486 based medicine here. Is that what you are suggesting?

1487 Mr. {Hackbarth.} That is the goal. We need information  
1488 for physicians, as well as patients, to guide that.

1489 Mr. {Murphy of Pennsylvania.} I mean, this is a  
1490 critical thing, Mr. Chairman, and one I hope we continue  
1491 dialogue on because it is going to be a factor that I think  
1492 makes or breaks the budget, is how we go through there, and I  
1493 think also deal with the issue of who is making the  
1494 decisions, and I think a valuable place where this Committee  
1495 can have tremendous oversight in working with medicine, and  
1496 with that, I yield back. Thank you, sir.

1497 Mr. {Pallone.} Thank you, Mr. Murphy. Gentlewoman from  
1498 Wisconsin, Ms. Baldwin.

1499 Ms. {Baldwin.} Thank you, Mr. Chairman.

1500 Mr. Hackbarth, welcome back to the Subcommittee. I  
1501 recall when you were here in March we had quite a dialogue

1502 about--as we have today, about the difference between pilot  
1503 projects and demonstration projects, and you expressed then,  
1504 as you have here today, some hesitation about the  
1505 administrative and regulatory burdens associated with  
1506 demonstration projects, and how that affects the ability to  
1507 scale those up, if they have proven successful.

1508         This draft health care reform legislation offers new  
1509 pilot projects in accountable care organizations and medical  
1510 home models, and I am wondering if it is your sense that  
1511 these pilots will provide us, the Congress, and MedPAC with  
1512 sufficient evidence to make broader payment reforms. And  
1513 also, if you have examined these provisions in the draft, if  
1514 you have any recommendations for further improvement.

1515         Mr. {Hackbarth.} Well, on the issue of pilots, we  
1516 welcome the fact that the Committee is looking at pilots, and  
1517 what MedPAC has advocated, and we have talked about this  
1518 before, is that Congress give the Secretary discretion to  
1519 test a new payment method and to implement it, if the pilot  
1520 is successful, establish goals in advance, and then give the  
1521 Secretary discretion, plus the resources necessary.

1522         And an important part of this, I think, is a much larger  
1523 budget for the Department to not just test ideas that come  
1524 through the Congress, but to generate new ideas independently  
1525 in the Department. Right now the demonstration budget is way

1526 too small for that.

1527           Ms. {Baldwin.} In your--in MedPAC's most recent  
1528 reports, there is an interest sidebar concerning the  
1529 physician group practice demonstration, which serves, really,  
1530 as a foundation for the accountable care organization pilot  
1531 in the draft bill that we are looking at. You noted that a  
1532 surprising number of the sites for the physician group  
1533 practice demonstration project had high cost growth, and it  
1534 is linked to the risk profiles of the patients at those  
1535 sites. And it strikes me that basically there is an  
1536 inference that these demonstration sites may be picking up  
1537 more of their patients' medical issues, resulting in more  
1538 treatments, and increasing costs. What lessons do you  
1539 suggest that we take from this demonstration?

1540           Mr. {Hackbarth.} Well, in setting payment rates for new  
1541 payments systems like ACO, the details are very important,  
1542 and how the targets are set, how the potential gains are  
1543 shared between the providers in the Medicare program, and how  
1544 you adjust for things like risk, the risk profile of the  
1545 patients. And so there are important steps that have to be  
1546 taken from endorsement of a broad concept, like ACOs, to  
1547 making it an operational effective idea. And this is part of  
1548 why we think the Secretary needs some flexibility and  
1549 discretion and design in the resources, to be able to do that

1550 quickly and effectively.

1551           On an idea like ACOs, we are unlikely to get it exactly  
1552 right the first time, so there needs to be ongoing cycles of  
1553 refinement and improvement. That requires discretion and  
1554 resources.

1555           Ms. {Baldwin.} And we can certainly relate to the  
1556 difficulty to create a national program to rein in Medicare  
1557 spending. And on the ACOs, the idea is to set spending  
1558 targets to hold the providers accountable to the targets. If  
1559 you tied spending targets to national averages, I guess I  
1560 would like to ask how are we going to attain or incent  
1561 participation in higher cost areas, and do you have any ideas  
1562 of how we would address that challenge?

1563           Mr. {Hackbarth.} Yeah. Well, this goes back to the  
1564 dialogue that I had with Mr. Braley. One of the very  
1565 important details in these new payment systems, like ACOs, is  
1566 how you set those targets. If you take a group that has a  
1567 very low historic level of utilization, they have been very  
1568 efficient, very high quality, and say, okay, we are going to  
1569 set your target at your historic level of costs, it is going  
1570 to be more difficult for them to beat that and earn rewards  
1571 than for a practice that is in a very high cost state and  
1572 performing very poorly. That is not an equitable way to get  
1573 to where we want to go, so setting the target rate so that

1574 your reward historic performance, as well as future  
1575 performance is, for me, a goal in the target setting.

1576 Now, in order to do that, you are going to have to  
1577 squeeze someplace else. You are going to have to squeeze  
1578 those high cost places to offset the cost. So the--again,  
1579 the details in this are very important, and the Secretary  
1580 needs to be given the latitude to strike that balance.

1581 Mr. {Pallone.} Thank you. Mr. Pitts is next.

1582 Mr. {Pitts.} Thank you, Mr. Chairman.

1583 Mr. Levinson, in your testimony, you mentioned Medicaid  
1584 specific services that--there are services unique to Medicaid  
1585 that could lead to significant savings, and one example you  
1586 cite is school based health services. You say that OIG  
1587 ``consistently found that school had not adequately supported  
1588 their Medicaid claims for school based health services, and  
1589 identified almost a billion dollars in improper Medicaid  
1590 payments.'' Can you go into this further?

1591 Mr. {Levinson.} Mr. Pitts, we do make audit  
1592 recommendations to the Centers for Medicare and Medicaid  
1593 Services based on our audit findings, as our auditors look at  
1594 programs that are supported by the program, and that is an  
1595 area that the OIG has identified over the last few years as  
1596 one that CMS needs to focus on more clearly to make sure that  
1597 those dollars are really spent appropriately.

1598 Mr. {Pitts.} Well, what were some examples of these  
1599 improper payments? What was Medicaid paying for?

1600 Mr. {Levinson.} Well, overall, they were paying for  
1601 those kinds of services that are not included in the program,  
1602 but I would need to provide more detail to you as a follow up  
1603 to our hearing.

1604 Mr. {Pitts.} Now, the Bush administration proposed  
1605 regulations which would stop these fraudulent services and  
1606 stop wasting taxpayer dollars. However, the present  
1607 administration has put a moratorium on these regulations. Do  
1608 you believe that this moratorium should be lifted?

1609 Mr. {Levinson.} We do not comment on what the Executive  
1610 Branch decides to do with those kinds of regulations or not.  
1611 We certainly, you know, advance what we believe would be  
1612 appropriate ways of being able to account for the Medicare  
1613 dollars better, and our recommendations are given in the  
1614 first instance, in these kinds of cases, to the Centers for  
1615 Medicare and Medicaid Services.

1616 Mr. {Pitts.} Do you have any idea how much money in  
1617 total might have been wasted in this way?

1618 Mr. {Levinson.} Our audit findings will indicate the  
1619 dollars that we believe are not appropriately spent under the  
1620 Medicare program, and I don't have that dollar figure  
1621 immediately at my fingertips. We will certainly provide as

1622 much detail as we can, based on the audit findings we already  
1623 have.

1624       Mr. {Pitts.} All right. In your testimony, you mention  
1625 the creation of the Health Care Fraud Prevention and  
1626 Enforcement Action Team. Can you give me some examples of  
1627 what cases this team is currently addressing?

1628       Mr. {Levinson.} Well, the most recent example would be  
1629 the case that was publicized yesterday in Detroit, a Medicare  
1630 infusion drug fraud case that has resulted in 53 indictments.  
1631 There have been 40 arrests so far. 40 of our agents have  
1632 been involved in what is claimed as \$50 million in false  
1633 claims.

1634       This is a strike team in which we are working with the  
1635 FBI and local law enforcement to clean up a significant  
1636 Medicare infusion drug problem that now infects the city of  
1637 Detroit. Some of these issues have actually migrated from  
1638 South Florida, so the strike force effort is to try to  
1639 provide both national and regional focus on those kinds of  
1640 frauds that not only tend to plague particular cities in the  
1641 country, but that also have regional impact. We already have  
1642 strike forces in operation in a number of cities, but the  
1643 effort now will be to extend that to more cities over the  
1644 course of the next year.

1645       Mr. {Pitts.} Mr. Chairman, I don't know--

1646 Mr. {Pallone.} You want the time? You have a minute  
1647 left.

1648 Mr. {Pitts.} One minute left?

1649 Mr. {Pallone.} I am sorry--

1650 Mr. {Pitts.} How do you get the provider ID--the  
1651 criminals get the provider ID numbers?

1652 Mr. {Levinson.} Well, obviously through a variety of  
1653 fraudulent means, but it is too easy at this point in our  
1654 system to get provider numbers, and that has been a constant  
1655 theme of our office over the years, that enrollment standards  
1656 have not been sufficiently rigorous to ensure that we are not  
1657 allowing, in effect, criminals to masquerade as health care  
1658 providers.

1659 Mr. {Pitts.} Um-hum.

1660 Mr. {Levinson.} And that has been a significant problem  
1661 not just in Detroit and Miami, but really throughout the  
1662 country. And one of the key principles we have in terms of  
1663 our anti-fraud fighting effort is to make more rigorous who  
1664 actually gets in the program, because historically there has  
1665 been too much a right to access, as opposed to the privilege  
1666 of actually being enrolled in the program.

1667 Mr. {Pitts.} Mr. Buyer wants to follow up.

1668 Mr. {Buyer.} I guess--to be responsive here. How are  
1669 they--are they relying on insiders within the system to get

1670 these ID numbers, or you don't want to tell us so that others  
1671 will know how to--I mean, we can always--you can tell us  
1672 offline.

1673 Mr. {Pallone.} Mr. Buyer--let him answer the question,  
1674 but the time is expired. I have to apologize. The  
1675 electronics have gone off again, so I am going to just have  
1676 to tell everybody when their 5 minutes is up. But go ahead  
1677 and answer your question.

1678 Mr. {Levinson.} Thank you. I think it probably would  
1679 be better to have an offline conversation, because the  
1680 schemes are varied, and some of them are rather  
1681 sophisticated, and it is probably better not to discuss in  
1682 any detail what actually occurs in a public hearing.

1683 Mr. {Pitts.} Thank you, Mr. Chairman.

1684 Mr. {Pallone.} Thank you. Next is Ms. Eshoo, and I  
1685 will just tell you when the 5 minutes are up.

1686 Ms. {Eshoo.} Thank you, Mr. Chairman. Gentlemen, thank  
1687 you for your testimony today, and to the Chairman for this  
1688 series of hearings with many panels this week.

1689 As we look to reshape America's health care system, we  
1690 have very clear goals that we have set down. We want it to  
1691 be universal, it needs to be affordable. We think that  
1692 choice is important. We believe that many of the rules that-  
1693 -need to be rewritten that the insurers, the private

1694 insurers, employ, amongst them knocking people out because  
1695 they have pre-existing conditions and gender based issues, et  
1696 cetera. So that is on the--kind of on the one side of the  
1697 ledger.

1698         The other side of the ledger, in my view, are two major  
1699 issues. One, that we be able to achieve this without raising  
1700 taxes, and number two--maybe I should have said number one.  
1701 Number one, that we reform Medicare and strengthen it. We  
1702 have read the report of the trustees. We know that they  
1703 shaved off two years, and that we have got until 2017. 2017,  
1704 believe it or not, is not that--it sounds like it is another  
1705 century away. It is a handful of years away. So my question  
1706 to both of you is what are the large ticket items that you  
1707 can name today for us that will strengthen Medicare?

1708         Now, Mr. Levinson, I recall a hearing here many years  
1709 ago on waste, fraud and abuse and what--essentially the  
1710 private sector ripping off the public sector, and you have  
1711 touched on that today. In fact, we had testimony from  
1712 someone whose case had been adjudicated, and he was on his  
1713 way to prison, and he came here and explained how he had  
1714 ripped Medicare off. And it was, essentially, the private  
1715 sector ripping off the public sector. So what are the price  
1716 tags that you can tell us about in these efforts that will  
1717 save us money, save Medicare money, and overall strengthen

1718 Medicare as we come through this large effort, this overall  
1719 effort, to reform our nation's health care system? Because I  
1720 believe if we don't reform and strengthen Medicare that we  
1721 will not have accomplished what needs to be accomplished.

1722 Mr. {Hackbarth.} I am going to go first. I would name  
1723 four things. One is that we need to continue to apply  
1724 pressure under the existing payment systems of Medicare.

1725 Ms. {Eshoo.} Can you speak a little louder, please?  
1726 Can you speak just a little louder?

1727 Mr. {Hackbarth.} We need to continue to apply pressure  
1728 to the update factors in the existing payments systems.

1729 Ms. {Eshoo.} And what is that going to--what do you  
1730 think that is going to save us?

1731 Mr. {Hackbarth.} Well, you know, it depends on exactly  
1732 what the levels are, but it is, you know--

1733 Ms. {Eshoo.} Has MedPAC done that work?

1734 Mr. {Hackbarth.} Well, the CBO does the estimates of  
1735 the budget impact of different recommendations.

1736 Ms. {Eshoo.} Do you have any idea what that might be?

1737 Mr. {Hackbarth.} You know, we are--again, it depends on  
1738 the specific level, but tens of billions or more over a 10  
1739 year horizon. A second area that I had mentioned is Medicare  
1740 Advantage. There, as I think you know, the CBO estimate is  
1741 higher than \$150 billion over 10 years. A third area that I

1742 mentioned is re-admissions, excess re-admissions, and off the  
1743 top of my head I don't know what the estimate is for that,  
1744 but there was a proposed one. President Obama's budget on  
1745 that--a fairly significant number. And the fourth area that  
1746 I would emphasize is assuring primary care. Now, that  
1747 doesn't lead to a direct savings, but I mention it here  
1748 because if we allow things to go as they are right now, our  
1749 primary care base is going to continue to erode away money.

1750 Ms. {Eshoo.} You spoke to that earlier, so I appreciate  
1751 that.

1752 Mr. Levinson?

1753 Mr. {Levinson.} Yes, Ms. Eshoo--

1754 Ms. {Eshoo.} And thank you for your wonderful work as  
1755 IG.

1756 Mr. {Levinson.} Thank you very much.

1757 Ms. {Eshoo.} We really can't function well and do  
1758 oversight without the IGs, and I just think that you all  
1759 should be canonized, so--

1760 Mr. {Levinson.} Well, on behalf of--

1761 Ms. {Eshoo.} Be interesting to have a Levinson  
1762 canonized, right? I am pretty ecumenical, though, so--

1763 Mr. {Levinson.} Well, it so happens that, of course,  
1764 Dante was talking about fraud 700 years ago--

1765 Ms. {Eshoo.} That is right.

1766 Mr. {Levinson.} --so it is an issue that is both  
1767 timely--

1768 Ms. {Eshoo.} Right.

1769 Mr. {Levinson.} --and has a long--

1770 Ms. {Eshoo.} Um-hum.

1771 Mr. {Levinson.} --and very troublesome pedigree. But  
1772 on behalf of 1,600 very dedicated auditors and evaluators and  
1773 investigators and lawyers--

1774 Mr. {Pallone.} Somebody want to tell her--

1775 Mr. {Levinson.} --thank you so much.

1776 Mr. {Pallone.} --time has--

1777 Ms. {Eshoo.} Um-hum.

1778 Mr. {Pallone.} --expired?

1779 Mr. {Levinson.} And just--as I look at some of the  
1780 recommendations that are in our compendium of unimplemented  
1781 recommendations, our auditors estimate that we could--the  
1782 program could save \$3.2 billion over 5 years if we just  
1783 limited the rental time for oxygen equipment. I mean, I  
1784 think that there are specific areas where there are  
1785 significant savings that can be had.

1786 As I look at just our most recent semi-annual report, in  
1787 terms of monies returned to the Treasury, we are expecting,  
1788 just in the first 6 months of the fiscal year, \$275 million  
1789 in audit receivables and \$2.2 billion in investigative

1790 receivables. A lot of that has to do with pharmaceutical  
1791 cases. Pharmaceutical pricing, of course, is a very  
1792 significant area that can also, if properly addressed, can  
1793 save significant dollars.

1794       It would be hard to come up with total figures on a list  
1795 of top ten, but certainly pharmaceuticals, DME, getting the  
1796 dish payments right. We think that it is important to  
1797 clarify exactly what Medicare should be paying, the Medicare  
1798 and the Medicaid dish payments, and how the states handle  
1799 those dollars. We need to avoid gaming the Federal dollar,  
1800 so that it is clear, it is transparent about who is actually  
1801 paying for what, and how the states account for the dollars  
1802 that come from Washington.

1803       I would hesitate to put a dollar savings on it, but I  
1804 think that there is a great need for much more significant  
1805 transparency and accountability in our programs, and that is  
1806 a very helpful trend, from the standpoint of our office.

1807       Ms. {Eshoo.} Do I have any time left, Mr. Chairman?

1808       Mr. {Pallone.} No. I am trying not to--

1809       Ms. {Eshoo.} Okay. Thank you very much.

1810       Mr. {Pallone.} --interrupt now.

1811       Ms. {Eshoo.} Thank you.

1812       Mr. {Pallone.} Sure. Next is the gentlewoman from  
1813 Illinois, Ms. Schakowsky. I am going to just tell everybody

1814 when the 5 minutes are up, just so you know. Thanks.

1815 Ms. {Schakowsky.} Mr. Levinson, one of the biggest  
1816 single expenditures out of Medicaid is for long term nursing  
1817 home care, and I have been working with Chairman Waxman and  
1818 Chairman Stark on a nursing home quality and transparency  
1819 legislation, which has been included in the draft bill. And  
1820 I would like to know what you have found, in terms of  
1821 problems with nursing homes, that would necessitate more  
1822 transparency and oversight of them.

1823 Mr. {Levinson.} Yes. Congresswoman, it has been  
1824 difficult, actually, to find out who makes the decisions when  
1825 we investigate substandard care in nursing homes and try to  
1826 locate exactly who, financially, is in charge. So I think  
1827 the effort to create greater transparency in terms of  
1828 ownership, in terms of management, and get a clear  
1829 understanding of actually who is in charge would help our  
1830 investigators and lawyers significantly in being able to both  
1831 investigate and resolve some of the very serious quality of  
1832 care cases that have emerged in the nursing home area.

1833 Ms. {Schakowsky.} We are going to hear some testimony a  
1834 bit later that disparages the notion that there is any  
1835 substantial fraud or wasteful spending on the part of some  
1836 doctors that participate in the Medicare program. Would you  
1837 agree with that assessment?

1838           Mr. {Levinson.} Well, I can only point to individual  
1839 cases that we have actually worked on. We try not to  
1840 generalize. Our investigators and auditors are very focused,  
1841 very anchored on particular instances when it comes to either  
1842 individual venues or a larger corporate structure, and we do  
1843 have an existing, and unfortunately a growing, case load,  
1844 work load.

1845           Ms. {Schakowsky.} But let me ask this, though. Would  
1846 you say that some may be fraudulent, some may be wasteful,  
1847 but that in general the decisions about utilization are  
1848 provider driven, as opposed to the kind of fraud of--or  
1849 wasteful spending that is generated by individuals in the  
1850 program?

1851           Mr. {Levinson.} You know, I would hesitate, again, to  
1852 make any kind of generalizations because these individual  
1853 cases are very much focused on the facts as we find them.  
1854 But there are certainly cases in which we have found that we  
1855 are frustrated in our ability to actually understand who  
1856 makes the decisions in the nursing home chain.

1857           Ms. {Schakowsky.} Let me ask Mr. Hackbarth about the  
1858 Medicare Advantage plans. It is great that, in the Medicare  
1859 program, consumers can actually go online and find out what  
1860 Medicare pays for health care services. To your knowledge,  
1861 is there a place where consumers can actually access rates

1862 that Medicare Advantage plans pay providers, or other private  
1863 insurers?

1864 Mr. {Hackbarth.} The actual payment rates for--

1865 Ms. {Schakowsky.} Uh-huh.

1866 Mr. {Hackbarth.} --providers? Not to my knowledge. I  
1867 think most private plans consider that information  
1868 proprietary business information.

1869 Ms. {Schakowsky.} In your view, will Medicare Advantage  
1870 plans remain in the market if we eliminate overpayments?

1871 Mr. {Hackbarth.} I believe that they will, many will.  
1872 Some will leave the market because they have a model that  
1873 can't compete with traditional Medicare. But, as I said  
1874 earlier, we would be sending an important market signal about  
1875 the type of plan we want to participate. We want plans that  
1876 can help us improve the efficiency of the system, not plans  
1877 that just add more cost to the system. And when you send  
1878 that signal, I believe, in the market, I believe that we will  
1879 get more plans that can compete effectively with traditional  
1880 Medicare.

1881 Ms. {Schakowsky.} What mechanisms will we need to  
1882 ensure that Medicare Advantage plans and private insurers in  
1883 the exchange meet a minimum loss requirement--a minimum loss  
1884 ration requirement?

1885 Mr. {Hackbarth.} Yeah. The minimum loss ratio, I

1886 think, is--it is a tricky issue. As you may know, I used to  
1887 work for Harvard Community Health Plan, Harvard Pilgrim  
1888 Health Care, two very well regarded HMOs, and this was a big  
1889 issue for us sometimes with employers, how you calculate loss  
1890 ratios. Our piece of the organization, the one I ran, is an  
1891 integrated pre-paid group practice, and we have a lot of  
1892 clinical programs that we believe improve patient care that  
1893 sometimes employers wanted to characterize not as medical  
1894 care, but as administrative cost, so the--and that works  
1895 against you, in terms of calculating the loss ratio. So the  
1896 details of this can be pretty tricky, in my personal  
1897 experience. I am always a little uneasy about just having  
1898 simple rules on loss ratios. How you define those loss  
1899 ratios is very important.

1900 Ms. {Schakowsky.} Thank you.

1901 Mr. {Pallone.} The time is expired. I am sorry. Thank  
1902 you, and next is the gentleman from Maryland, Mr. Sarbanes.

1903 Mr. {Sarbanes.} Thank you, Mr. Chairman. Thank you  
1904 all. I have got a couple of quick questions at the outset.

1905 Mr. Levinson, you talked about the--trying to step up  
1906 efforts to curb some of the fraud, and particularly you  
1907 talked about, in response to one question, the application  
1908 process for new provider numbers, and having that vet  
1909 properly. Have resources been an issue, in terms of the

1910 capacity of those people that do the processing and the  
1911 review? Has resource, in terms of the number of folks that  
1912 can do that, been an issue or not an issue?

1913         Mr. {Levinson.} Well, that is an important question,  
1914 Mr. Sarbanes, that, in the first instance, I think needs to  
1915 be addressed and responded to by CMS, which is the agency  
1916 that runs the program. And, as an office that looks to see  
1917 where the vulnerabilities, where the weaknesses are in the  
1918 administration of a program, we have identified for some  
1919 years now that enrollment standards are too lax, especially  
1920 in specific areas of vulnerability, like DME. And whether or  
1921 not there are resource issues, we find too many of the wrong  
1922 kinds of people are getting into the program, and, therefore,  
1923 we have urged--we have recommended, over the course of the  
1924 last few years, that enrollment standards be strengthened.

1925         Mr. {Sarbanes.} Well, I would imagine--I mean, I used  
1926 to do some of that work, and I would imagine that the best  
1927 way to vet it on the front end is with a little more  
1928 intensity of resources applied. Actually going out and  
1929 finding out who is behind these applications that are being  
1930 filed.

1931         Let me shift gears. I was really intrigued by the  
1932 discussion on the school based health centers, and some of  
1933 the findings of fraud. In that discussion, there was an

1934 allusion to the possibility that there were services being--  
1935 that reimbursement was being sought for services that were  
1936 not actually provided, but possibly there were other services  
1937 being provided that might--that one might view as important  
1938 services, they just aren't services that Medicare or Medicaid  
1939 reimburses. And I wanted to ask the question of whether this  
1940 phenomenon--and this is--in my view, the problem is whether  
1941 you are talking about fee for service or you are talking  
1942 about capitation, either one of those can work okay if you  
1943 are paying for quality, as opposed to paying for quantity,  
1944 and if you are paying for the right things, as opposed to not  
1945 paying for the right things. But maybe both of you could  
1946 comment on whether the potential for fraud is greater when  
1947 you have a system that pays for quantity versus quality, or  
1948 is paying for the wrong things.

1949         And while I don't want to excuse fraud, if somebody is  
1950 trying to find some payment for what they view as a very  
1951 important service that is not covered under Medicare or  
1952 Medicaid, that is a different kind of impulse than seeking to  
1953 get paid for a service that is not being provided at all.  
1954 And it seems to me the way the system is structured right  
1955 now, and it is so distorted, that it leads to that kind of  
1956 thing, because people say, this service is valuable, but  
1957 Medicare won't pay me for it. And if we can move in a

1958 direction where we are paying smarter for things that make a  
1959 difference, we might actually make some progress on this  
1960 fraud issue. So maybe you could each--

1961 Mr. {Levinson.} Well, I do think the facts that you  
1962 have laid out, Mr. Sarbanes, are important ones to focus on.  
1963 The notion that there can be monies spent that are just not  
1964 appropriately covered by the program, and in many instances  
1965 we are really not talking about fraud in terms of the legal  
1966 definition of fraud. We are talking about dollars that  
1967 Congress--that the program says should be directed in a  
1968 particular way, and our audit people, not our criminal  
1969 investigators, find have not been spent appropriately, and  
1970 then we make the appropriate findings and recommendations to  
1971 CMS.

1972 Not all of our recommendations are acted upon by CMS.  
1973 There unquestionably are judgments. Perhaps some of the  
1974 kinds of judgments you are talking about here and judgments  
1975 that, programmatically, are made by CMS over the course of  
1976 looking of our recommends, because--just by the fact that we  
1977 make those recommendations doesn't necessarily mean that the  
1978 dollars will actually be collected. And I do think that it  
1979 is important to distinguish, you know, between those who have  
1980 an intent to take advantage of the program and those who,  
1981 unfortunately, are simply not paying appropriate attention to

1982 our rules. But, of course, given the precious resources, we  
1983 take the rules as set by Congress and the Department  
1984 seriously, and we report accordingly.

1985 Mr. {Pallone.} Now the time has expired. I am sorry.  
1986 Next is Ms. DeGette.

1987 Ms. {DeGette.} Thank you very much, Mr. Chairman, and  
1988 thanks to this Committee.

1989 I know you have discussed some of the issues in general  
1990 that I want to talk about, I would like to hone in on them a  
1991 little more. My first question is you talked about--  
1992 actually, Mr. Hackbarth, the MedPAC has talked about changing  
1993 the Medicare payment system incentives by basing a portion of  
1994 provider payment on quality of care, and to do this, Congress  
1995 could establish a quality incentive payment policy for  
1996 physicians and other plans, Medicare Advantage plans, health  
1997 care facilities. I am wondering if you have some specific  
1998 recommendations you can make as to what kind of quality  
1999 measures people would have to include to be--or to develop to  
2000 be included in a quality incentive payment policy.

2001 Mr. {Hackbarth.} Well, let me focus on a few different  
2002 areas of the program. For example, in the Medicare Advantage  
2003 program, we have long advocated that a piece of the payment  
2004 be adjusted to reflect the quality, and--

2005 Ms. {DeGette.} How do you do that?

2006 Mr. {Hackbarth.} There are well established industry  
2007 measures developed by NCQA that private employers use to  
2008 assess health plans. We believe Medicare should be doing the  
2009 same and adjusting payment accordingly. In the case of  
2010 dialysis services, again, there is a pretty strong consensus  
2011 about what the critical quality measures are. We have  
2012 advocated that the dialysis payments be adjusted to reflect  
2013 those outcomes for patients.

2014 Likewise, in hospitals, we think there are some strong  
2015 consensus measures. In fact, Medicare requires, as you know,  
2016 specific measures be reported. We would like to see  
2017 payment--

2018 Ms. {DeGette.} Do you think that the current--and I do  
2019 know that, because my heroine, Patty Gabow from Denver  
2020 Health, is here on the next panel--

2021 Mr. {Hackbarth.} Um-hum.

2022 Ms. {DeGette.} --but do you think that we could--do you  
2023 think that the--that these quality measures that we have in  
2024 place now are sufficient as we move forward with a  
2025 comprehensive health care plan? Do we need some kind of  
2026 additional mechanism? Do we need additional quality  
2027 measures? What do we need--

2028 Mr. {Hackbarth.} Yeah, I think the measures need to  
2029 evolve over time. I think we have got starter sets, if you

2030 will, for a lot of providers, but we need to invest in  
2031 developing in the long term.

2032 Ms. {DeGette.} And who should do that?

2033 Mr. {Hackbarth.} Well, Congress has invested some money  
2034 now in NQF, the National Quality Forum, which I think is a  
2035 wise investment to build infrastructure for ongoing  
2036 improvement and quality measures.

2037 Ms. {DeGette.} And do you think some of these quality  
2038 measures that you talk about for Medicare Advantage can also  
2039 be used for physicians in other types of health care  
2040 facilities, like hospitals and community health facilities?

2041 Mr. {Hackbarth.} Well, each provider group presents its  
2042 own challenges and will require unique measures. I mentioned  
2043 three areas, Medicare Advantage, ESRD and hospitals, but I  
2044 think there is a pretty strong consensus on a starter set of  
2045 measures. Other areas are more challenging. Physicians are  
2046 more challenging just because of the nature of a medical  
2047 practice. You often have small groups, or even solo  
2048 physicians, so not a lot of numbers to do measurement.

2049 Ms. {DeGette.} But you know what, though, people like  
2050 Geisinger and Kaiser and others have been able to develop  
2051 quality measures for doctors, that it would seem to me you  
2052 could develop, and if you don't develop those for physicians,  
2053 then it is hard to see how you can get the improvement in

2054 medical care at the same time that you get the cost  
2055 containment in our system.

2056 Mr. {Hackbarth.} And I agree with that, that we do have  
2057 initial measures--they are not comprehensive measures for  
2058 physicians. They tend to be very focused process measures.

2059 Ms. {DeGette.} Right.

2060 Mr. {Hackbarth.} I think we can do a better job in  
2061 assessing physician performance as we move to bundle payment  
2062 systems. Where we get groups of physicians working together,  
2063 we can start to measure outcomes, not just--

2064 Ms. {DeGette.} That was my next question. So to  
2065 develop those measures, again, what kind of mechanism do you  
2066 think--would it be the same one you talked about that  
2067 Congress--there is a group of us--

2068 Mr. {Hackbarth.} Yeah?

2069 Ms. {DeGette.} --Senator Whitehouse and myself and  
2070 others who are very concerned that if we don't develop  
2071 quality measures throughout the system--

2072 Mr. {Hackbarth.} Yeah.

2073 Ms. {DeGette.} --that we are really not going to have--

2074 Mr. {Hackbarth.} Yeah.

2075 Ms. {DeGette.} --improvements in patient outcomes.

2076 Mr. {Hackbarth.} So we need a process for forging  
2077 consensus and establishing a set of measures.

2078 Ms. {DeGette.} Right.

2079 Mr. {Hackbarth.} You don't want, you know, 12 different  
2080 ones--

2081 Ms. {DeGette.} Right.

2082 Mr. {Hackbarth.} --and everybody using different  
2083 measures.

2084 Ms. {DeGette.} Right.

2085 Mr. {Hackbarth.} That is a burden on providers.

2086 Ms. {DeGette.} Right.

2087 Mr. {Hackbarth.} And NQF can be that process. It can  
2088 grow into that process, where we have consensus. Then we  
2089 also have to invest in the research about what works--

2090 Ms. {DeGette.} What works.

2091 Mr. {Hackbarth.} -- and that is where comparative  
2092 effectiveness comes in. That can provide raw material for  
2093 specialty societies and the like to develop guidelines on  
2094 what constitutes good care, and that can also feed,  
2095 ultimately, into the assessment process.

2096 Ms. {DeGette.} Thank you. Thank you, Mr. Chairman.

2097 Mr. {Pallone.} Thank you. Gentleman from Texas, Mr.  
2098 Gonzalez.

2099 Mr. {Gonzalez.} Thank you very much, Mr. Chairman.

2100 This will go to the Chairman.

2101 There are two major components of what we are

2102 considering, and the experience gleaned from Medicare is  
2103 going to be used either by the proponents or the opponents.  
2104 Just--again, it will be the performance of Medicare in the  
2105 eye of the beholder. One is the public option, the other is  
2106 the health insurance exchange. So I am going to pose a  
2107 couple of questions, and then just let you respond, and that  
2108 way the--it will be the Chairman that will be advising you  
2109 that my five minutes are over.

2110           But first, I haven't met with a group of doctors in San  
2111 Antonio yet that have agreed with the compensation adequacy.  
2112 And what they are all saying is that you guys are basically  
2113 working with stale data and information, that it is at least  
2114 two years behind the times of what modern medicine, in its  
2115 practice, entails. That is the first question, and I know  
2116 that we have touched on it more or less, but that is going to  
2117 be very important as we go out there with a broader plan  
2118 that, again, has something that will mimic what we have been  
2119 doing under Medicare. So that is the first complaint that we  
2120 get.

2121           My colleague, Ms. DeGette, also touched on something,  
2122 and that was how do you establish proper protocols? What is  
2123 acceptable--practices and standards? On the Small Business  
2124 Committee, we had Governor Pawlenty who came up, and I asked  
2125 him that, because my doctors asked the same thing. Different

2126 patient populations may dictate different practices and such.

2127         Well, Governor Pawlenty told me, he says, we have got  
2128 Mayo. They establish the standards, pretty much, and no one  
2129 is going to argue with them. The question to you is how do  
2130 we ever really achieve nationwide standards that may address  
2131 diverse populations and such? The last question is somewhat  
2132 interesting, one, because it presents a real dilemma for me  
2133 back home. Texas has probably the greatest number of  
2134 specialty hospitals. The question really is how is modern  
2135 medicine being delivered in this country, and--to keep up  
2136 with that?

2137         There are portions of this bill that would discourage,  
2138 of course, specialty hospitals, yet we are looking at what we  
2139 refer to as bundling, and that is more centralization, more  
2140 coordination, medical home, all that that entails. But in  
2141 essence, isn't that what specialty hospitals and many of  
2142 these specialty practices provide? And that is, when a  
2143 patient goes into those settings, that there are many  
2144 different services that are being provided within that  
2145 environment that otherwise would be separated out to  
2146 different locales, offices and other doctors. And we even  
2147 have different specialists that argue among themselves as to  
2148 what extent they should be able to do that. And I would just  
2149 like your views on those three points, and again, thank you

2150 for your service.

2151           Mr. {Hackbarth.} Okay. That is a lot of ground to  
2152 cover in just a minute or two. Starting with the stale data,  
2153 I imagine what your physician constituents are referring to  
2154 is Medicare claims data, which, in fact, is a couple years  
2155 old by the time it is used in the policy process. That is a  
2156 problem. That is an area where I think some wise investments  
2157 in Medicare infrastructure would pay dividends. I am not  
2158 sure, however, that the age of the data would alter any of  
2159 the recommendations we are talking about for reforming the  
2160 payment system.

2161           With regard to standard setting, I do believe it is very  
2162 important to have a process that is coherent and credible  
2163 from the perspective of providers. I fear that sometimes we  
2164 have embarrassment of riches. We have a lot of different  
2165 people saying this is what constitutes quality of care. Some  
2166 of it is well-founded in research, other pieces of it are  
2167 not. If we want to send clear, consistent, signals to  
2168 providers, not just from Medicare but from private insurers  
2169 as well, we need to have a coherent standard setting process.

2170           As I said a minute ago, Congress, I think, wisely has  
2171 invested some money in NQF to start building that  
2172 infrastructure.

2173           On the last issue of specialty hospitals, roughly 2

2174 years ago now MedPAC at Congress' request invested a lot of  
2175 effort in analyzing specialty hospitals. Our basic findings  
2176 were that when physician-owned specialty hospitals enter the  
2177 market, costs tended to increase, not decrease. More  
2178 procedures were done. The evidence on the quality of care  
2179 was there was not definitive evidence one way or the other  
2180 that it was better or worse. It seemed to be about the same.

2181 At the time we did our analysis, our big concern, our  
2182 immediate concern was that at least some physician-owned  
2183 specialty hospitals were exploiting flaws in the Medicare  
2184 payment system. They were focused on procedures where the  
2185 Medicare rates were too high. We made recommendations which  
2186 Congress adopted and CMS has now largely implemented to  
2187 change payment rates so there aren't those gaping  
2188 opportunities to exploit the system.

2189 Mr. {Pallone.} Thank you.

2190 Mr. Matheson is next.

2191 Mr. {Matheson.} Thank you, Mr. Chairman.

2192 I am sorry I was not able to be here for all your  
2193 testimony but I do appreciate your coming before the  
2194 committee today. A question I wanted to raise is, MedPAC has  
2195 had the opportunity to make a lot of recommendations about  
2196 how we can achieve greater efficiencies or greater value or  
2197 good practices, and often when it comes to implementation,

2198 Congress has not necessarily followed through on that. Do  
2199 you have suggestions if there would be a better structure to  
2200 help assist in allowing these recommendations to be  
2201 implemented in a more effective way?

2202 Mr. {Hackbarth.} Well, one of my themes this morning  
2203 has been that I think the Secretary of Health and Human  
2204 Services and CMS need both more discretion and more resources  
2205 so they need the flexibility to refine change, payment  
2206 systems, overtime to achieve goals established by the  
2207 Congress. For every small change to have to come back  
2208 through the legislative process is a very cumbersome process  
2209 and it makes progress very slow and I am not sure that is a  
2210 luxury we can afford at this point, so more discretion and  
2211 more resources for the Department would be my first  
2212 recommendation.

2213 Mr. {Matheson.} Do you have--in terms of making that  
2214 recommendation, is there a specific proposal about what the  
2215 resource needs might be or is that something that we can look  
2216 to maybe get some information?

2217 Mr. {Hackbarth.} I would urge you to go to the  
2218 Department for that information. They are the best judges of  
2219 exactly what they need.

2220 Mr. {Matheson.} Do you feel like the way MedPAC is  
2221 structured right now that you are adequately insulated from

2222 having Members of Congress come in and tell you here is what  
2223 we think you really ought to be doing?

2224 Mr. {Hackbarth.} Well, we welcome our exchange with  
2225 Members of Congress and the MedPAC staff works very closely  
2226 with both the committee and personal staffs to understand  
2227 Congressional perspective. I have never felt undue pressure  
2228 from any Member of Congress.

2229 Mr. {Matheson.} Do you feel like you are adequately  
2230 structured to be an independent entity? I guess that is what  
2231 I am asking.

2232 Mr. {Hackbarth.} Yes.

2233 Mr. {Matheson.} Okay. Thanks, Mr. Chairman. That will  
2234 be it for me.

2235 Mr. {Pallone.} Thank you.

2236 Mr. Barrow.

2237 Mr. {Barrow.} Thank you, Mr. Chairman, and thank you  
2238 gentlemen for being here today. I too along with Jim had  
2239 several other meetings this morning so I apologize for being  
2240 a little late but I am glad to have the chance to visit with  
2241 you. Thank you for coming and offering your testimony.

2242 You know, fixing what is broke with Medicare Part D is a  
2243 large part of comprehensive health care reform and a lot of  
2244 attention has been given to ways and means of trying to plug  
2245 the donut hole, among other things. I want to focus on a

2246 problem with the Medicare Part D program that has bedeviled  
2247 the people I represent. I hear about it at every one of my  
2248 town hall meetings, and that is the excessive degree of  
2249 discretion and variety in the formularies that all of these  
2250 various for-profit insurers are paid by the public  
2251 essentially to assume a public risk and the incredible  
2252 confusion. You know, there is such a thing as too much of a  
2253 good thing. When there is too much variety and choice in the  
2254 marketplace, you have a hard time finding what you need and  
2255 you have to do a lot of hunting and trying to find the drug  
2256 that you want and then with a potential for bait and switch  
2257 that can exist and the formulary being changed on you. That  
2258 just makes things so much worse.

2259 My question to you is, and I guess Chairman Hackbarth,  
2260 you are probably in the best position to answer this, is any  
2261 thought being given, since this is a public financed plan, to  
2262 get the for-profit insurance industry to compete with each  
2263 other to make money trying to offer a benefits package to  
2264 assume a public risk in providing this benefit? Any thought  
2265 given to trying to make more--to have a centralized or more  
2266 standardized formula that is comprehensive in its scope but  
2267 provides all of the necessary flexibility and variety to  
2268 allow doctors to opt out when there is a medical necessity  
2269 that they know about, a generally good reason to do so, but

2270 to make it clear that when folks go into this very confusing  
2271 marketplace with so many people competing for the customers'  
2272 business that they know that they are comparing apples to  
2273 apples, they know that the benefits package is substantially  
2274 the same just as the entity that is paying for this is  
2275 substantially the same, just as what you hope to get is  
2276 substantially the same. Is any effort being made to do that?

2277       Mr. {Hackbarth.} Well, you are absolutely right, that  
2278 the choices that Medicare beneficiaries face are complicated  
2279 and choosing among plans because of, among other things,  
2280 differences in formularies. I would add that it doesn't stop  
2281 with the beneficiaries. You know, differences in formularies  
2282 also have a significant impact on practicing physicians and  
2283 how they deal with patients. What they prescribe needs to  
2284 vary according to the plan that the patient is covered by,  
2285 and that can be a real problem for physicians. There is a  
2286 tradeoff here, though. The flexibility around formularies  
2287 and the exact benefit structure, those are tools that private  
2288 plans can use to try to offer a better value for Medicare  
2289 beneficiaries. Those are the tools that they can use to  
2290 reduce the cost of the plan, and so there is a tradeoff to be  
2291 made.

2292       Mr. {Barrow.} If you have a plan that is designed to  
2293 the health profile of the patient, in theory you can get

2294 yourself into a much smaller risk pool and be shopping for  
2295 something that is just tailored for you, but the point is, at  
2296 least the quality of the insurance and it takes on the  
2297 quality of being sort of a revolving loan program.

2298         Mr. {Hackbarth.} And some people have expressed concern  
2299 in particular about specialty drugs, very high-cost drugs for  
2300 patients with serious illnesses.

2301         Mr. {Barrow.} Well, there is a medical necessity for  
2302 that. The smaller the risk pool of folks buying into the  
2303 program, the more expensive that is going to be when it is  
2304 absolutely necessary to get it, so that sort of drives up the  
2305 cost for those folks who need it when they need it I guess  
2306 what I am getting at is, if you really have too much choice,  
2307 you don't know what you are choosing and the other party on  
2308 the other side of this deal can change the deal on you after  
2309 you have signed up. We make this thing much more complicated  
2310 and much user friendly than it has to be, and I want to make  
2311 sure we are not driving up the cost by having exotic stuff  
2312 driving up the cost for the ordinary, everything stuff but  
2313 there is a profile, there is a comprehensive scope of  
2314 conditions that we can treat effectively, cost-effectively  
2315 with medication, and it seems to me the more we can eliminate  
2316 the confusion in this, the more--and make it genuinely  
2317 available and comprehensive in its scope, the better service

2318 we are providing all our customers. Because after all, we  
2319 are paying these folks to assume this public risk and we  
2320 ought to make sure that folks know what they are getting when  
2321 they go into the marketplace. What is MedPAC doing about  
2322 this? Are you all looking into this?

2323 Mr. {Hackbarth.} Well, on the specific issue of the  
2324 complexity, we have looked at the choices that Medicare  
2325 beneficiaries have to make in choosing among plans, and  
2326 looked at the tools that beneficiaries have available to  
2327 them. CMS does have some tools, as you know, to try to help  
2328 beneficiaries compare plans and choices. We think here again  
2329 this is another area where some investment could pay  
2330 dividends in helping beneficiaries understand their choices.  
2331 There is no way around, though, the ultimate tradeoff that  
2332 you are going to face between complexity on the one hand and  
2333 flexibility for plans to manage the costs on the other.  
2334 There is no answer on how to strike that balance.

2335 Mr. {Barrow.} I think doctors--

2336 Mr. {Pallone.} Your time is expired, but if you want to  
2337 say something--

2338 Mr. {Barrow.} I think doctors ought to be able to make  
2339 those calls. Thank you, Mr. Chairman.

2340 Mr. {Pallone.} Thank you.

2341 Unless anyone else has questions, we are going to

2342 proceed to the next panel, so thank you very much. Your  
2343 input is obviously very important as we proceed on this and  
2344 we appreciate your being here this morning. Thank you.

2345 I ask the next panel to come forward. Could we ask that  
2346 everyone be seated and that everyone else clear the room,  
2347 because we do have to get moving. We have three more panels.  
2348 Those who are talking and socializing, please leave the room.

2349 Okay. Our second panel is on doctor, nurse, hospital  
2350 and other provider views, and as you can see, it is a rather  
2351 large panel so we want to get started, and let me--I don't  
2352 think I have seen such a large panel. We will start on my  
2353 left with Dr. Ted Epperly, who is president of the American  
2354 Academy of Family Physicians, and then we have Dr. M. Todd  
2355 Williamson, who is president of the Medical Association of  
2356 Georgia, and then is Dr. Karl Ulrich, who is clinical  
2357 president and CEO of the Marshfield Clinic, and Dr. Janet  
2358 Wright, who is vice president of Science and Quality at the  
2359 American College of Cardiology, Dr. Kathleen White, who is  
2360 chair of the Congress on Nursing Practice and Economics at  
2361 the American Nurses Association, Dr. Patricia Gabow, who is  
2362 chief executive officer of the Denver Health and Hospital  
2363 Authority for the National Association--well, she will be  
2364 speaking for the National Association of Public Hospitals,  
2365 Dan Hawkins, who is senior vice president of public policy of

2366 research for the National Association of Community Health  
2367 Centers, and Bruce Roberts, who is executive vice president  
2368 and CEO of the National Community Pharmacists Association,  
2369 Bruce Yarwood, president and CEO of the American Health Care  
2370 Association, and Alissa Fox, who is senior vice president of  
2371 the Office of Policy and Representation for the Blue Cross  
2372 Blue Shield Association.

2373         Now, before we begin, I just wanted to point something  
2374 out that I believe has been shared with staff but I think  
2375 needs to be repeated because of the panel. It would touch  
2376 upon some of the things particularly with regard to community  
2377 health centers. In several sections of the draft--well, I  
2378 should say in several sections of that part of the draft that  
2379 deals with the public health and workforce development, in  
2380 that division, a sentence that was supposed to be an addition  
2381 to current authorizations was instead drafted to take the  
2382 place of them. So instead of ``in addition'' it says ``to  
2383 take the place of'' in that decision, and this is an error.  
2384 It was caught on Friday afternoon shortly after the draft was  
2385 announced and we did notify both Democrat and Republican  
2386 committee staff of the mistake and corrections have been sent  
2387 to the Office of Legislative Counsel, but I did want to point  
2388 that out before I started here today because I wasn't sure  
2389 that all of you who are testifying were aware of that. The

2390 mistake is particularly glaring in the provision related to  
2391 community health centers, and I think Mr. Hawkins knows this,  
2392 but just let me point it out to everyone, that the draft is  
2393 supposed to include an additional \$12 billion over 5 years in  
2394 new money and that is over and above the current  
2395 appropriation. Again, that is why we have drafts, I guess.

2396         But let us start. As you know, we ask you to keep your  
2397 oral comments to 5 minutes and of course all of your written  
2398 testimony will be included in the record, and we will start  
2399 with Dr. Epperly.

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2400 ^STATEMENTS OF TED D. EPPERLY, M.D., PRESIDENT, AMERICAN  
2401 ACADEMY OF FAMILY PHYSICIANS; M. TODD WILLIAMSON, M.D.,  
2402 PRESIDENT, MEDICAL ASSOCIATION OF GEORGIA; KARL J. ULRICH,  
2403 M.D., CLINIC PRESIDENT AND CEO, MARSHFIELD CLINIC; JANET  
2404 WRIGHT, M.D., VICE PRESIDENT, SCIENCE AND QUALITY, AMERICAN  
2405 COLLEGE OF CARDIOLOGY; KATHLEEN M. WHITE, PH.D., CHAIR,  
2406 CONGRESS ON NURSING PRACTICE AND ECONOMICS, AMERICAN NURSES  
2407 ASSOCIATION; PATRICIA GABOW, M.D., CHIEF EXECUTIVE OFFICER,  
2408 DENVER HEALTH AND HOSPITAL AUTHORITY, NATIONAL ASSOCIATION OF  
2409 PUBLIC HOSPITALS; DAN HAWKINS, SENIOR VICE PRESIDENT, PUBLIC  
2410 POLICY AND RESEARCH, NATIONAL ASSOCIATION OF COMMUNITY HEALTH  
2411 CENTERS; BRUCE T. ROBERTS, RPH, EXECUTIVE VICE PRESIDENT AND  
2412 CEO, NATIONAL COMMUNITY PHARMACISTS ASSOCIATION; BRUCE  
2413 YARWOOD, PRESIDENT AND CEO, AMERICAN HEALTH CARE ASSOCIATION;  
2414 AND ALISSA FOX, SENIOR VICE PRESIDENT, OFFICE OF POLICY AND  
2415 REPRESENTATION, BLUE CROSS BLUE SHIELD ASSOCIATION

|

2416 ^STATEMENT OF TED D. EPPERLY

2417 } Dr. {Epperly.} Chairman Pallone, Ranking Member Deal  
2418 and members of the Energy and Commerce Health Subcommittee, I  
2419 am Ted Epperly, president of the American Academy of Family  
2420 Physicians, which represents 94,600 members across the United

2421 States. I am a practicing family physician from Boise,  
2422 Idaho. I am delighted to say that your draft bill goes a  
2423 long way towards providing quality, affordable health care  
2424 coverage for everyone in the United States.

2425         The AAFP has called for fundamental reform of our health  
2426 care system for over 2 decades. We commend you for your  
2427 leadership and commitment to find solutions to this complex  
2428 national priority. We appreciate efforts to improve primary  
2429 care through this draft bill. The Academy believes that  
2430 making primary care the foundation of health care in this  
2431 country is critical. Primary care is the only form of health  
2432 delivery charged with the long-term care of the whole person  
2433 and has the most effect on health care outcomes. Primary  
2434 care is performed and managed by a personal physician leading  
2435 a team, collaborating with other health professionals and  
2436 using consultation or referral as needed.

2437         Many studies demonstrate that primary care is high  
2438 quality and cost-effective because it includes coordination  
2439 and integration of health care services. The Academy  
2440 believes the key to designing a new health care system is to  
2441 emphasize the centrality of primary care by including the  
2442 patient-centered medical home where every patient has a  
2443 personal physician, emphasizing cognitive clinical decision  
2444 making rather than procedures, and ensuring the adequacy of

2445 our primary care workforce and aligning incentives to embrace  
2446 value over volume.

2447 Many of these key provisions are contained in your draft  
2448 legislation. Specifically, we applaud the committee for  
2449 including a medical home pilot program in Medicare as a step  
2450 towards primary care system. Your definition of the patient-  
2451 centered medical home is consistent with the one established  
2452 by the AAFP and other primary care organizations. We also  
2453 support the PCMH demonstration project in Medicaid. Use of  
2454 the medical home will achieve savings and improve quality.  
2455 We appreciate the inclusion of a bonus of 5 percent for  
2456 primary care services and up to 10 percent for services  
2457 provided in a health profession shortage area. We urge you  
2458 to make this bonus permanent.

2459 Medicare is a critical component of the U.S. health  
2460 system and must be preserved and protected. With this draft,  
2461 you take the first bold steps needed to remedy the Medicare  
2462 physician payment system. The AAFP appreciates your  
2463 recognition of the longstanding problems with the  
2464 dysfunctional formula known as the sustainable growth rate,  
2465 or SGR. We thank you for proposing that it be rebased. This  
2466 is an important, necessary and welcome step.

2467 We also appreciate the bill's attention to workforce  
2468 issues. Numerous studies indicate that more Americans

2469 dependent on family physicians than on any other medical  
2470 specialty. We are deeply concerned about the decline in the  
2471 number of medical students pursuing a career in primary care  
2472 at a time when the demand for primary care services will only  
2473 be increasing. The majority of health care is provided in  
2474 physicians' offices now and will be in the future. We must  
2475 revitalize the programs to train the primary care physician  
2476 workforce that will meet our needs in those locations.

2477         We thank you for reauthorizing and providing a  
2478 substantial investment in section 747 of the health  
2479 professions primary care medicine training program. The  
2480 National Health Care Workforce Commission in the discussion  
2481 draft is needed to recommend the appropriate numbers and  
2482 distribution of physicians.

2483         The AAFP is also pleased that the Medicaid title  
2484 provides for a substantial expansion of coverage to the  
2485 uninsured. In particular, we support increases to the  
2486 Medicaid primary care payment so that it is equal to Medicare  
2487 by 2012. The AAFP supports a public plan option consistent  
2488 with the principles included in our written testimony.  
2489 Patients should have a choice of health plans and a public  
2490 plan should be one of them. However, the public plan should  
2491 not be Medicare. We acknowledge that for transition  
2492 purposes, there may be some similarities to the federal

2493 program but we urge Congress to delink the public plan from  
2494 Medicare by a date certain.

2495         The AAFP strongly supports the inclusion of comparative  
2496 effectiveness research in the draft bill. We appreciate the  
2497 establishment of a center within the Agency for Health Care  
2498 Research and Quality. If we wish to improve the patient care  
2499 and control costs in this country, this type of research is  
2500 crucial. It is only with CER that we can provide evidence-  
2501 based information to patients and physicians for use in  
2502 making health care decisions.

2503         Finally, we support a number of insurance market changes  
2504 that will help our patients in regards to the health  
2505 insurance exchange where they can one-stop shop for a health  
2506 care plan, a sliding-scale subsidy so that people can  
2507 purchase meaningful coverage, guaranteed availability and  
2508 renewability of coverage, prohibition of preexisting  
2509 conditions exclusions and denials, and benefit packages that  
2510 allow consumers to select the one that best meets their needs  
2511 as well as a requirement for a core set of benefits.

2512         In conclusion, the Academy believes that health care  
2513 should be a shared responsibility and applauds the section of  
2514 the bill that requires all individuals have coverage. Now is  
2515 the time to provide affordable, high-quality health care  
2516 coverage. The status quo is not working. We urge Congress

2517 to invest in the health care system we want, not the one we  
2518 have. Thank you very much, Mr. Chairman.

2519 [The prepared statement of Dr. Epperly follows:]

2520 \*\*\*\*\* INSERT 3 \*\*\*\*\*

|

2521           Mr. {Pallone.} Thank you, Dr. Epperly.

2522           Dr. Williamson.

|  
2523 ^STATEMENT OF M. TODD WILLIAMSON

2524 } Dr. {Williamson.} Good morning, Chairman Pallone and  
2525 Mr. Deal. My name is Todd Williamson, and I want to thank  
2526 you for the opportunity to speak to you today. I am a  
2527 neurologist from Atlanta and I serve as the president of the  
2528 Medical Association of Georgia, and I am speaking on behalf  
2529 of that association.

2530 I recently had the privilege on speaking on behalf of a  
2531 coalition of 20 State and specialty medical societies  
2532 representing more than 100,000 physicians, which is nearly  
2533 half of the practicing physicians in the United States. This  
2534 coalition believes that ensuring the patient's right to  
2535 privately contract with their physician is the single most  
2536 important step we could take to reform our medical care  
2537 system.

2538 I would like to begin by addressing three assumptions  
2539 that underpin the discussion draft. The first relates to  
2540 geographic disparities in spending. Peter Orszag recently  
2541 said that nearly 30 percent of Medicare's costs could be  
2542 saved without negatively affecting health outcomes of  
2543 spending in high- and medium-cost areas could be reduced to  
2544 the level in low-cost areas. We do not agree. This flawed

2545 claim was first made by the Dartmouth Group, which used only  
2546 Medicare data to analyze spending and quality. Please  
2547 consider the work of Dr. Richard Cooper, which shows that an  
2548 examination of total medical spending per capita reveals that  
2549 quality and cost are indeed connected. He also demonstrates  
2550 that Medicare payments are disproportionately higher in  
2551 States with high poverty levels and low overall medical care  
2552 spending. The suggestion that our medical care expenditures  
2553 are greater than other countries is also misleading,  
2554 countries that account for expenditures such as out-of-pocket  
2555 payments and the cost of long-term care in different ways.  
2556 Some countries drive down costs by rationing care. The cost  
2557 of research and development distorts our expenditures as  
2558 well.

2559 A third faulty assumption is that medical care outcomes  
2560 in the United States are worse than in other countries.  
2561 America's often-cited infant mortality statistics cannot be  
2562 directly compared to statistics from other countries that do  
2563 not record the deaths of low birth weight newborns that we  
2564 try to save. Comparisons of a host of specific diseases such  
2565 as diabetes clearly show our outcomes are superior.

2566 We cannot support and would actively oppose the  
2567 discussion draft. As I noted, we believe that allowing  
2568 patients and physicians to privately contract is the single

2569 most important step we can take towards reforming the  
2570 Nation's medical care system. This will empower patients to  
2571 choose their physician, spend their own money on medical care  
2572 and make their own medical decisions. Medical expenditures  
2573 can only be appropriately controlled and allocated where  
2574 there is complete transparency and acknowledgement of  
2575 necessity and value at the time of the patient-physician  
2576 interaction. Private contracting will enhance access to  
2577 medical care. Many physicians opt out of government plans  
2578 because payments do not cover costs. If private contracting  
2579 was allowed, every patient would have access to every doctor.  
2580 This option is currently not available under government plans  
2581 and is prohibited in the discussion draft. Critics cite that  
2582 private contracting will disadvantage impoverished patients.  
2583 I would argue that they will benefit from increased access  
2584 and competition in the medical community and their physicians  
2585 will be at liberty to waive copays, which is currently  
2586 forbidden in government plans.

2587       We applaud the draft sponsors for planning to rebase the  
2588 SGR payment system but we remain concerned that they continue  
2589 to rely on a target-based approach. We support the emphasis  
2590 on prevention, wellness and claims transparency. We agree  
2591 that primary care should receive greater support and  
2592 administrative burdens should be reduced. We do not believe

2593 that the federal government should replace current research  
2594 and development mechanisms or the training and judgment of  
2595 physicians with federally controlled comparative  
2596 effectiveness research.

2597         While we recognize the need for reform, we believe that  
2598 the private marketplace should remain the primary means of  
2599 obtaining insurance. A government-sponsored health insurance  
2600 program for working-age adults will invariably eliminate  
2601 private options. Recall that Medicare was originally  
2602 introduced as an option for seniors but today it has  
2603 essentially become their only choice.

2604         We can reduce obstacles to individual ownership and  
2605 control of mental illness by adopting new tax policies. This  
2606 would eliminate the phenomenon of preexisting conditions  
2607 because individuals could carry their insurance with them for  
2608 life independent of their occupation or employer. To those  
2609 who assert that the private sector has failed our patients, I  
2610 say that our patients have been disadvantaged in the  
2611 marketplace by a tax system that penalizes individual  
2612 ownership of health insurance. When all Americans own their  
2613 policies, insurance companies will be forced to compete for  
2614 the business of millions of individuals and they will focus  
2615 on satisfying the patient, not the patient's employer.  
2616 Finally, we can significantly reduce health care expenditures

2617 and improve access by enacting proven, effective medical  
2618 liability reform measures.

2619 I appreciate this opportunity to present the views of  
2620 practicing physicians to you today. Thank you.

2621 [The prepared statement of Dr. Williamson follows:]

2622 \*\*\*\*\* INSERT 4 \*\*\*\*\*

|  
2623           Mr. {Pallone.} Thank you, Dr. Williamson.  
2624           Dr. Ulrich.

|  
2625 ^STATEMENT OF KARL J. ULRICH

2626 } Dr. {Ulrich.} Mr. Chairman, Ranking Member Deal and  
2627 members of the subcommittee, my name is Karl Ulrich and I am  
2628 president and CEO of Marshfield Clinic in Marshfield,  
2629 Wisconsin. On behalf of myself, our staff and the tens of  
2630 thousands of patients that we care for, we commend you for  
2631 advancing the national health reform debate.

2632 At our clinic, we continue to follow closely this  
2633 dialog, especially reorienting the system towards quality and  
2634 efficiency while at the same time ensuring that any  
2635 meaningful reform is not built upon the flawed incentives of  
2636 the current program. Therefore, we strongly urge this  
2637 committee to be bold and address the problems of  
2638 affordability, quality and disparities in payment that plague  
2639 the program, hurting beneficiaries and providers alike.

2640 As background, Marshfield Clinic is one of the largest  
2641 medical group practices in Wisconsin and indeed the United  
2642 States with almost 800 physicians, 6,500 additional staff and  
2643 3.6 million annual patient encounters per year. As a  
2644 501(c)(3) not-for-profit organization, our clinic is a public  
2645 trust serving all who seek care regardless of their ability  
2646 to pay. As part of our commitment, the clinic has invested

2647 in sophisticated tools that complement and support our  
2648 mission such as an internally developed certified electronic  
2649 medical record, a data warehouse and an immunization  
2650 registry. With this infrastructure, the clinic is presently  
2651 publicly reporting clinical outcomes and providing quality  
2652 improvement tools to analyze processes, eliminate waste and  
2653 improve consistency while still reducing unnecessary costs.  
2654 These initiatives are consistent with the stated goals of the  
2655 national health reform debate. Our clinic has long used  
2656 information to facilitate care redesign and we expanded these  
2657 efforts after becoming a participant in the federal physician  
2658 group demonstration project. As a result, we have improved  
2659 care, reduced costs and achieved significant savings for the  
2660 Medicare program. In the first 2 years of the demonstration,  
2661 we have saved taxpayers more than \$25 million with our  
2662 redesigns while meeting or exceeding all 27 possible quality  
2663 metrics. We believe that equivalent or even greater results  
2664 are possible with the creation of the proposed accountable  
2665 care organizations, especially if the subcommittee aligns the  
2666 incentives of the Medicare program reimbursement with value  
2667 and efficiency.

2668         However, of concern is the current tri-committee mark.  
2669 The authors have proposed the establishment of a public  
2670 health insurance option. Providers who voluntarily

2671 participate in Medicare would be required to participate in  
2672 the public option and would be paid at Medicare rates plus  
2673 some incremental percentage for the first 3 years of  
2674 operation. This raises substantial financial and operational  
2675 questions around how the federal government could compel  
2676 physicians to see those patients. For instance, would this  
2677 mean that patients must be seen when they present or would  
2678 providers be compelled to see the patient within a certain  
2679 time frame? Further, if the public plan pays at Medicare  
2680 rates, the reduction in commercial service revenue would  
2681 compel radical restructuring of our institution, perhaps  
2682 resulting in our demise. As such and in this current form,  
2683 Marshfield Clinic strongly opposes the public plan  
2684 alternative based on the belief that a true level playing  
2685 field could never exist between public and private providers.  
2686 In Wisconsin, where commercial rates vary between 180 to 280  
2687 percent of Medicare rates, this public plan would have such a  
2688 profound competitive advantage that one needs to be concerned  
2689 that providers would uniformly abandon the Medicare program  
2690 to survive in the practice of medicine.

2691 Further, there is a significant problem with the  
2692 Medicare payment rates in Wisconsin as well as the rest of  
2693 rural America. For example, Medicare currently reimburses us  
2694 at only 51.6 percent of our allowable costs. We believe that

2695 this is a result of Medicare's failed formulas for  
2696 reimbursing physician work and practice expense and  
2697 Medicare's geographic adjustment. To address these systemic  
2698 problems, we believe that Congress and CMS must refine  
2699 Medicare payment systems to address the problems of access  
2700 and encourage appropriate care by providing incentives that  
2701 focus on quality and efficiency. Similarly, we are also  
2702 concerned about the practice expense components of the  
2703 Medicare physician formula. It is widely agreed that the  
2704 data used to estimate non-physician wages does not reflect  
2705 current patterns and practice of medicine. As a result, the  
2706 formula distorts payments, paying some too much and others  
2707 too little. To resolve this disparity, we would like to  
2708 heighten the legislative work of Congressmen Braley and Kind,  
2709 who have each authored legislation to correct this inequity,  
2710 and we urge the subcommittee to include these members'  
2711 thoughtful provisions in any health care reform legislation  
2712 that advances.

2713         Again, Marshfield Clinic appreciates the opportunity to  
2714 share our views and we look forward to advancing our shared  
2715 vision of a healthy America. Thank you.

2716         [The prepared statement of Dr. Ulrich follows:]

2717 \*\*\*\*\* INSERT 5 \*\*\*\*\*

|

2718            Mr. {Pallone.} Thank you, Dr. Ulrich.

2719            Dr. Wright.

|  
2720 ^STATEMENT OF JANET WRIGHT

2721 } Dr. {Wright.} Chairman Pallone and Ranking Member Deal  
2722 and members of the subcommittee, thank you for the  
2723 opportunity to appear before the subcommittee today. My name  
2724 is Janet Wright. I am a board-certified cardiologist, having  
2725 trained in San Francisco and practiced in northern California  
2726 for 25 years. For the last year I have been serving as the  
2727 American College of Cardiology's senior vice president for  
2728 science and quality here in Washington, and in that role I  
2729 oversee our registries, our scientific documents like  
2730 guidelines and performance measures and appropriate-use  
2731 criteria and also our quality improvement projects and  
2732 programs.

2733 On behalf of the 37,000 members of the ACC, I commend  
2734 you for setting out the health care reforms in the current  
2735 draft bill. We see so many improvements and we commend you  
2736 and applaud your efforts to both attend to and correct the  
2737 flawed physician payment model. We also register concerns  
2738 about proposed cuts in imaging and the effect they may have  
2739 on patients' access to care. But in broad overview, the ACC  
2740 is completely committed to comprehensive reform and we are  
2741 very grateful for your attention to the matter.

2742           Ranking Member Barton invited me to speak today about  
2743 his draft proposal, the Health Care Transparency Commission  
2744 Act of 2009, and I am delighted to offer these comments. The  
2745 American College of Cardiology values performance  
2746 measurements, its analysis and improvement and it  
2747 demonstrates this commitment through a 25-year history of  
2748 producing guidelines for clinical practice, the more recent  
2749 generation of a particular kind of guidance called  
2750 appropriate-use criteria, to help clinicians choose the  
2751 appropriate type of treatment or technology or procedure that  
2752 best fits that patient's clinical scenario, and in our  
2753 efforts in what is now called implementation science, taking  
2754 what we know works and trying to get that into the practice  
2755 of medicine in a systematic way. Examples of that in recent  
2756 years are the Door To Balloon project of the Alliance for  
2757 Quality, over 1,100 hospitals here in the United States and  
2758 beyond trying to shorten up that time from diagnosis of a  
2759 myocardial infarction until the balloon opens that artery.  
2760 And more recently we are about to launch a program called  
2761 Hospital to Home, Excellence in Transition, along with key  
2762 partnerships, particularly with the Institute for Health Care  
2763 Improvement. And finally, we are beginning to implement our  
2764 appropriate-use criteria, both in imaging and soon in  
2765 revascularization, to help clinicians, their patients and

2766 their surgeons make good decisions about revascularization.

2767         In fact, our vision is not just separate projects but a  
2768 network of practices in hospitals. Our registries are in  
2769 about 2,300 hospitals around the country and our ambulatory  
2770 registry called the Improvement Program is just beginning but  
2771 we are out into about 600 practices in the country. Our  
2772 fully realized vision is to connect these practices and  
2773 hospitals in a quality network. Those individuals practicing  
2774 in the hospitals and outpatient settings are committed to the  
2775 systematic delivery of scientifically sound patient-centered  
2776 care, and fully realize that vision will include a primary  
2777 care network as well because we understand most of cardiac  
2778 diseases are actually managed by primary care docs and  
2779 nurses. In order to effect this vision to make this come  
2780 true, obviously payment needs to be readjusted from the  
2781 volume that we have known to the value that we treasure. I  
2782 enlist and again appreciate your efforts to make that happen.

2783         We believe that good data are the foundation for quality  
2784 improvement and serve to stimulate innovation, very healthy  
2785 competition amongst providers and rapid and continuous  
2786 learning network. As the science of performance measurement  
2787 improves and the skill of all of us at communicating  
2788 complicated statistics to lay people, as that skill is honed,  
2789 consumers will likewise find great value in quality

2790 information. The ACC strongly supports the public's right to  
2791 valid, actionable and current data to help inform and enhance  
2792 decision making. We find Mr. Barton's proposal to be a  
2793 laudable one and should Congress proceed in this direction,  
2794 we recommend consideration of the following principles.  
2795 These were published in 2008 and I am only going to hit the  
2796 high points.

2797 But number one, the driving force for performance  
2798 measurements and public reporting should be quality  
2799 improvement. We acknowledge and support Mr. Barton's  
2800 critical inclusion in his draft bill of quality ratings along  
2801 with pricing information. Number two, public reporting  
2802 programs should be based on performance measures with  
2803 scientific validity. Number three, public reporting programs  
2804 should be developed in partnership with health care  
2805 professionals, those being measured. Number four, every  
2806 effort should be made to use standardized data elements to  
2807 assess and report performance, and to make the submission  
2808 process uniform across all public reporting programs. This  
2809 helps reduce the measurement fatigue and the disengagement  
2810 that we often see in health care professionals who are  
2811 exhausted with the effort of measuring. Number five,  
2812 performance reporting should occur at the appropriate level  
2813 of accountability. I think this is true in all areas of

2814 medicine but certainly in cardiology. The most effective  
2815 care is delivered by teams. Focusing on an individual within  
2816 that team may skew the measurement and the result of that  
2817 measurement in a way that has adverse consequences.

2818         Mr. {Pallone.} Dr. Wright, you are almost a minute  
2819 over, so if you could just summarize.

2820         Dr. {Wright.} Number six is avoiding those unintended  
2821 consequences. Thank you very much.

2822         [The prepared statement of Dr. Wright follows:]

2823 \*\*\*\*\* INSERT 6 \*\*\*\*\*

|

2824 Mr. {Pallone.} Thank you. Sorry.

2825 Dr. White.

|  
2826 ^STATEMENT OF KATHLEEN M. WHITE

2827 } Ms. {White.} Chairman Pallone, Ranking Member Deal,  
2828 distinguished committee members and Congressional staff, I am  
2829 Kathleen White, a registered nurse, speaking today on behalf  
2830 of the American Nurses Association, and we thank you for this  
2831 opportunity to testify. The ANA is the only full-service  
2832 national association representing the interests of the  
2833 Nation's 2.9 million registered nurses in all educational and  
2834 practice settings. ANA advances the nursing profession by  
2835 fostering high standards of nursing practice.

2836 ANA commends the committee for its work in the tri-  
2837 committee's draft legislation which represents a movement  
2838 toward much-needed comprehensive and meaningful reform for  
2839 our health care system. We appreciate the committee's  
2840 recognition that in order to meet our Nation's health care  
2841 needs, that we must have an integrated and well-resourced  
2842 national workforce policy that fully recognizes the vital  
2843 role of nurses and other health care providers and allows  
2844 each to practice to the fullest extent of their scope. ANA  
2845 remains committed to the principle that health care is a  
2846 basic human right and all persons are entitled to ready  
2847 access to affordable, quality health care services that are

2848 patient centered, comprehensive and accessible. We also  
2849 support a restructured health care system that ensures  
2850 universal access to a standard package of essential health  
2851 care services for all.

2852         That is why ANA strongly supports the inclusion of a  
2853 public health insurance plan option as an essential component  
2854 of comprehensive health care reform. We believe that  
2855 inclusion of a public plan option would assure that patient  
2856 choice is a reality and not an empty promise and that a high-  
2857 quality public plan option will above all provide the peace  
2858 of mind that is missing from our current health care  
2859 environment. It will guarantee the availability of quality,  
2860 affordable coverage for individuals and families no matter  
2861 what happens and generate needed competition in the insurance  
2862 market. ANA looks forward to partnering with you to make  
2863 this plan a reality.

2864         There are a wide variety of ideas currently circulating  
2865 on health care reform but all include discussion of  
2866 prevention and screening, health education, chronic-disease  
2867 management, coordination of care and the provision of  
2868 community-based primary care. As the committee has clearly  
2869 recognized in its drafts, these are precisely the  
2870 professional skills and services that registered nurses bring  
2871 to patient care. As the largest group of health care

2872 professionals, registered nurses are educated and practice  
2873 within a holistic framework that views the individual family  
2874 and committee as an interconnected system. Nurses are the  
2875 backbone of the health care system and are fundamental to the  
2876 critical shift needed in health services delivery with the  
2877 goal of transforming the current sick care system into a true  
2878 health care system.

2879 ANA deeply appreciates the committee's recognition of  
2880 the need to expand the nursing workforce and thanks you for  
2881 your commitment to amend the title VIII nursing workforce  
2882 development programs under the Public Health Service Act and  
2883 commend the inclusion of the definition of nurse-managed  
2884 health centers under the title VIII definitions. We applaud  
2885 the removal of the 10 percent cap on doctoral traineeships  
2886 under the advanced education nursing grant program and the  
2887 inclusion of special consideration to eligible entities that  
2888 increase diversity among advanced educated nurses.

2889 Additionally, the expansion of the loan repayment  
2890 program eligibility to include graduates who commit to  
2891 serving as nurse faculty for 2 years will help address this  
2892 critical shortage of both bedside nurses and nursing faculty.  
2893 We are also grateful for the funding stream created through  
2894 the public health investment fund and the commitment of  
2895 dollars through 2014 that would offer vital resources and

2896 much-needed funding stability for these title VIII programs.

2897 ANA applauds the use of community-based  
2898 multidisciplinary teams to support primary care through the  
2899 medical home model. ANA is especially pleased that under  
2900 this proposal nurse practitioners have been recognized as  
2901 primary care providers and authorized to lead medical homes.  
2902 Nurse practitioners' skills and education, which emphasize  
2903 patient- and family-centered whole person care, make them  
2904 particularly well-suited providers to lead in the medical  
2905 home model, focused on coordinated chronic care management  
2906 and wellness and prevention. Many recent studies have  
2907 demonstrated what most health care consumers already know:  
2908 nursing care and quality patient care are inextricably linked  
2909 in all care settings but particularly in acute and long-term  
2910 care.

2911 Because nursing care is fundamental to patient outcomes,  
2912 we are pleased that the legislation places a strong emphasis  
2913 on reporting nurse staffing and long-term care settings, both  
2914 publicly and to the Secretary. The availability of nurse  
2915 staffing information on the nursing home compare website  
2916 would be vital to help consumers make informed decisions and  
2917 the full data reported to the Secretary will ensure staffing  
2918 accountability and enhance resident safety. ANA hopes that  
2919 in the same vein the committee will look toward incorporating

2920 public reporting of similar nurse staffing measures and  
2921 nursing-sensitive indicators in acute care through the  
2922 hospital compare website as recommended by the National  
2923 Quality Forum.

2924         Finally, a reformed health care system must value  
2925 primary care and prevention to achieve improved health status  
2926 of individuals, families and the community. ANA supports the  
2927 renewed focus on new and existing community-based programs  
2928 such as community health centers, nurse home visitation  
2929 programs and school-based clinics and applauds the  
2930 committee's recognition of the vital importance of addressing  
2931 health disparities.

2932         Once again, the American Nurses Association thanks you  
2933 for the opportunity to testify before this committee. We  
2934 appreciate your understanding of the important role nurses  
2935 play in the lives of our patients and the health system at  
2936 large. Nurses are ready to work with you to support and  
2937 advance meaningful health care reform today. Thank you.

2938         [The prepared statement of Ms. White follows:]

2939 \*\*\*\*\* INSERT 7 \*\*\*\*\*

|

2940 Mr. {Pallone.} Thank you, Ms. White.

2941 Dr. Gabow.

|  
2942 ^STATEMENT OF PATRICIA GABOW

2943 } Dr. {Gabow.} Chairman Pallone, Ranking Member Deal and  
2944 members of the committee, thank you for the opportunity to  
2945 testify. I am Dr. Patricia Gabow and I am speaking for  
2946 Denver Health and National Association of Public Health and  
2947 Hospital System. Please excuse my voice.

2948 Denver Health is an integrated safety-net institution  
2949 that includes the State's busiest hospitals, all Denver  
2950 federally qualified health centers, the public health  
2951 department, all the school-based clinics and more. Since  
2952 1991, we have provided \$3.4 billion in uninsured care and  
2953 have been in the black every year. We have state-of-the art  
2954 facilities and sophisticated HIT. These characteristics have  
2955 enabled amazing quality. Ninety-two percent of our children  
2956 are immunized. Our hospital mortality is one of the lowest  
2957 in the country. Sixty-one percent of our patients have their  
2958 blood pressure controlled compared to 34 percent in the  
2959 country. This is despite the fact that 46 percent of our  
2960 patients are uninsured, 70 percent are minorities and 85  
2961 percent are below 185 percent of federal poverty level.

2962 So you may ask if we are doing so well and meeting  
2963 patients' needs, why am I here supporting health reform. The

2964 answer is straightforward. As the safety-net physician  
2965 leader, I see every day that America is failing to meet  
2966 people's health care needs in a coordinated, high-quality,  
2967 low-cost way. The number of uninsured at our door and the  
2968 cost of their care increases every year. In 2007, our  
2969 uninsured care was \$275 million. Last year it was \$318  
2970 million, and is projected to be \$360 million this year. This  
2971 is not sustainable. Moreover, not every American city has a  
2972 Denver Health. As a doctor, I ask myself why should where  
2973 you live in America determine if you live. Why should an  
2974 uninsured cancer patient get care if they live in Denver but  
2975 not if they live in another Colorado county?

2976       You have included important reform components in your  
2977 draft bill. We support your goal to ensure affordable,  
2978 quality care for all. I agree that costs must be reduced if  
2979 we are to cover everyone and costs can be reduced by  
2980 developing integrated systems that get patients to the right  
2981 place at the right time with the right level of care, with  
2982 the right provider and the right financial incentives. We  
2983 support your continued investment in DSH hospitals, community  
2984 health centers and public health. I would encourage  
2985 incentives to integrated systems. These entities will be  
2986 important during the transition to full coverage and  
2987 afterwards to vulnerable patients including Medicaid, which

2988 will be a building block for much of the coverage expansion.  
2989 Integrated systems are cost efficient. Our charges for  
2990 Medicaid admission are 30 percent below our peer hospitals.

2991 Your investment in primary care and nurse training and  
2992 the National Health Service Corps is critical. Without this,  
2993 we will not be able to get patients to the right provider for  
2994 the right level of care. As a public entity, we believe in  
2995 the power of the public sector to meet the needs not only of  
2996 those patients on public programs but also private patients.  
2997 We are the major Medicaid provider for our State but our HMO  
2998 also serves private patients including Denver's mayor. We  
2999 and other safety-net systems would welcome the opportunity to  
3000 continue to be a plan of choice.

3001 In summary, as a physician and a CEO of a public safety-  
3002 net system, I urge you to continue this effort to  
3003 substantially reform our delivery system, our payment model  
3004 and to provide care for all Americans. Our current system  
3005 cannot and should not be sustained. America deserves better.  
3006 I and NPH are eager to help you in this very important task.  
3007 Thank you.

3008 [The prepared statement of Dr. Gabow follows:]

3009 \*\*\*\*\* INSERT 8 \*\*\*\*\*

|

3010 Mr. {Pallone.} Thank you, Doctor.

3011 Mr. Hawkins.

|  
3012 ^STATEMENT OF DAN HAWKINS

3013 } Mr. {Hawkins.} Well said, Dr. Gabow.

3014 Good morning, Mr. Chairman, Ranking Member Deal and  
3015 distinguished members of the subcommittee, distinguished  
3016 meaning present and accounted for. On behalf of the National  
3017 Association of Community Health Centers, the Nation's more  
3018 than 1,200 community health center organizations and the more  
3019 than 18 million people they serve today, thank you for the  
3020 opportunity to contribute to today's discussion. In  
3021 community health centers all across the country, we witness  
3022 the urgent need for fundamental health reform every single  
3023 day in the faces and the struggles of our patients who for  
3024 too long have been left behind by our dysfunctional health  
3025 care system.

3026 Our 43 years' experience in caring for America's  
3027 medically disenfranchised and underserved has taught us three  
3028 things. First and foremost, that health reform must achieve  
3029 universal coverage that is available and affordable for  
3030 everyone and especially for low-income individuals and  
3031 families, second, that that coverage must be comprehensive  
3032 and must emphasize prevention and primary care, and third,  
3033 that it must guarantee that everyone has access to a medical

3034 or a health care home where they can receive high-quality,  
3035 cost-effective care for their needs.

3036         Mr. Chairman, we believe that the plan we have before us  
3037 today meets those principles and also moves our Nation much  
3038 closer to achieving the equity and social justice in health  
3039 care that has proven so elusive over the past century.  
3040 Community health centers strongly support the draft  
3041 legislation's call to expand Medicaid to cover everyone with  
3042 incomes up to 133 percent of poverty without restriction.  
3043 This Medicaid expansion may well be the most important and  
3044 the most essential feature of this plan, especially for the  
3045 patients we serve.

3046         At the same time, we urge you to ensure that as these  
3047 Medicaid beneficiaries are potentially moved into the health  
3048 insurance exchange, they can continue receiving supplemental  
3049 Medicaid benefits, those key services like outreach,  
3050 transportation, nutrition and health education, screening and  
3051 case management that will remain so vital to their health and  
3052 well-being but will most likely not be covered by their  
3053 exchange plans. It is also clear that the expansion of  
3054 insurance coverage, while a vital first step, can only take  
3055 the country so far. Most importantly, the increased demand  
3056 for care that comes from expanding coverage must be met with  
3057 an augmented primary health care system as the people of

3058 Massachusetts learned in the wake of their State's reform.  
3059 Here again, the draft legislation delivers a solid response  
3060 to this challenge and we applaud its call to expand the  
3061 health center system of care through increased funding as  
3062 part of the new public health investment fund. The members  
3063 of this committee have consistently provided broad,  
3064 bipartisan support for health centers over the years and we  
3065 deeply appreciate that, and I can assure that health centers  
3066 are repaying your trust and your investment in their every  
3067 day.

3068         For example, a recent national study done in  
3069 collaboration with the Robert Graham Center found that people  
3070 who use health centers as their usual source of care have 41  
3071 percent lower total health care costs and expenditures than  
3072 people who get their care elsewhere. As a result, health  
3073 centers saved the health care system \$18 billion last year  
3074 alone, more than nine times the federal appropriation for the  
3075 program and better than \$2 for every dollar they spent in  
3076 care. With the new funding in the draft bill, these savings  
3077 will grow even larger. The National Health Service Corps is  
3078 a vital tool for health centers and underserved communities  
3079 seeking to recruit new clinicians and the draft legislation  
3080 would bring an historic investment to the program, leading to  
3081 thousands more primary care providers to practice in

3082 underserved communities.

3083           The committee has also historically recognized that it  
3084 makes sense for all insurers to reimburse health centers and  
3085 other safety-net providers appropriately and predictably for  
3086 the comprehensive primary and preventive care they provide.  
3087 In order to accomplish this goal, we recommend that Congress  
3088 align health center payments from all insurers, public and  
3089 private, with the structure currently in place under  
3090 Medicaid. As you continue deliberations, we urge the  
3091 committee to consider improving the bill further by including  
3092 language from H.R. 1643, which would align the current  
3093 Medicare health center payment methodology with the  
3094 successful Medicaid prospective payment system.

3095           Finally, as full participants in a reformed health care  
3096 system, America's health centers stand ready to deliver  
3097 quality improvement, increased access and cost containment  
3098 that will be necessary to make this reform successful. To  
3099 that end, we applaud the committee's inclusion of network  
3100 adequacy standards for all exchange plans to ensure that  
3101 people living in underserved communities have access to the  
3102 health centers and other essential community providers  
3103 located there.

3104           Mr. Chairman and members of the committee, we again  
3105 thank you for your leadership and your commitment to make

3106 health care reform work for all Americans and we pledge  
3107 ourselves to work with you to make that a reality this year.

3108 Thank you.

3109 [The prepared statement of Mr. Hawkins follows:]

3110 \*\*\*\*\* INSERT 9 \*\*\*\*\*

|

3111 Mr. {Pallone.} Thank you, Mr. Hawkins.

3112 Mr. Roberts.

|  
3113 ^STATEMENT OF BRUCE T. ROBERTS

3114 } Mr. {Roberts.} Chairman Pallone, Congressman Deal and  
3115 members of the Health Subcommittee, I am Bruce Roberts, the  
3116 executive vice president and CEO of the National Community  
3117 Pharmacists Association, NCPA. I am a licensed pharmacist in  
3118 the State of Virginia and I have owned four community  
3119 pharmacies over the last 33 years in Loudon County, Virginia.  
3120 NCPA represents the owners and operators of 23,000  
3121 independent community pharmacies in the United States. We  
3122 appreciate the opportunity to testify before you today on the  
3123 role of pharmacy in health care reform.

3124 In many communities throughout the United States,  
3125 especially in urban and rural areas, independent community  
3126 pharmacies are often the primary source of a broad range of  
3127 health care products and services, services such as  
3128 medication therapy management and immunization programs for  
3129 seniors under Medicare Part B and D. We believe that a  
3130 reformed health care system should expand the availability of  
3131 these programs because they can help improve the quality of  
3132 care and reduce health care costs.

3133 The reality is that for every dollar the health care  
3134 system spends paying for prescription medications, we spend

3135 at least another additional dollar on health care services to  
3136 treat the adverse effects of medications that are taken  
3137 incorrectly or not at all. For example, a primary cause for  
3138 costly hospital readmissions is the lack of patient adherence  
3139 to medications used to treat chronic medical conditions such  
3140 as hypertension and high cholesterol. Pharmacists can play  
3141 an important role in the post-acute care and helping patients  
3142 manage their medications through education, training and  
3143 monitoring. We applaud the fact that the draft House  
3144 language would allow the involvement of non-physician  
3145 practitioners such as pharmacists in the medical home pilot  
3146 project. Pharmacists can help improve the use of  
3147 prescription medications, especially in those individuals  
3148 that have multiple chronic diseases.

3149 NCPA is very much appreciative of the fact that the  
3150 draft House legislation includes reform of the average  
3151 manufacturer's price, AMP, based reimbursement system for  
3152 Medicaid generic drugs. We would like to get this fixed this  
3153 year. We are concerned that the Medicaid generic  
3154 reimbursement at 130 percent of the weighted average AMP as  
3155 proposed in the draft House bill combined with low dispensing  
3156 fees paid by States will in total still significantly  
3157 underpay pharmacies for the dispensing of low-cost generics  
3158 in the Medicaid program. This could create a disincentive

3159 for the use of generic drugs causing a rise in Medicaid costs  
3160 over the long term. NCPA asks the committee to consider a  
3161 higher FUL reimbursement rate for generic medications,  
3162 especially for critical access community pharmacies that  
3163 serve a higher percentage of the Medicaid recipients or rural  
3164 pharmacies.

3165         With respect to our ability to continue to provide  
3166 durable medical equipment, DME, to Medicare beneficiaries, we  
3167 believe that requiring State-licensed, State-supervised  
3168 community retail pharmacies to obtain both accreditation and  
3169 surety bonds to simply sell demipost items such as diabetes  
3170 testing supplies to Medicare beneficiaries is basically  
3171 overkill. Thousands of pharmacies across the country, mostly  
3172 small pharmacies, will not be accredited at all or not be  
3173 finished the accreditation process by October 1, which will  
3174 mean that they will not be able to provide diabetes testing  
3175 supplies for Medicare beneficiaries. We applaud the 90  
3176 bipartisan members of the House and 13 members of the Energy  
3177 and Commerce Committee who supported H.R. 616, the bill that  
3178 was introduced by Congressman Barry and Congressman Moran  
3179 that would exempt pharmacies from redundant and unnecessary  
3180 accreditation requirements. We also appreciate the work of  
3181 Congressman Space in introducing H.R. 1970, which would  
3182 exempt pharmacies from unnecessary surety bonds. We ask that

3183 the provisions from these bills be included in the chairman's  
3184 mark. If there is willingness to exempt pharmacies from  
3185 these requirements, we ask that Congress consider acting by  
3186 October 1, which is the deadline for providers to obtain  
3187 accreditation and surety bonds.

3188 Finally, I would make a few comments regarding the  
3189 public plan option. Under the House proposal, payment rates  
3190 for prescription drugs under the public plan proposal would  
3191 be negotiated by the Secretary. We would be very concerned  
3192 giving the Secretary authority to set payment rates for  
3193 prescription drugs without some basic guidance to how these  
3194 rates should be established and updated. We also ask that  
3195 the language be clarified such as the administration of any  
3196 benefit under the public plan would be accomplished by a  
3197 pharmacy benefit administrator as opposed to a pharmacy  
3198 benefit manager. We would prefer a model used in the  
3199 Medicaid program or in the Department of Defense Tri-Care  
3200 program where the administrator is used. Under this model,  
3201 most, if not all, the negotiated drug manufacturer rebates  
3202 would be passed through to the public program.

3203 In conclusion, we look forward to working with Congress  
3204 and the Administration to reform the health care system and  
3205 we look forward to the opportunity to work with you to meet  
3206 that end.

3207 [The prepared statement of Mr. Roberts follows:]

3208 \*\*\*\*\* INSERT 10 \*\*\*\*\*

|

3209 Mr. {Pallone.} Thank you, Mr. Roberts.

3210 Mr. Yarwood.

|  
3211 ^STATEMENT OF BRUCE YARWOOD

3212 } Mr. {Yarwood.} I should first of all saying thank you  
3213 for including me in the distinguished panel. I mean, doctor,  
3214 doctor, doctor, doctor, pharmacy, and here is old Yarwood  
3215 sitting right in between them all. Thank you very much. I  
3216 appreciate being here.

3217 As you know, I am Bruce Yarwood. I am president and CEO  
3218 of American Health Care Association and the National Center  
3219 for Assisted Living, which we represent about 11,000  
3220 facilities across the country with a great cross-section of  
3221 the profession. We have big, we have small, we have rural,  
3222 we have urban, proprietary, non-proprietary. And I would be  
3223 remiss if I didn't say we look at ourselves as a pretty  
3224 significant portion of the economy right now. We are about  
3225 1.1 percent of the gross domestic product when you kind of  
3226 sort it all out.

3227 Now, having said that, we have taken a look at the 800  
3228 pages and it is a significant bill, and I must admit one that  
3229 does not include long-term care reform. At the same time, it  
3230 includes a whole bunch of stuff that has impact on us. And  
3231 let me try to synthesize a little bit of the comments.

3232 First, as we move forward and try to do a better job in

3233 terms of quality, it is really important for us to have  
3234 economic stability, and one of the things we find in the bill  
3235 is we have three pretty big problems with it. First of all,  
3236 the bill has a provision that would institutionalize what the  
3237 CMS is doing to cut 3.3 percent out of our Medicare rate  
3238 based on a formulary mistake that was made by them 4 years  
3239 ago. Secondly, we are concerned about the discussion draft  
3240 that will eliminate a part of the market basket and so what  
3241 we are looking at then is not only a 3.3 percent cut in our  
3242 rate coming from CMS but then an additional cut coming from  
3243 the committee that would significantly take resources out in  
3244 terms of our ability to pay, and as you know, we are two-  
3245 thirds to three-quarters or 75 percent labor based, and so a  
3246 significant reduction in reimbursement causes us a big  
3247 problem in terms of our ability to pay and keep staff.

3248         Third, which is not your doing, but Medicare cuts are  
3249 being considered at the same time we are looking at what we  
3250 call the unfortunate reality of Medicaid underfunding. What  
3251 we have seen, the stimulus package was a help. However, in  
3252 response to the recession, we see 46 percent of the States  
3253 are freezing or cutting nursing home rates and that the 75  
3254 percent are not keeping up with inflation. So in a short  
3255 statement, what is occurring is that we are looking down the  
3256 barrel of a Medicare cut and at the same we are looking

3257 across the country at Medicaid rates either staying stable or  
3258 falling in a period of inflation and so we are feeling caught  
3259 in an economic vise, if you will.

3260 Now, let me talk a little bit about some other stuff  
3261 that is I would say very positive. Regarding Part B, we  
3262 applaud you for the proposal to extend the therapy cap  
3263 extension process exception process. Second, I think in  
3264 testimony earlier we talked about Medicare re-  
3265 hospitalization. We have a re-hospitalization problem and we  
3266 need to address that issue. We think there are ways to do  
3267 that. In a short statement, we find that our re-  
3268 hospitalization comes on day 2, 3 and 4 of admission and  
3269 typically they go back to the hospital because they come on  
3270 the weekend or things of that nature. So we think we should  
3271 continue work on that together. Third, we think that we  
3272 should be looking at the whole post-acute setting and trying  
3273 to integrate that much better than it is now and we have  
3274 numbers that would show that if we either on a pilot or  
3275 demonstration basis, we find that if we would integrate and  
3276 pay based on diagnosis, not on site, we can save multibillion  
3277 dollars ranging above \$50 billion over the next 10 years, and  
3278 that simply stated is that we can take a knee or a hip that  
3279 is not an IRF but in a nursing home and do it for about half  
3280 the cost.

3281 I would be remiss if I didn't respond a little bit to  
3282 100 pages of your bill that was addressed somewhat earlier by  
3283 the prior panel that talks about transparency in long-term  
3284 care. Very basically put, the question is that what we need  
3285 to do is take a lot better look at who owns places, how they  
3286 are owned, who makes the decisions. We he been in  
3287 discussions with the staff for about the last 18 months and  
3288 frankly we support the concept and the direction of the  
3289 committee and we believe firmly that by continuing to work  
3290 together, the final legislation that we can parse together,  
3291 we can absolutely support.

3292 I would say there are a few specifics though that I  
3293 would be remission if I didn't say that we have a problem  
3294 with. First, we have a difficult time with what a  
3295 disclosable party, and in the bill itself, for example, it  
3296 mentions that we should be disclosing our bankers' boards of  
3297 directors. That is something we don't have or can't get to.  
3298 Secondly, we would suggest the provisions that you are  
3299 looking at be tailored to talk about exactly who we want to  
3300 disclose. We take a look at the bill and we are in the  
3301 position of disclosing people like who are landscapers are,  
3302 painters are and things of that nature that don't have a  
3303 significant amount so we think we can work that out. Third,  
3304 we heard a lot about compliance programs from the Inspector

3305 General. We have no problem with compliance programs but  
3306 what we need is to tailor those based on the size of the  
3307 facility. A compliance program for Kindred Health Care, the  
3308 largest in the country, versus the compliance program for a  
3309 35-bed facility in Oakland are two different things so we  
3310 just need to be sympathetic as to what those are.

3311 Mr. {Pallone.} You are a minute over.

3312 Mr. {Yarwood.} Let me say this. Thank you very much  
3313 for letting us be here. We certainly want to work together  
3314 and there are great things in the workforce area and the  
3315 transparency stuff. We are here to make it work for you.

3316 [The prepared statement of Mr. Yarwood follows:]

3317 \*\*\*\*\* INSERT 11 \*\*\*\*\*

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3318           Mr. {Pallone.} Thank you. Thanks a lot.

3319           Ms. Fox.

|  
3320 ^STATEMENT OF ALISSA FOX

3321 } Ms. {Fox.} Thank you very much, Chairman Pallone,  
3322 Ranking Member Deal and other members of the committee. I  
3323 really appreciate the opportunity to be here today.

3324 Blue Cross Blue Shield plans strongly support enactment  
3325 of health reform. We must rein in costs, improve quality,  
3326 and importantly we must cover everyone. Today the Blue  
3327 system provides coverage to more than 100 million people in  
3328 every community and every zip code in this country. For the  
3329 past 2 years we have been supporting five key steps to reform  
3330 our system.

3331 First, we believe Congress should encourage research on  
3332 what treatments work best by establishing a comparative  
3333 effectiveness research institute. We are very pleased the  
3334 House draft bill recognizes the importance of this key step.  
3335 Second, in order to attack rising costs, we must change the  
3336 incentives in the payment systems both private and in  
3337 Medicare to promote better care instead of just more  
3338 services. The draft bill includes some of the Medicare  
3339 delivery system recommendations we support. We also agree  
3340 with provisions in the bill to help build an adequate medical  
3341 workforce to care for everyone in the country. Third,

3342 consumers and providers should be empowered with information  
3343 and tools to make more-informed decisions. Fourth, we need  
3344 to promote health and wellness and prevention and managed  
3345 care for those with chronic illnesses. Finally, we believe a  
3346 combination of public and private coverage solutions are  
3347 needed to make sure everyone is covered. We support a new  
3348 individual responsibility program for all Americans to obtain  
3349 coverage along with subsidies to ensure coverage is  
3350 affordable. We also support expanding Medicaid to cover  
3351 everyone in poverty. We are also supporting major reforms in  
3352 our own industry including new federal rules to require  
3353 insurers to open the doors, accept everyone regardless of  
3354 preexisting conditions and eliminate the practice of varying  
3355 premiums based upon health status, and we also support a  
3356 national system of state exchanges to make it easier for  
3357 individuals and small employers to purchase coverage. I know  
3358 there is a perception that this is a new position for the  
3359 insurance industry. It is not for the Blue system. We had  
3360 the same position in 1993.

3361 We appreciate this opportunity to comment on the tri-  
3362 committee bill. We support the broad framework of the bill  
3363 which includes many of the critical steps we believe are  
3364 needed. However, we have very strong concerns that specific  
3365 provisions will have serious unintended consequence that will

3366 undermine the committee's goals. Our chief concern is  
3367 creation of a new government-run health program. We believe  
3368 a government-run health program is unnecessary for reform and  
3369 will be very problematic for three reasons. First, many  
3370 people are likely to lose the private coverage they like and  
3371 be shifted into the government plan. This is because the  
3372 government plan will have many price advantages that the  
3373 private plans won't including paying much lower Medicare  
3374 rates than the private sector. This is an enormous advantage  
3375 on its own as Medicare rates are already 20 to 30 percent  
3376 lower than what we pay in the private side, and that is a  
3377 national average. I think here you heard Marshfield Clinic  
3378 talk about much huger variations in Wisconsin. But there are  
3379 other advantages in the bill as well. I will give you two  
3380 examples. Individuals in the government plan, they can only  
3381 sue in federal court for denied services. However,  
3382 individuals in private plans can sue in State court for  
3383 punitive, compensatory and other damages. In addition,  
3384 private plans would have to meet 1,800 separate State benefit  
3385 and provider requirements while the government plan would  
3386 not. Second, the draft bill would underpay providers in the  
3387 government plan. This is likely to lead to major access  
3388 issues in the health care system such as long waits for  
3389 services. And third, the government plan would undermine

3390 much-needed delivery system reforms that are critical to  
3391 controlling costs. We agree Medicare needs to be reformed to  
3392 reward high-quality care. We commend the committee for  
3393 including reforms to modernize Medicare. However, history  
3394 has shown the government can be slow to innovate and  
3395 implement changes through the complex legislative and  
3396 regulatory processes. The private sector, on the other hand,  
3397 is free to innovate, and let me just give you one example  
3398 from our program that is improving outcomes and lowering  
3399 costs through our Blue Distinction Centers of Excellence.  
3400 Recent data shows that readmission rates at our cardiac care  
3401 centers around the country have 26 to 37 percent lower  
3402 readmission rates than other hospitals.

3403         In closing, I would like to emphasize the Blue system's  
3404 strong support for health care reform including major changes  
3405 in how insurers do business today. We believe the federal  
3406 government has a vital and expanded role to play in reform by  
3407 expanding Medicaid to cover everyone in poverty and enrolling  
3408 all the people that are now eligible for Medicaid coverage,  
3409 by reforming Medicare to pay for quality and assuring  
3410 Medicare's long-term solvency and setting strict new rules  
3411 for insurers to assure access to everyone regardless of their  
3412 health. We are committed to working with all of you to enact  
3413 meaningful health care reform this year. Thank you very

3414 much.

3415 [The prepared statement of Ms. Fox follows:]

3416 \*\*\*\*\* INSERT 12 \*\*\*\*\*

|  
3417           Mr. {Pallone.} Thank you, Ms. Fox, and now we will have  
3418 questions starting with me. Obviously I can't reach everyone  
3419 so I am going to direct my question--I will try to get in  
3420 three questions about primary care, Medicaid and DSH if I  
3421 could, and I am going to start with Dr. Epperly on the  
3422 primary care promotion issue.

3423           We have obviously heard a lot of testimony about the  
3424 primary care shortages. We have heard that action on a  
3425 single front is not enough but that concerted action across  
3426 the health system is going to be required, and the discussion  
3427 draft reflects these calls for action and proposes major  
3428 investments, and I will list first increasing the rate paid  
3429 by Medicaid for primary care services, second, the primary  
3430 care workforce including increases for the National Health  
3431 Service Corps and scholarship and loan programs, third,  
3432 payment increase in Medicare and the public option for  
3433 primary care practitioners including an immediate 5 percent  
3434 in payments and high-growth allowances under a reformed  
3435 physician fee schedule, fourth, an additional payment  
3436 incentive for primary care physicians in health profession  
3437 shortage areas, and finally, an expansion of medical home  
3438 payments and added flexibility for that model of care. The  
3439 draft also proposes a reform to graduate medical education

3440 programs funded by Medicare and Medicaid. Two questions.  
3441 First, will these proposals help to reverse the decline in  
3442 interest in primary care among medical students, Dr. Epperly?

3443 Dr. {Epperly.} Absolutely.

3444 Mr. {Pallone.} Okay.

3445 Dr. {Epperly.} Did you want me to expand on that?

3446 Mr. {Pallone.} Well, let me give you the second one and  
3447 then you can talk. The second is, will the rate increases  
3448 proposed for primary care services in Medicaid and Medicare  
3449 help to address problems with access we have seen in those  
3450 programs over the past several years? So generally will you  
3451 reverse the decline among medical students, and secondly,  
3452 what will it do for access to Medicaid and Medicare?

3453 Dr. {Epperly.} Thank you, Mr. Pallone. I would say to  
3454 you that the return to a primary care-based system in this  
3455 country is essential. If you will, it is foundational to  
3456 building the health care system of our future. To get  
3457 primary care physicians back into a position where they can  
3458 integrate and coordinate care, lower costs and increase  
3459 quality, we must do that. Right now, primary care is in  
3460 crisis. A lot of that has to do with the dysfunctional  
3461 payment system. Primary care practices are barely making it  
3462 in regards to their margins, so what we have to do in terms  
3463 of the reform measures is, number one, make this viable

3464 financially for physicians to choose primary care.

3465           Mr. {Pallone.} But tell me whether you think these  
3466 proposals that are in our draft discussion will accomplish  
3467 that. Will we get more medical students to go into primary  
3468 care and what will it mean for access to Medicare and  
3469 Medicaid specifically with this proposal before us?

3470           Dr. {Epperly.} Right. So medical students now are  
3471 opting not to choose primary care because they can see that  
3472 incomes can be three to five times higher if they choose  
3473 subspecialties so the payment reform will help narrow that  
3474 gap in disparity so that they choose more to do primary care.  
3475 The derivative effect of that is that workforce will then be  
3476 enhanced, access then increases. What we must do in the  
3477 system is not only coverage people but we have got to have  
3478 the right types of physicians and the right communities to  
3479 see them. So it is kind of multifaceted, multilayered. We  
3480 have got to fix payment, which will increase workforce.  
3481 Workforce will enhance access. That is how it is all linked.  
3482 What it saves America is cost in the long run, increases  
3483 affordability and access as a derivative.

3484           Mr. {Pallone.} Do you believe that this discussion  
3485 draft will accomplish that?

3486           Dr. {Epperly.} Yes.

3487           Mr. {Pallone.} Okay. Now, let me just ask my Medicaid

3488 and DSH question of Dr. Gabow, if I can. Can you talk to us  
3489 on Medicaid, what will it mean to have Medicaid covering up  
3490 to 133 percent of the federal poverty level, having subsidies  
3491 that help people access health care up to 400 percent and to  
3492 have individuals response to encourage all else to make sure  
3493 that their dependents have health insurance. So basically,  
3494 you know, the increase to the poverty level eligibility for  
3495 Medicaid, the subsidy in the health marketplace and the  
3496 individual mandate. That is a lot.

3497 Dr. {Gabow.} Yes. Well, clearly, anything that expands  
3498 coverage, particularly for low-income, vulnerable people,  
3499 will reduce our \$360 million of uninsured care. But as it  
3500 relates to Medicaid disproportionate share payment, I think  
3501 the timing is important. We would like to make sure that we  
3502 see that the patients actually who are eligible get enrolled  
3503 and that they are covered and that our uninsured costs go  
3504 down before there is any change in disproportionate share  
3505 payments. So we applaud your version of the draft bill  
3506 regarding DSH. We know that many patients who we hope to get  
3507 enrolled are the most difficult to enroll, for example,  
3508 homeless for whom we did over \$100 million of care last year,  
3509 the chronically mentally ill, illiteracy. These patients  
3510 have been difficult to enroll in Medicaid. So I think  
3511 expanding Medicaid is terrific. I don't know that

3512 immediately it will reduce our need for other coverage.  
3513 Ultimately it should and I think we have seen in  
3514 Massachusetts that reduction of DSH at the front end has had  
3515 negative effect on the two principal safety-net institutions.  
3516 So I think the expansion of coverage that you are planning  
3517 will reduce the amount of uninsured care over time and we  
3518 need to deal with that sequentially as regards DSH.

3519 Mr. {Pallone.} Thank you.

3520 Mr. Deal.

3521 Mr. {Deal.} Thank you.

3522 I am going to ask for a yes or no answer from a couple  
3523 of you on this first question. We just heard the preceding  
3524 panel member who is chairman of MedPAC say that he felt that  
3525 Medicare reimbursements were adequate, and I would ask if you  
3526 concur with that. Dr. Williamson?

3527 Dr. {Williamson.} No.

3528 Mr. {Deal.} Dr. Ulrich?

3529 Dr. {Ulrich.} No.

3530 Mr. {Deal.} Dr. Wright?

3531 Dr. {Wright.} No.

3532 Mr. {Deal.} Dr. Epperly, I am going to ask you that  
3533 question in the context of the current reimbursements under  
3534 Medicare, not counting the bonuses that are proposed in this  
3535 legislation. Do you consider the current Medicare

3536 reimbursements to be adequate?

3537 Dr. {Epperly.} No, sir, I don't.

3538 Mr. {Deal.} Have you, Dr. Epperly, as a result of that  
3539 inadequacy seen many of the members of your organization not  
3540 take Medicare patients?

3541 Dr. {Epperly.} Yes, sir, I have.

3542 Mr. {Deal.} Dr. Williamson, first of all, let me  
3543 acknowledge that he is the president of my Georgia Medical  
3544 Association and I am pleased to have him here. I made those  
3545 statements yesterday in your absence as we began these things  
3546 yesterday. Dr. Williamson, let me ask you what you think the  
3547 impact would be for the public option plan to adopt the  
3548 Medicare reimbursement plan as its model. How would that  
3549 impact the delivery of health care under the public option  
3550 plan and also as it then migrates, in my opinion, to the  
3551 private insurance market?

3552 Dr. {Williamson.} I think it would have a very adverse  
3553 impact on access for patients and on the delivery of quality  
3554 medical care. Right now, access for Medicare patients I  
3555 think is really a house of cards. A lot of doctors are there  
3556 simply by inertia, and surveys that have been done in Georgia  
3557 amongst practicing physicians show that a large percentage of  
3558 doctors plan on dropping Medicare in the near future, and I  
3559 think that is just basically a train coming down the track,

3560 and I think any system that is modeled on that premise is  
3561 really going to fail in the short run, not the long run.

3562 Mr. {Deal.} The doctor-patient relationship has been  
3563 really the cornerstone of the importance of our health care  
3564 delivery system that makes it work. I would ask you, Dr.  
3565 Williamson, in light of this draft legislation, in particular  
3566 the comparative effectiveness portion of it, how do you see  
3567 that potentially impacting that doctor-patient relationship?

3568 Dr. {Williamson.} I think it is going to push us  
3569 farther and farther away from it, which is really I think the  
3570 opposite direction that we need to be going. I have a  
3571 serious concerns that bundling payments is going to drive a  
3572 wedge between patients and their physicians. I know that in  
3573 some clinics that we have looked at as examples, that type of  
3574 environment works but those are rare and I think they are  
3575 different than the general practice of medicine across the  
3576 country and they have a different patient population in some  
3577 cases. I have grave concerns about comparative effectiveness  
3578 as well. I think this would essentially give the federal  
3579 government the ability to practice medicine, and I know that  
3580 is a strong statement but let me say this. Scientific  
3581 research is not new. It has always been done and it has  
3582 always been the basis of medical learning and medical  
3583 treatment but the art of medicine is taking this science,

3584 these large studies and applying it to an individual patient.  
3585 When you try to treat the individual from the 30,000-foot  
3586 level, it is very difficult, and I am afraid that this would  
3587 drastically diminish our choice of options for our patients.  
3588 I can tell you that I am well aware as a neurologist of the  
3589 importance of the last 20 years in pharmaceutical research.  
3590 I have a lot of options for my patients now that weren't  
3591 available before. And some of these things are found quite  
3592 by accident, and we take them and we apply them and they may  
3593 be off-label drugs and that sort of thing and they may even  
3594 be therapies that have not been shown to work in large  
3595 randomized controlled trials that take many years and  
3596 millions of dollars to accomplish, and if we are limited by  
3597 that we are going to have a lot of therapies taken off the  
3598 table for our patients. And I will also tell you that I  
3599 think it is a bit of a conflict of interest to have the  
3600 government deciding what is valuable to patients because they  
3601 are serving as the largest payer. I think that the physician  
3602 and the patient ought to be able to decide in the context of  
3603 private contracting what is value and what is appropriate  
3604 care.

3605 Mr. {Deal.} Thank you.

3606 Mr. Roberts, you have alluded to the issue with AMP. As  
3607 you know earlier this year, I introduced an amendment that I

3608 think was more appropriately dealing with this federal upper  
3609 limit for reimbursement of going to 300 percent of the volume  
3610 weighted average and also included a minimum prescribing fee  
3611 for pharmacists, or dispensing fee, I should say, for  
3612 pharmacists. Which of those options do you prefer, what I  
3613 offered earlier this year versus what is in this bill?

3614         Mr. {Roberts.} Well, I think, Congressman Deal, that  
3615 your--the challenge that we have is that we really don't know  
3616 what this benchmark is so there are changes made in the  
3617 current version that redefine the benchmark in a way that  
3618 will make it much better than what it is but the reality of  
3619 what you are proposing and having a minimum dispensing fee I  
3620 think is absolutely critical. The challenge that we have is  
3621 that, you know, the benchmark is just meant to get us to  
3622 even, to break even on the cost of the product. But the  
3623 reality is, the States set the dispensing fees and the  
3624 dispensing fees are all over the place from one State to  
3625 another. And so unless the federal government takes some  
3626 action to say, you know, that our costs of dispensing and a  
3627 small profit are available to the pharmacy, it is going to be  
3628 very difficult to have pharmacies remain viable.

3629         Mr. {Deal.} Mr. Chairman, I take that as an endorsement  
3630 of my approach and I will yield back.

3631         Mr. {Pallone.} Thank you.

3632 Our vice chair, Ms. Capps.

3633 Mrs. {Capps.} Thank you, Mr. Chairman, and I want to  
3634 thank again all of the panelists for appearing today. It was  
3635 a very interesting presentation that each of you made, a lot  
3636 of linking, which I think is really important for us to have  
3637 a part of this discussion.

3638 Of course, Dr. White, I want to single you out and thank  
3639 you for being here today to represent the voice of America's  
3640 nurses who are so important every day in delivery of health  
3641 care but also in understanding what this crisis is all about.  
3642 I was very pleased to hear that the American Nurses  
3643 Association has endorsed a public plan option. I also  
3644 support this option and the one that we are developing in  
3645 this legislation and want to hear your perspective a bit more  
3646 as a nurse on why this is so essential because it is one of  
3647 the crucial parts of the choice that people are going to make  
3648 whether or not they support this reform legislation. I will  
3649 ask you to do it within this framework. I often speak about  
3650 the role that nurses have not only as providers of health  
3651 care and delivering service but we are also patient  
3652 advocates, and would you talk about maybe the reason you  
3653 endorse as ANA the public plan option and why you feel it is  
3654 best for patients and perhaps are encouraging patients to  
3655 advocate for this as well as the choice, to have this choice

3656 me made available?

3657           Ms. {White.} Thank you, Ms. Capps. I am happy to  
3658 answer that question because I do think it is extremely  
3659 important, the American Nurses Association endorsing a public  
3660 option plan because, as you said, our role in direct care.  
3661 We are there 24/7, 24 hour a day, 7 days a week, 365, you  
3662 know, depending on how long a patient is in there. We don't  
3663 like to think it is that long. But we see patients and  
3664 families and how they are dealing with the catastrophic  
3665 impact of illness whether it is an episode, a single, acute  
3666 that affects the patient and their family or whether it is a  
3667 long-term kind of chronic condition that, you know, includes,  
3668 you know, many admissions or many returns. And not being  
3669 able to have a choice of insurance I think is key and  
3670 unfortunately we have seen employer plans rising, the costs  
3671 of those to patients rising greater than wages over the last  
3672 several years, and so patients are looking for other ways of  
3673 paying for their health care insurance and sometimes those  
3674 plans may not be exactly what they think they are or they may  
3675 have surprises so certainly a public plan that includes some  
3676 type of defined or essential benefit package that the  
3677 patient, the family could be sure will be there when they  
3678 need it I think it is extremely important.

3679           Mrs. {Capps.} Let me follow this by another aspect of

3680 our reform legislation. One of the ways--Dr. Epperly  
3681 mentioned this but he wasn't the only one on the panel, which  
3682 was interesting, who is stressing now primary care as one of  
3683 the ways we can lower health costs and the ways he discussed  
3684 on how we can improve our primary care workforce and there  
3685 are many advanced practice nurses, nurse practitioners and  
3686 others who can and do serve as primary care providers and  
3687 this bill ensures that nurse practitioners can be the lead  
3688 providers in medical home models and increases  
3689 reimbursements, for example, for certified nurse midwives.  
3690 Can you discuss this a little bit? You mentioned one bill  
3691 that I coauthored on nurse-managed clinics but that is not  
3692 the only avenue, and you might mention a few others for the  
3693 record.

3694 Ms. {White.} Absolutely. Obviously the nurse-managed  
3695 clinics is an extremely important way for many vulnerable  
3696 populations, inner city, rural areas that get primary care  
3697 and other even other follow-up care in those areas, and as  
3698 far as nurse practitioners, as our advance practices nurses  
3699 functioning within the primary care medical home and being  
3700 able to lead those teams, we have seen in the demonstration  
3701 projects throughout the country that nurse practitioners have  
3702 been paneled. They do function to their scope of practice in  
3703 the different states and the different demonstration projects

3704 and have been able to lead their panel of patients and  
3705 provide that primary care. I think it is extremely important  
3706 when we are talking about the shortage of primary care that  
3707 all providers be able to be used to the fullest extent of  
3708 their scope that they can provide the care.

3709 Mrs. {Capps.} Thank you very much. I will yield back.

3710 Mr. {Pallone.} The gentleman from Indiana, Mr. Buyer.

3711 Mr. {Buyer.} The challenge we have with a panel this  
3712 large is to try to get our questions in, so if you can take  
3713 out a pen and pad, I am going to rip through some questions.  
3714 They won't apply to all of you. First I am going to go Mr.  
3715 Yarwood. When you stated the provisions in the draft bill  
3716 would cut Medicare reimbursement rates to skilled nursing  
3717 facilities by \$1.05 billion in fiscal year 2010 alone and  
3718 ultimately \$18 billion from skilled nursing care over 10  
3719 years, I would like to know whether you have calculated the  
3720 number of jobs that would be lost due to these cuts.

3721 The next question I have would go to Dr. Ulrich. The  
3722 draft bill provides that physicians who treat both Medicare  
3723 and the public plan, patients would receive Medicare plus 5  
3724 percent for treating their public plan, really the government  
3725 plan, patients for the first 3 years. What is the, quote,  
3726 magic number, end quote, regarding the percent of Medicare  
3727 that it would take to keep you whole? Is it Medicare plus 10,

3728 plus 12, plus 13, plus 14?

3729 The other question I have for Blue Cross Blue Shield,  
3730 what are the advantages that the government plan would have  
3731 over the private insurers? What about State premium taxes,  
3732 State solvency regulations, State benefit mandate  
3733 requirements?

3734 And the last question I have, I am going to go right  
3735 down the line with all of you. Medical liability reform that  
3736 restricts excess compensatory awards, limits on punitive  
3737 damages and attorney fees, should this be part of the public  
3738 plan option? Let us go right down the line. Dr. Epperly?

3739 Dr. {Epperly.} Yes, we believe that--

3740 Mr. {Buyer.} Dr. Williamson?

3741 Dr. {Williamson.} Absolutely.

3742 Mr. {Buyer.} Dr. Ulrich?

3743 Dr. {Ulrich.} Yes.

3744 Mr. {Buyer.} Dr. Wright?

3745 Dr. {Wright.} Yes.

3746 Mr. {Buyer.} Dr. White?

3747 Ms. {White.} Yes.

3748 Dr. {Gabow.} Yes.

3749 Mr. {Hawkins.} We have FTCA coverage so I can't really  
3750 comment.

3751 Mr. {Buyer.} All right. One equivocator.

3752 Mr. {Roberts.} Yes.

3753 Mr. {Hawkins.} Yes.

3754 Ms. {Fox.} Yes.

3755 Mr. {Buyer.} All but one except Mr. Hawkins testified  
3756 in the affirmative that it should be included. The other is,  
3757 would everyone on this panel agree that individual liberty is  
3758 a cornerstone of our society as an inalienable right? Would  
3759 everyone on this panel agree? Okay. Mr. Hawkins, are you  
3760 in?

3761 Mr. {Hawkins.} Yes, I am in.

3762 Mr. {Buyer.} He is in. All right. Awesome. Now, an  
3763 individual right, if in this scheme we are moving people into  
3764 the government plan, what about an individual's right to  
3765 contract with a physician of their choice? Should an  
3766 individual in America have the right to contract with an  
3767 individual doctor of their choice? Yes or no. Dr. Epperly?

3768 Dr. {Epperly.} Yes.

3769 Mr. {Buyer.} Oh, let me--without penalty from their  
3770 government. Dr. Epperly?

3771 Dr. {Epperly.} Yes.

3772 Mr. {Buyer.} Dr. Williamson?

3773 Dr. {Williamson.} Yes.

3774 Dr. {Ulrich.} Yes.

3775 Dr. {Wright.} Yes.

3776 Ms. {White.} Individual provider, yes.

3777 Mr. {Buyer.} Thatta girl.

3778 Dr. {Gabow.} Yes.

3779 Mr. {Hawkins.} With their own money, yes.

3780 Mr. {Buyer.} Thatta boy.

3781 Mr. {Roberts.} Yes.

3782 Mr. {Hawkins.} Yes.

3783 Mr. {Yarwood.} Yes.

3784 Ms. {Fox.} Yes.

3785 Mr. {Buyer.} We are on a roll. Now, does everyone

3786 agree that in the capital economic system that we have, even

3787 though we may have a public option plan, that the marketplace

3788 should be able to create some type of an instrument that

3789 would be a supplement, a potential medical insurance

3790 supplement plan? Should that be some type of an option that

3791 the marketplace could create? Dr. Epperly?

3792 Dr. {Epperly.} Yes.

3793 Dr. {Williamson.} Yes.

3794 Dr. {Ulrich.} Yes.

3795 Dr. {Wright.} Yes.

3796 Ms. {White.} I am not sure.

3797 Mr. {Buyer.} Okay. Dr. White is an unsure.

3798 Dr. {Gabow.} No.

3799 Mr. {Buyer.} A no.

3800 Mr. {Hawkins.} I am not sure I understand--  
3801 Mr. {Buyer.} I am not sure.  
3802 Mr. {Roberts.} I am not sure I do either.  
3803 Mr. {Buyer.} Two I am not--  
3804 Mr. {Yarwood.} I am number three not sure.  
3805 Ms. {Fox.} Well, we are hoping that there is no public  
3806 plan.  
3807 Mr. {Buyer.} Pardon?  
3808 Ms. {Fox.} We are hopeful there will be no public plan  
3809 in the program.  
3810 Mr. {Buyer.} All right. But if there is a public plan,  
3811 should individuals in the marketplace be able to create  
3812 supplemental coverage?  
3813 Ms. {Fox.} Yes.  
3814 Mr. {Buyer.} Yes?  
3815 Ms. {Fox.} Yes, like Medicare.  
3816 Mr. {Buyer.} All right. Thank you. Now I will rest  
3817 and allow those individuals to answer the questions that I  
3818 had asked.  
3819 Dr. {Ulrich.} The answer is Medicare plus 100, and I  
3820 can expound as to why if you would prefer. I think in my  
3821 testimony I cited the fact that we currently in Wisconsin  
3822 from the private sector get anywhere from 180 to 280 percent  
3823 of Medicare in payment. Medicine is changing, and this is

3824 what is really interesting, is that we have gone from kind of  
3825 being a cottage industry to now much more high tech. Our  
3826 costs are very different than what Medicare allocates to us  
3827 now. We now employ, for example, systems engineers. Why?  
3828 Trying to understand efficiency of work flow. We also in our  
3829 clinic and others as well employ many people in information  
3830 technology. We developed our own electronic medical record.  
3831 We have close to 350 employees now, software engineers, et  
3832 cetera. Our cost structure has shifted dramatically from  
3833 what the traditional concept of what medical practice is, you  
3834 know, a nurse practitioner, physician, a nurse, a technician,  
3835 et cetera, and so the costs keep changing. The other thing I  
3836 would ask this committee to keep in mind is that medicine as  
3837 an entity is an ever-evolving one in the sense that we have  
3838 come from--

3839 Mrs. {Christensen.} [Presiding] Dr. Ulrich, could you--  
3840 -

3841 Dr. {Ulrich.} Yes?

3842 Mrs. {Christensen.} We are way over time. Could you  
3843 wrap up your response, please?

3844 Dr. {Ulrich.} I will just stop there, if my initial  
3845 answer satisfied you.

3846 Mr. {Buyer.} Mr. Yarwood, do you have an answer?

3847 Mr. {Yarwood.} Thirty thousand jobs.

3848 Mr. {Buyer.} Thirty thousand jobs would be lost?

3849 Mr. {Yarwood.} Over 10 years, yes.

3850 Mrs. {Christensen.} Thank you. The gentleman's time  
3851 has expired. The chair now recognizes Ms. Castor for 5  
3852 minutes.

3853 Ms. {Castor.} Thank you, Madam Chair, very much, and I  
3854 would like to return to the workforce issues.

3855 This bill rightfully targets workforce incentives  
3856 because we must bolster the primary care workforce  
3857 especially. Fifty years ago, half of the doctors in America  
3858 practiced family medicine and pediatrics. Today, 63 percent  
3859 or specialists and only 37 percent are family doctors, and it  
3860 is those family doctors and the nurses on the front lines and  
3861 the pediatricians that really help us contain costs over  
3862 time. I do not know what I would do if I did not have the  
3863 ability to call the nurse in my daughter's pediatrician's  
3864 office and ask a question and they have had a consistent  
3865 medical home over time and yet millions of American families  
3866 do not have that type of medical home and relationship with  
3867 their primary care providers.

3868 So I think our bill does take important steps to bolster  
3869 primary care workforce but one place that I think it falls  
3870 short, and I would be very interested in your opinions, is  
3871 that we are not increasing the residency slots for our

3872 medical school graduates, these doctors in training. The  
3873 discussion draft provides a redistribution of unused  
3874 residency slots to emphasize primary care, which is a good  
3875 first step because we are going to hopefully send them to  
3876 community health centers and other hospitals in need and  
3877 other communities in need. But we have got to enact the  
3878 second step, the complementary step, to even out the  
3879 residency slots because, for example, in my home State of  
3880 Florida, the fourth largest State in the country, we rank  
3881 44th in the number of residency slots and most folks do not  
3882 understand that those slots are governed by an old, outdated,  
3883 arbitrary formula that assigned distribution many years ago  
3884 and has not changed, even though the population of the  
3885 country has shifted. So I would like to know, do you agree--  
3886 Dr. Epperly, you might be the one most in tune but I think  
3887 many of you would have an opinion on that. Do you agree we  
3888 need to alter the residency in toto? And then are there  
3889 sections in the bill--the sections in the bill related to  
3890 scholarships and loan repayments, are they adequate? Are we  
3891 doing enough?

3892 Dr. {Epperly.} Yes, ma'am. Can I expand for just a  
3893 second?

3894 Ms. {Castor.} Yes.

3895 Dr. {Epperly.} In my day job, I am a residency program

3896 director of a family medicine program in Boise, Idaho, and  
3897 you are right on. In fact, the workforce numbers are about  
3898 70/30 subspecialists to generalists. We must increase  
3899 residency training, especially for primary care, and what are  
3900 we trying to build, what system are we after. We think there  
3901 should be some regulation of what kind of physicians medical  
3902 schools are producing. It needs to meet community needs and  
3903 so we are in agreement with some sort of workforce policy  
3904 center to kind of take a look at this and what it is we are  
3905 trying to accomplish. I totally agree with you in terms of  
3906 scholarships and loan repayment. Scholarships on the front  
3907 end will be more effective than loan repayment on the back  
3908 end because it helps shape the types of physicians you are  
3909 trying to train.

3910 Ms. {Castor.} Does anyone else want to comment quickly?  
3911 Okay. Then I will move on.

3912 Ms. Fox, thank you so much. It is great to hear that  
3913 Blue Cross is supportive of health care reform. What I  
3914 wanted to share with you, I had a great meeting last week  
3915 with the Florida CEO, president and CEO of Blue Cross, and  
3916 you all are a very important provider in the State of  
3917 Florida. You have about 32 percent of the market share in  
3918 the State of Florida. Four million Floridians are enrolled  
3919 in Blue Cross and depend on you all every day. It was

3920 interesting that the CEO from Florida had a slightly  
3921 different take and spoke much more favorably of the public  
3922 option because while Blue Cross in Florida has 30 percent of  
3923 the market share and over 4 million folks enrolled, you know,  
3924 in Florida we have 5.8 million people who do not have access  
3925 to health insurance because it is so expensive, and I think  
3926 that in the discussion we had, he saw it as an opportunity,  
3927 that you all are so effective that you wouldn't have any  
3928 trouble competing against a startup public option, and I  
3929 thought we had a great discussion and exchange and I was  
3930 heartened to hear that maybe it is not--maybe while big Blue  
3931 Cross has a certain position, the folks on the ground in my  
3932 State are not daunted by the challenge ahead.

3933 Ms. {Fox.} Well, I would respond that I think people  
3934 are looking at, can you create a level playing field and I  
3935 think it is very difficult to imagine how you can. I mean, I  
3936 look at the House draft bill, I just see huge advantages for  
3937 the government plan ranging from, you know, big advantages in  
3938 the payment levels to lawsuits to covering different--the  
3939 government plan would cover a lot fewer benefits than private  
3940 plans would be required to do. There is just a long list.  
3941 For example, if the government plan didn't estimate their  
3942 premiums correctly, would the government step and--

3943 Ms. {Castor.} But where do these 5, almost 6 million

3944 residents of my State go now? How do they--we can't afford--  
3945 America can't pay for all of them to go into subsidized  
3946 Medicaid. We have got to provide a level playing field and  
3947 real opportunity for them to access affordable care.

3948 Ms. {Fox.} We agree we need to cover everyone and we  
3949 are recommending covering everyone in poverty under Medicaid  
3950 and then above that having subsidies as you do in your bill  
3951 for private insurance to help people afford coverage. We  
3952 think that is absolutely critical. You know, I have been  
3953 doing health care issues for over 25 years, and it used to be  
3954 that everybody believed that if you have individual mandate,  
3955 employer mandate, alliances, insurance reforms, that really  
3956 would cover everyone. It has only been the past year--

3957 Mrs. {Christensen.} Ms. Fox.

3958 Ms. {Fox.} --we talked about a public plan. We think  
3959 it is totally unnecessary and very problematic.

3960 Mrs. {Christensen.} Thank you. The gentlelady's time  
3961 has expired. I now recognize Mr. Burgess for 5 minutes.

3962 Mr. {Burgess.} Thank you, Madam Chairman.

3963 Ms. Fox, let us continue on that and maybe if I could, I  
3964 think Mr. Buyer was asking a question or you were answering a  
3965 question when time ran out and maybe we could just get the  
3966 answer to the question that Mr. Buyer posed about the  
3967 advantages of a public plan would have over private insurance

3968 in premium taxes, State solvency regulations, State benefit  
3969 mandates.

3970 Ms. {Fox.} Yes. I mean, private plans have to pay a  
3971 wide range of premium taxes, assessments, federal taxes. The  
3972 government would be exempt from that. We have actually  
3973 prepared a little chart that we would love to submit that  
3974 actually walks through what are the rules private plans have  
3975 to abide by.

3976 Mr. {Burgess.} If you will suspend for a moment, I  
3977 would ask unanimous consent that that chart be made available  
3978 to the members and made part of the record.

3979 Ms. {Fox.} And raises questions, would the public plan  
3980 abide by that, and when we look at the draft bill, we see  
3981 there is a huge unlevel playing field where the government  
3982 would have so many advantages that you could see why people  
3983 will estimate that millions of people will leave private  
3984 coverage that they like today and go into the public plan.

3985 Mr. {Burgess.} Okay. Great. I appreciate that answer  
3986 very much.

3987 Dr. Ulrich, let me just address you for a second. I  
3988 really appreciate--well, I appreciate all of you being here.  
3989 I know that many of you are taking time off of your private  
3990 individual practices and it is with great expense and  
3991 inconvenience to your families, and we have had a long day

3992 and appreciate your willingness to be part of the panel here.  
3993 The physician group practice demonstration project that you  
3994 referenced at your clinic, I am somewhat familiar with that.  
3995 I think that does hold a lot of promise. In fact, you may  
3996 have heard me question Mr. Hackbarth from MedPAC about the  
3997 feasibility of using the Federal Tort Claims Act for Medicare  
3998 providers under a physician group practice model, the  
3999 accountable care model if you comport with all of the  
4000 requirements, disease management, care coordination, the IT,  
4001 the e-prescribing, if you do all of those things, getting  
4002 some relief from liability under the Federal Tort Claims Act.  
4003 Do you think that is--is that a reasonable thing to look at?

4004 Dr. {Ulrich.} Absolutely.

4005 Mr. {Burgess.} Thank you. I appreciate your brevity.  
4006 Let me ask you this, since we are in agreement. One of the  
4007 things about the physician group practice demonstration  
4008 project was you were going to actually benefit financially by  
4009 doing things better, faster, cheaper, smarter, and in fact  
4010 there are some great lessons for us that have come out of  
4011 that, those management techniques. But there is a barrier to  
4012 entry. Do you think the bar to that has been set too high?  
4013 You have got to make a lot of initial investment when you get  
4014 into that and then your return for your doctors, for the  
4015 people in your practice is a little slow in coming. Is that

4016 not correct?

4017 Dr. {Ulrich.} Dr. Burgess, you show keen insight here  
4018 into this, and if I can just take a second to explain this?

4019 Mr. {Burgess.} Sure.

4020 Dr. {Ulrich.} As part of the group demonstration  
4021 project, what we are finding is that it is not just trying to  
4022 strive for quality outcomes. There are operational changes  
4023 that you need to make in how you deliver care. For example,  
4024 we have consolidated all of our anticoagulation patients into  
4025 one entity. Rather than being in each physician's practice,  
4026 we now share that coordinated care under one entity, and what  
4027 we found is that our capacity to have bleeding times, for  
4028 example, are much better within the therapeutic range. We  
4029 also are consolidating care of congestive heart failure  
4030 rather than being in a particular individual physician's  
4031 office, whether it be a cardiologist or a primary care  
4032 physician into a congestive heart failure clinic. Physicians  
4033 craft the criteria we want. Our nurses watch those. We are  
4034 proactive in working with the patients. The problem with  
4035 doing all that is no one pays us, you know, to undertake  
4036 those operational changes at first. What we are hoping and  
4037 why we partnered with the federal government through the CMS  
4038 PGP project is that we are trying to prove that yes, by  
4039 undertaking these, ultimately there are cost savings.

4040 Lastly, I would just make the point that we are just  
4041 beginning the process of understanding the cost of care in  
4042 chronic illness over time. We understand what the costs are  
4043 to provide care on an individual visit but not over time.

4044 Mr. {Burgess.} One of the things that concerns me about  
4045 our approach to things and what little I know of the great  
4046 successes you have shown, for example, like bringing a  
4047 hospitalized CHF patient back to the doctor's office within 5  
4048 days, not just you make an appointment in 2 weeks, you get  
4049 that patient back to the office in 5 days and you really  
4050 reduce the re-hospitalization rate significantly and yet you  
4051 have got CMS now writing a rule that says well, if that is  
4052 the case and you can do that, we are just going to pay for  
4053 one hospitalization every 30 days and that will cut our costs  
4054 down. It is absolutely backward way of looking at what the  
4055 data that you all are generating, and instead of building on  
4056 your successes in fact we are going to make things punitive  
4057 then for Dr. Williamson in Georgia who may have an entirely  
4058 different type of practice. Again, that is one of the things  
4059 that concerns me about this. Do you have a concept? You  
4060 mentioned about the rate of reimbursement on the Medicare  
4061 side. What would that multiplier have to be in your  
4062 accountable care organization or physician group practice?  
4063 What would that Medicare multiplier have to be in a public

4064 plan?

4065 Dr. {Ulrich.} We would say Medicare plus 100.

4066 Mr. {Burgess.} Medicare plus 100 percent?

4067 Dr. {Ulrich.} Yes.

4068 Mr. {Burgess.} So double what the Medicare rates are?

4069 Dr. {Ulrich.} Exactly.

4070 Mr. {Burgess.} That is fairly significant.

4071 Dr. {Ulrich.} That is significant, but it is also a

4072 realistic significantly--

4073 Mr. {Burgess.} And do you have data to back that up

4074 that you can share with the committee?

4075 Dr. {Ulrich.} I would be happy to provide information

4076 to you in written form relative to that, yes.

4077 Mr. {Burgess.} That would be tremendous.

4078 Dr. Williamson, in words of one syllable, we heard Glenn

4079 Hackbarth say that no doctors are not seeing Medicare

4080 patients now because of the reimbursement rate. Is that your

4081 sense? Do you think doctors are restricting their practice

4082 because of the reimbursement rates in Medicare?

4083 Dr. {Williamson.} Yes.

4084 Mr. {Burgess.} Thank you.

4085 Mrs. {Christensen.} Thank you. The gentleman's time

4086 has expired. I now recognize myself for 5 minutes.

4087 Let me just welcome everyone. It is great to have such

4088 a diverse panel of witnesses here and we thank you for all of  
4089 the good work that all of you have been doing in this  
4090 dysfunctional system that really doesn't always give you the  
4091 kind of support that you need, and I want to particularly  
4092 welcome Dr. Epperly, president of the American Academy of  
4093 Family Physicians. I want to direct my first question to  
4094 you, Dr. Epperly. In meetings, for example, with the tri-  
4095 caucus, we are on record as supporting a public plan, and I  
4096 do support a public plan but also a public plan that is  
4097 linked to Medicare. I have raised concerns about that in our  
4098 meetings and I would like you to elaborate on your concerns  
4099 about linking the public plan to Medicare.

4100 Dr. {Epperly.} Yes, ma'am. Thank you. First, we are  
4101 definitely in support of a public plan option but we do have  
4102 a couple caveats. One of them is linked to Medicare, just as  
4103 you are saying. We recognize there is going to be a huge  
4104 infrastructure cost in getting this thing up and running so  
4105 our position is that it can be the Medicare rate for the  
4106 first 2 years but with a date certain then to elevate that.  
4107 More of just Medicare rates won't cut it for the physicians  
4108 across America. It is already a problem. But we recognize  
4109 that there is going to be a transition period. We recognize  
4110 that flexibility. So what we would say is yes, we are in  
4111 favor of a public plan. Medicare rates could be what it

4112 would be aimed at for the first 2 years but by a date certain  
4113 that has to elevate.

4114 Mrs. {Christensen.} Thank you. And I guess I can't ask  
4115 everyone this question, so Dr. Epperly, Dr. Gabow and Mr.  
4116 Hawkins, you have heard reference to bundling of payments by  
4117 Mr. Hackbarth of MedPAC and I wanted to know if you are in  
4118 support of the proposal to bundle payments to providers. Dr.  
4119 Epperly?

4120 Dr. {Epperly.} Yes, ma'am. We are in favor of bundling  
4121 in terms of a team approach. We do have concerns that we  
4122 would want to make sure that primary care and the patient-  
4123 centered medical home is a very important part of that  
4124 bundling was not denigrated nor belittled into its  
4125 importance. For instance, with the heart failure example, we  
4126 are talking about heart failure patients and readmissions.  
4127 Let us prevent it in the first place. So with a bundling  
4128 model, which looks at already this has occurred, it is in the  
4129 hospital, how do we pay for this, why don't we take a better  
4130 approach and look at what it takes to prevent that in the  
4131 first place. So therefore the patient-centered medical home,  
4132 primary care is critical in that. Bundling could be a very  
4133 interesting option if the primary care is reincorporated into  
4134 that in a big way.

4135 Mrs. {Christensen.} Dr. Gabow?

4136 Dr. {Gabow.} As an integrated system that deploys  
4137 physicians, we favor moving away from fee for service to a  
4138 more global payment, and we would favor the ultimate bundle,  
4139 capitation, and think that capitation or more global bundling  
4140 would have less administrative costs than if you bundle small  
4141 things. I would encourage it to be global but we favor it  
4142 given a big, integrated system.

4143 Mr. {Hawkins.} Congresswoman, or--

4144 Mrs. {Christensen.} Would it affect--

4145 Mr. {Hawkins.} Madam Chair--

4146 Mrs. {Christensen.} Would it affect community health  
4147 centers?

4148 Mr. {Hawkins.} Really, there are some important points  
4149 to make here. On today's panel, we are very fortunate to be  
4150 joined by Dr. Epperly, who runs a family medicine residency  
4151 program, Dr. Ulrich, who runs the Marshfield Clinic, and Dr.  
4152 Gabow, who runs Denver Health, unique and especially with the  
4153 last two, fully integrated health care systems. What may not  
4154 be known generally but should be is that all three are  
4155 community health centers or have community health centers  
4156 embedded in them. As such, two examples, Denver Health and  
4157 Marshfield Clinic, are good examples of integrated health  
4158 systems that include community health centers, but I am sure,  
4159 as Dr. Gabow and Dr. Ulrich would agree, the primary care

4160 component, the very issue that Dr. Epperly expressed concern,  
4161 appropriate concern over, is identified and, I am not going  
4162 to say separate but it is able to function on a sort of co-  
4163 equal basis with the specialty and inpatient care components  
4164 of their institutions. To the extent that that is done, I  
4165 think that is what Dr. Epperly was relating to when he said  
4166 primary care needs to be recognized and appropriately  
4167 integrated. We would agree. The notion of integrated care  
4168 systems, accountable care organizations and the like and  
4169 rewarding results is something that we all absolutely  
4170 support. What should not be lost, however, in the  
4171 integration of care, the vertical integration of care across  
4172 primary, secondary, tertiary care is the small ambulatory  
4173 care practice, be it independent practice, private practice  
4174 physicians, health centers or other forms of ambulatory care  
4175 within the context of a large, multilevel institution like  
4176 Denver Health, and I am sure Dr. Gabow would agree with that.

4177       Mrs. {Christensen.} Thank you. To be a good example,  
4178 my time is up but I want to also without objection accept the  
4179 chart from Blue Cross Blue Shield into the record that was  
4180 brought to us by Dr. Burgess.

4181       [The information follows:]

4182 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

|  
4183 Mrs. {Christensen.} The Chair now recognizes Dr.  
4184 Gingrey for 5 minutes.

4185 Mr. {Gingrey.} Madam Chair, thank you so much. I want  
4186 to direct my first questioning to my colleague from Georgia,  
4187 Gainesville, Georgia, and the president of the Medical  
4188 Association of Georgia. Glad to see you, Dr. Williamson.  
4189 And I have a series of questions that I would like to ask  
4190 you. First off, do you support a government-run plan?

4191 Dr. {Williamson.} No, the Medical Association of  
4192 Georgia does not support a public option or a government-run  
4193 plan in addition to the public plans that already exist,  
4194 Medicare and Medicaid.

4195 Mr. {Gingrey.} Right. We are talking about the  
4196 government option plan that would be competing with the  
4197 private insurance plans that--

4198 Dr. {Williamson.} Right. We do not support a public  
4199 option.

4200 Mr. {Gingrey.} What would a government-run health plan  
4201 that I just described do to your ability and those of your  
4202 colleagues to treat your patients? What do you fear the most  
4203 about that type of a government-run option?

4204 Dr. {Williamson.} My biggest concern is that it like  
4205 Medicare will become the only option, and I think over time I

4206 think the plan as it is set up in the discussion draft  
4207 already has the framework for that, for basically all private  
4208 plans to have to conform to certain rules over time, and my  
4209 fear, and I think it is a very real concern, is that over  
4210 time other plans will disappear and the public option will  
4211 become the only option and we will be left with a single-  
4212 payer system which I think if you look at what has happened  
4213 across the planet, single-payer systems basically save money  
4214 by rationing care and I see that as an inevitable consequence  
4215 of the creation of a public option, no matter how benign it  
4216 looks at first glance.

4217         Mr. {Gingrey.} Well, that was going to be my next  
4218 question. You pretty much answered my question, which would  
4219 be, Dr. Williamson, do you support a government-run health  
4220 care system with the ability to ration care based on cost?

4221         Dr. {Williamson.} I absolutely do not support that. I  
4222 think that care decisions should be made on an individual  
4223 basis when the patient sits down in the physician's office  
4224 and I don't think that the government can substitute for the  
4225 training that a physician has and the opportunity that a  
4226 physician has to look the patient in the eye and decide what  
4227 that patient needs.

4228         Mr. {Gingrey.} Let us see, I am going to skip over  
4229 number four. My fifth question, fourth actually, we have

4230 heard testimony in this committee recently regarding the  
4231 Massachusetts health care system and the fact that those with  
4232 public health insurance in the State are twice as likely as  
4233 those who choose private health insurance to be turned away  
4234 from a desired physician. As a physician, practicing  
4235 physician, what are your thoughts on the reasons behind that  
4236 kind of disparity in access between a public and a private  
4237 insurance plan?

4238 Dr. {Williamson.} Well, public plans in general, and I  
4239 am speaking in general now, are associated with quite a lot  
4240 of paperwork. They are associated with the hand of  
4241 government and, you know, right now in Georgia we are looking  
4242 at these recovery auditor contractors that are moving across  
4243 the Nation and coming back and recouping money, saying that  
4244 you coded something wrong 20 years ago or 10 years ago and  
4245 coming after those dollars. These sorts of things that the  
4246 federal government has the power to do makes dealing with  
4247 them as a payer a very daunting prospect, and traditionally,  
4248 government payers have been at the bottom of the barrel in  
4249 terms of covering costs and so physicians feel like they  
4250 can't deliver to patients what they have been trained to do  
4251 and the downsides associated with the government as a payer  
4252 are daunting, and, you know, I recently had the opportunity  
4253 to go to the AMA and one of my colleagues from Massachusetts

4254 stood and spoke loudly in support of a national public  
4255 option, but I believe that the folks from Massachusetts  
4256 probably want a public option nationally so they don't have  
4257 to pay for their own anymore.

4258         Mr. {Gingrey.} Well, Doctor, I appreciated that  
4259 response and the reason I asked you the question is because  
4260 what we are talking about here is something very, very  
4261 similar to the Massachusetts model, and we have even heard  
4262 suggestions from the majority that it may be that physicians  
4263 who are treating people within this exchange would absolutely  
4264 have to accept the public option plan or they would be ruled  
4265 ineligible to participate in Medicare or Medicaid. So they  
4266 would have their arm twisted behind their back and have no  
4267 choice, which is pretty frightening.

4268         I have got just a little bit of time left and I wanted  
4269 to go to Dr. Ulrich and also Dr. Gabow if we have a chance.  
4270 If time permits, Madam Chair, I hope you will let me get this  
4271 in. If health reform were to include a requirement that all  
4272 Americans purchase health insurance, do you think that  
4273 hospitals would need continued federal funding to offset  
4274 cases of uncompensated or charity care and why? And  
4275 basically I am talking about DSH hospitals and the suggestion  
4276 that we are going to save money by eliminating all DSH  
4277 payments when we pass this bill.

4278 Dr. {Ulrich.} Well, my sense is, the answer to that is  
4279 yes, you would still need to have some supplemental dollars  
4280 rolling in, simply because the reality is that there still  
4281 are things as bad debt, you know, people who need care get it  
4282 and then can't pay for it because of competing priorities of  
4283 their own pocketbook and plus the fact that, you know, we  
4284 really haven't gotten to the point of having fair practice  
4285 expense accountability within the remunerative system yet and  
4286 that is absolutely critical to any kind of a public plan. If  
4287 we are going to go that way, then we have to have fair  
4288 practice expenses covered before we can go forward.

4289 Mr. {Gingrey.} That would be a pretty painful pay-for  
4290 for your--

4291 Dr. {Ulrich.} That is correct.

4292 Mr. {Gingrey.} Dr. Gabow?

4293 Mr. {Gabow.} My understanding, Congressman, is that  
4294 this bill does not cut disproportionate share payments and I  
4295 think that that will be necessary to be sustained at least in  
4296 the foreseeable future because we know that many of the  
4297 patients that we serve, the homeless, the chronically  
4298 mentally ill, are traditionally difficult to enroll and so I  
4299 think if we got to full coverage, certainly we may be able to  
4300 decrease it but I doubt that it will ever go away. So we  
4301 support the preservation of DSH as outlined in the draft

4302 bill.

4303 Mr. {Gingrey.} You support the elimination of DSH  
4304 payment? Is that what you said?

4305 Dr. {Gabow.} We support the maintenance of DSH  
4306 payments--

4307 Mr. {Gingrey.} Oh, absolutely, as I expected you would,  
4308 Dr. Gabow, and as Dr. Ulrich and hospitals all across the  
4309 11th Congressional district of Georgia support the  
4310 continuation of those DSH payments. Thank you for your  
4311 patience, Madam Chair. I yield back.

4312 Mrs. {Christensen.} Thank you. The Chair now  
4313 recognizes Congresswoman Baldwin for 5 minutes.

4314 Ms. {Baldwin.} Thank you, Madam Chairwoman.

4315 I want to welcome a fellow Wisconsinite, Dr. Ulrich. I  
4316 am pleased to have you on the panel. I wanted to probe into  
4317 an area--I stepped out for a little while so I don't know if  
4318 anyone else has raised this, but in your testimony on page 7,  
4319 you talk a little bit about care issues at the end of life  
4320 and make some recommendations, and it is one of those very  
4321 challenging topics because we certainly hear from much  
4322 research that much of our health care dollar goes to treat  
4323 people at that stage of their lives. But that is one thing  
4324 much more disturbingly that that often doesn't align with the  
4325 wishes of the person being treated. Could you elaborate a

4326 little bit more about both your recommendations to this  
4327 committee in that arena but also the practices at the  
4328 Marshfield Clinic, what you have implemented in this regard?

4329 Dr. {Ulrich.} Yes. Thank you, Congresswoman. I  
4330 appreciate the question. At Marshfield Clinic, we do have in  
4331 conjunction with St. Joseph's Hospital, who is our hospital  
4332 partner, developed palliative care. We have palliative care  
4333 fellowships where we train young physicians who are  
4334 interested in that. We work with families, the patient,  
4335 obviously, et cetera, really try to do two things. One,  
4336 there is a humanistic process that occurs under palliative  
4337 care and that is taking care of people in comfortable  
4338 surroundings in their last few weeks or days of life, and  
4339 that really is a throwback, if you will, to the way medicine  
4340 used to be practiced before we were very fancy with  
4341 technology, et cetera, and it is not something that we should  
4342 ever forget. It is something that we need to continue. So  
4343 we are committed to doing that and will, and I think most  
4344 medical organizations throughout the country would be in sync  
4345 with that kind of concept.

4346 The question you raise about the cost of care at the end  
4347 of life is obviously an important one, and if you think about  
4348 the cost of medical care in our country, there are really two  
4349 main things we need to understand. One, as you point out,

4350 the costs escalate rather dramatically as life is ebbing away  
4351 from us because it is an emotional decision for families and  
4352 patients to keep mom or dad or grandma or grandpa alive for a  
4353 little while longer, et cetera. It is very difficult for  
4354 families to say it is time to say goodbye to someone. So we  
4355 continue then to provide medical care under those very  
4356 difficult circumstances. There is a cost to providing that  
4357 care. The other thing that I would like the subcommittee to  
4358 understand is that not all costs within the system are the  
4359 same so that we know from the Commonwealth Fund, for example,  
4360 that really it is only about 20 percent of patients that are  
4361 costing about 75 to 80 percent of care in this country so  
4362 that if we can manage these chronic illnesses and in  
4363 particular patients who have more than one or two chronic  
4364 illnesses concomitantly, that is where the cost savings will  
4365 come as we get better in managing folks with complicated  
4366 chronic illnesses who concurrently are suffering from several  
4367 of them at the same time.

4368 Ms. {Baldwin.} Your testimony specifically points to  
4369 things that we could do earlier in life to talk about having  
4370 people think about advanced directives or other documents. I  
4371 would offer you to elaborate on that, but also I see some  
4372 other nodding heads and I would open this up to any of the  
4373 panelists who would like to make a contribution on this

4374 point.

4375           Dr. {Epperly.} Thank you. What Dr. Ulrich just  
4376 described is the value of primary care. It is having that  
4377 relationship of trust with people over time in which you can  
4378 have that type of dialog, and I would say that those sorts of  
4379 decisions are so important, so critical to the family as a  
4380 whole and many of those decisions can take place outside of a  
4381 hospital in terms of where those final days and weeks are.  
4382 In fact, I would submit that most people would like to have a  
4383 very dignified death in the place where they can be  
4384 surrounded by most of their loved ones. And so again, we  
4385 return right squarely back to what primary care brings to the  
4386 system. It is what Dr. Ulrich said. It used to be part of  
4387 medicine. That is kind of gone now. We need to re-create  
4388 that kind of system. It is in that system that savings are  
4389 made, quality goes up, cost goes down.

4390           Ms. {Baldwin.} Please, Dr. Wright.

4391           Dr. {Wright.} Yes. I just would like to agree that  
4392 what needs to take place and is often missing is the  
4393 conversation, which begins with the relationship. So I  
4394 completely agree and would support recognition of the value  
4395 of the cognitive services, not to say that folks who do  
4396 procedures for a living are not thinking them, they certainly  
4397 are, but the importance--I have seen it over and over in my

4398 practice that while someone does indeed benefit from a  
4399 procedure, what is wrapped around that procedure, the  
4400 informed consent process, the education about the disease  
4401 process and right now the aftercare to try to prevent that  
4402 from ever happening again is incredibly valuable to that  
4403 individual and that family and our economy at this point.

4404 Ms. {Baldwin.} Dr. White, did you have a comment?

4405 Ms. {White.} Yes, I would just like to add that I think  
4406 as Congresswoman Capps had mentioned earlier that patient  
4407 advocate role that nurses provide is absolutely important and  
4408 I think the emphasis on primary care medical home, nurse  
4409 practitioners being involved in that who have the skills for  
4410 those conversations, discussions and the relationships I  
4411 think would be an important consideration for it all.

4412 Dr. {Williamson.} Thank you. I would like to briefly  
4413 add, I think that resources spent on time with the doctor  
4414 saves money in the long run. If you look at the percentage  
4415 of medical expenditures, physicians' services constitute a  
4416 small fraction of that. By concentrating on that whether it  
4417 be for primary care or for a specialist, you are going to  
4418 have money in other areas whether it is the end of life, very  
4419 sick patients. So funds, resources that are concentrated on  
4420 giving the patient or the patient's family face time with  
4421 their doctor is going to save you lots of money across the

4422 system.

4423           Mrs. {Christensen.} Thank you. The gentlelady's time  
4424 has expired, and I now recognize Congresswoman Blackburn for  
4425 5 minutes.

4426           Mrs. {Blackburn.} Thank you, Madam Chairman, and thank  
4427 you to all of you.

4428           I want to do a yes and no and show of hands to get where  
4429 you all are on some issues, and by the way, thank you for  
4430 your patience with us today. As you know, we have another  
4431 hearing that has been going on upstairs. Okay. Show of  
4432 hands, how many of you favor a single-payer system? Okay.  
4433 Nobody on the panel favors a single-payer system. Okay. How  
4434 many of you favor a strategy, putting in place a strategy  
4435 that would eventually move us to a single-payer system? So  
4436 nobody favors doing that. That is really interesting because  
4437 there are some of us that fully believe that this bill that  
4438 is before us, whether it is the House version, the Senate  
4439 version or the Kennedy plan would move us to a single-payer  
4440 system and we make that determination based on experience  
4441 that we have had from pilot projects and from programs that  
4442 have taken place in the States, my State of Tennessee being  
4443 one of those. Okay. How many of you favor having  
4444 government-controlled comparative research? Nobody favors  
4445 government-controlled comparative research. Okay. How many

4446 of you--okay. We have got some takers on that one. All  
4447 right. Just show of hands, the comparative research board  
4448 that they are talking about having, that this bill would put  
4449 in place, how many of you want to see that? Okay. So we  
4450 have Epperly, Ulrich, Wright, White and Gabow. Okay. And  
4451 then how many of you favor having that comparative research  
4452 board make medical decisions for patients? Nobody. Okay.  
4453 All right.

4454 Dr. Epperly, you know, it makes it kind of a head  
4455 scratcher to me and I appreciate having your views on this  
4456 because we know that the comparative research results board  
4457 would end up making a lot of the medical decisions for  
4458 patients and it would move that away from the doctor-patient  
4459 relationship. I wanted to ask you, you had mentioned in your  
4460 testimony that you felt that a public plan would be  
4461 actuarially sound. What I would like for you to do is cite  
4462 for me the research upon which you base that assessment and  
4463 that decision. How did you arrive at that?

4464 Dr. {Epperly.} You know, I would say that I don't--I am  
4465 not aware of anything I said that said that it would be  
4466 actuarially sound.

4467 Mrs. {Blackburn.} Well, I think that that is a  
4468 statement in your testimony.

4469 Dr. {Epperly.} What I will say as you look that up,

4470 though, is that we believe that expanding coverage to people  
4471 and giving them choice is a sound decision for America in  
4472 regards to helping people get health care coverage. We are  
4473 in agreement with that. As it presently stands, this would  
4474 have to be at an enhanced rate above Medicare. That is why  
4475 we say that, you know, if the model is Medicare, that is not  
4476 going to work, but anything that starts to promote primary  
4477 care as being a solution to that, that will work and that--

4478 Mrs. {Blackburn.} Okay. Let me interrupt you with that  
4479 that. You say that it would be at an enhanced model above  
4480 the rate of Medicare. So in other words, it is going to cost  
4481 more?

4482 Dr. {Epperly.} Yes, but the--

4483 Mrs. {Blackburn.} Okay. Now, yesterday, if I may  
4484 interrupt you again, Secretary Sebelius said that this would  
4485 be deficit neutral. So I am trying to figure out, and I  
4486 asked her yesterday how she could say it was deficit neutral.  
4487 We have not had one witness out of all the hearings we have  
4488 done that has said they felt like this would be deficit  
4489 neutral or would be a money saver. Everybody has said it is  
4490 going to cost more.

4491 Dr. {Epperly.} I would say that it would be beyond  
4492 deficit neutral in a positive way because where the savings  
4493 will come from the system is in regards to reduced

4494 hospitalizations, reduced readmissions, more efficient--

4495           Mrs. {Blackburn.} Okay. If I may interrupt you again,  
4496 do you have any kind of model that shows that actually  
4497 happens because you can look at TennCare in Tennessee, you  
4498 can look at Massachusetts and you can see that that does not  
4499 happen.

4500           Dr. {Epperly.} Yes, Community Care of North Carolina  
4501 proved that. Other international studies have proven that as  
4502 well. That is why when we talk about the value of primary  
4503 care, we are saying that there are systems savings from  
4504 across the existing system that will save the entire system  
4505 money.

4506           Mrs. {Blackburn.} All right, but I can tell you that in  
4507 Tennessee we found that did not happen, and so I appreciate  
4508 your input.

4509           Dr. Williamson, I have got 15 seconds left. Medicare  
4510 patients, senior citizens are just up in arms. They see that  
4511 their care is going to be diminished somewhat, that savings  
4512 from Medicare are going to go to pay for care for younger  
4513 enrollees in this public plan. My seniors are coming to me  
4514 and saying we are scared to death. What do I say to them?  
4515 What is Medicare going to look like after this public plan  
4516 goes in place?

4517           Dr. {Williamson.} I don't see anything in the

4518 discussion draft that gives me hope that we are moving in the  
4519 right direction in terms of payment. I think that private  
4520 contacting and empowering patients to buy their own health  
4521 care. I don't think we should ever take away a patient's  
4522 right to pay for their own health care, and if we do that, we  
4523 are committing a colossal mistake.

4524 Mrs. {Blackburn.} Thank you. I yield back.

4525 Mrs. {Christensen.} Thank you. The Chair now  
4526 recognizes Congresswoman Harman for 5 minutes.

4527 Ms. {Harman.} I thank you, Dr. Christensen, and point  
4528 out that our committee benefits a lot from the fact that many  
4529 members are medical doctors and nurses and have extensive  
4530 medical backgrounds. I hope the panel is impressed that we  
4531 actually, some of us, others here know a great deal about  
4532 this. In my case, I don't have either of those but I am the  
4533 daughter of a general practitioner who actually made house  
4534 calls to three generations of patients before he retired in  
4535 Los Angeles and I am the sister of an oncologist/hematologist  
4536 who was the head of that practice at Kaiser in San Rafael,  
4537 California, before he semi-retired. He is younger than I am,  
4538 so go figure. But he did win the healer of the year award in  
4539 Marin County for his compassionate treatment of patients, so  
4540 I love listening to a bunch of docs and experts who put that  
4541 on the front burner.

4542 I come from Los Angeles County, as you just heard. We  
4543 are extremely concerned, if not panicked, about the  
4544 President's proposed cuts in DSH payments. Listening to this  
4545 panel and listening to you, is it Dr. Gabow or--

4546 Dr. {Gabow.} Yes.

4547 Ms. {Harman.} And reading your excellent testimony, I  
4548 think your bottom line is, you don't want cuts on the front  
4549 end, you want to see how all this works and phase in cuts  
4550 later once the efficiencies take hold. Is that what you are  
4551 saying?

4552 Dr. {Gabow.} That is correct.

4553 Ms. {Harman.} Thank you. And on this point, Madam  
4554 Chair, I would like permission to put a letter in the record  
4555 from the board of supervisors of the county of Los Angeles  
4556 talking about the DSH--

4557 Mrs. {Christensen.} Without objection, it will be  
4558 admitted into the record.

4559 [The information follows:]

4560 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

|  
4561 Ms. {Harman.} Thank you. Well, I would just like to  
4562 invite the panel on this subject to address, and starting  
4563 with you, Dr. Gabow, and it seems like you may have a bit of  
4564 laryngitis. Am I right?

4565 Dr. {Gabow.} Congresswoman, I have a chronic voice  
4566 problem--

4567 Ms. {Harman.} Oh, my goodness.

4568 Dr. {Gabow.} --spastic dysphonia, and the treatment for  
4569 it is Botox but it doesn't do anything for my wrinkles.

4570 Ms. {Harman.} As my kids would say, I think that is  
4571 more information than we need. But I appreciate this. I  
4572 hope I am not stressing you, but I would really like the  
4573 record to be more complete on this subject because I think it  
4574 is an urgent subject for at least our large metropolitan  
4575 areas and one this committee has to take very seriously, and  
4576 based on the comments I heard from the minority side, I think  
4577 everyone here generally agrees about this. Yes?

4578 Dr. {Gabow.} Congresswoman, I think all of the safety-  
4579 net institutions would be very concerned if disproportionate  
4580 share funding were cut at the front end of this process. We  
4581 rely heavily on disproportionate share funding to cover not  
4582 only our uninsured patients but also the gap between what  
4583 Medicaid pays us and our costs. So I think that the timing

4584 of this issue is really critical, and as I said earlier, I  
4585 think what we have learned from expansions in the past with  
4586 Medicaid and SCHIP is that it takes a long time to enroll  
4587 certainly highly vulnerable populations. They are vulnerable  
4588 in so many ways that enrollment is not an easy process so it  
4589 is going to take a period of time to really get to full  
4590 coverage even with this bill so I don't think we can cut DSH  
4591 at the front.

4592 Ms. {Harman.} I realize I only have 48 seconds left, so  
4593 let me just expand the question in case anyone else wants to  
4594 answer it as well. One of my personal issues, since I focus  
4595 on Homeland Security issues generally, is surge capacity in  
4596 our hospitals in the event of a terror attack or a large  
4597 natural disaster, and so my question is, what is the  
4598 relationship between the ability of our level I trauma  
4599 centers which are located in many of our DSH hospitals, what  
4600 is the relationship between the ability of our level I trauma  
4601 centers to be available in the event of terror attack or a  
4602 natural disaster and the proposed cuts in DSH?

4603 Dr. {Gabow.} Congresswoman, I think you are right, that  
4604 these are related in that many of the trauma centers are at  
4605 the disproportionate share hospitals and also many of the  
4606 pre-hospital care services and burn units so that much that  
4607 you would need in disaster are located in these safety-net

4608 institutions so they need to be preserved and you can't  
4609 destabilize them financially at the beginning of the process  
4610 and still preserve those critical resources.

4611 Ms. {Harman.} Thank you very much.

4612 Mrs. {Christensen.} Thank you. The Chair now  
4613 recognizes Mr. Pitts for 5 minutes.

4614 Mr. {Pitts.} Thank you, Madam Chairman.

4615 Dr. Ulrich, if a large number of private-payer patients  
4616 were to shift into the public plan and the public plan is  
4617 paid based on Medicare rates, what would be the effect on  
4618 your ability to continue to offer the same level of services  
4619 that you provide today?

4620 Dr. {Ulrich.} Well, it would be impacted extremely  
4621 negatively and probably fairly rapidly. It would be beyond  
4622 my capacity to give you an exact timeframe but it would be  
4623 disastrous, I think, is a fair word to use.

4624 Mr. {Pitts.} Now, are you treating a large number of  
4625 Medicare- or Medicaid-eligible patients in your part of  
4626 Wisconsin?

4627 Dr. {Ulrich.} Absolutely. If I can enlarge on that  
4628 just a second, there already is a problem as you are  
4629 describing. In certain parts of the service area that we  
4630 provide, we comprise about 33 percent of the physicians. We  
4631 are caring, however, for 70 percent of what we call fixed

4632 payer, which is Medicare or Medicaid patients. Why? Because  
4633 other providers are not choosing to take care of those  
4634 patients. So this is already happening. This is not--

4635 Mr. {Pitts.} So how are you surviving now if you--

4636 Dr. {Ulrich.} Well, you know, we try to watch our costs  
4637 as closely as we can. I found it necessary to try to branch  
4638 into ancillary revenue streams, try to sell the electronic  
4639 medical record. We do food safety with Cargill, with Hormel,  
4640 et cetera because I am not confident that just providing  
4641 health care is going to be a way to sustain our organization.

4642 Mr. {Pitts.} Dr. Williamson, each year fewer and fewer  
4643 physicians are willing to accept Medicare and Medicaid  
4644 patients. From your perspective as a practicing physician,  
4645 could you tell us why you think this is?

4646 Dr. {Williamson.} I think as has been said, it is  
4647 becoming more and more impractical to do that. I think  
4648 inertia plays a large role here. Doctors have done it for a  
4649 long time. It is becoming less and less practical because  
4650 the Medicare and the Medicaid payment systems have not kept  
4651 pace with the cost of providing care, and physicians want to  
4652 keep taking care of these patients, we want to keep doing  
4653 that, and so what you are seeing across the Nation are  
4654 doctors basically doing the very best they can to control  
4655 costs and keep functioning in this environment, but as I

4656 said, it is a house of cards. Some doctors are retiring  
4657 early. They are getting out of medicine. They are going  
4658 into other ancillary revenue streams because these payment  
4659 systems simply are not adequate to cover the costs of  
4660 providing care and moving more patients onto those types of  
4661 payment schedules is going to adversely impact everybody's  
4662 health care in this country, not just those patients that are  
4663 taking--that are enrolled in the public option.

4664 Mr. {Pitts.} Now, if we allowed more people to purchase  
4665 health care services with untaxed dollars instead of relying  
4666 so heavily on third-party payers for routine health care  
4667 services, do you think that we could solve many of our  
4668 problems faced today by consumers or providers of health care  
4669 services?

4670 Dr. {Williamson.} Congressman, I think you just hit the  
4671 nail on the head. Right now what we are trying to do is  
4672 solve a problem for uninsured patients. That is what all  
4673 this is about. We wouldn't be sitting here if we weren't  
4674 dealing with this issue. I think that by making it feasible  
4675 for every person to own and control their own insurance  
4676 policy is the way to solve this problem, and I know that we  
4677 can do that with the tax system, with tax credits, tax  
4678 subsidies. We can put the control back into the hands of the  
4679 patients so that the government doesn't have to orchestrate

4680 this massive machine that we are looking at right now that is  
4681 going to not attend adequately to the needs of the individual  
4682 patient. I believe by restructuring the tax system, we can  
4683 take care of the uninsured patients and we can solve this  
4684 problem without putting private insurance companies out of  
4685 business and taking away the ability of individuals to  
4686 purchase their own health care.

4687 Mr. {Pitts.} Dr. Wright, if you could respond, polling  
4688 has suggested that over 95 percent of the American people  
4689 support the right to know the price of health care services  
4690 before they go in for treatment. What do you view as the  
4691 major barriers to the American people getting the price and  
4692 quality information that they want and they need?

4693 Dr. {Wright.} I think there has just not been enough  
4694 transparency in the pricing structures. It is Byzantine at  
4695 the very least. It is difficult to figure out. Even within  
4696 a practice often most of us have no idea what an individual  
4697 patient is paying for a service, so I think the system would  
4698 clearly benefit from additional transparency.

4699 Mr. {Pitts.} And how would the patients, the providers,  
4700 the taxpayers benefit by public disclosure price and risk  
4701 adjusted quality?

4702 Dr. {Wright.} Well, I think it lends to the--it is one  
4703 component of their decision-making process. I would not

4704 uncouple pricing information from quality information because  
4705 cheap care may not necessarily be the best care. On the  
4706 other hand, the best care can be less expensive than we are  
4707 delivering it now.

4708 Mr. {Pitts.} What about the agency that reports price  
4709 and risk adjusted quality information to be completely  
4710 separate from the Department of Health and Human Services?  
4711 Do you see any conflicts of interest with HHS reporting on  
4712 their own programs?

4713 Dr. {Wright.} No, I don't.

4714 Mr. {Pitts.} My time is up. Thank you very much, Madam  
4715 Chair.

4716 Mrs. {Christensen.} Thank you, Mr. Pitts. The Chair  
4717 now recognizes Mr. Gordon for 5 minutes.

4718 Mr. {Gordon.} Thank you, Madam Chair.

4719 Last week the President put forth a challenge to find  
4720 ways to reduce the number of medical liability suits without  
4721 capping malpractice awards. I agree with the President. I  
4722 think if you are going to be able to try to reduce the cost  
4723 of health care, you have got to get all the inefficiencies  
4724 out and this is certainly one area. PriceWaterhouseCooper  
4725 estimates there is \$280 billion spent in defensive medicine.  
4726 We can't wrench all that out but surely there is some savings  
4727 that can be made there. That is why I am drafting medical

4728 malpractice reform alternative legislation responding to the  
4729 President's challenge. The bill encourages States to step  
4730 outside the box and test so-called alternatives like health  
4731 courts and ``I am sorry'' methods. Also, I think that this  
4732 will help lower the cost of defensive medicine and I think it  
4733 will compensate patients faster and be more fair. In my home  
4734 State of Tennessee, we enacted a certificate of merit  
4735 requirement last October that has already proven that there  
4736 has been a 4 percent reduction in malpractice premiums.  
4737 Earlier you were all asked about whether you would think that  
4738 malpractice reform should be a part of the overall reform,  
4739 and you agreed. So I want to quickly ask you to say why and  
4740 what savings you think we might be able to achieve. Dr.  
4741 Epperly, why don't we start with you?

4742 Dr. {Epperly.} First, I applaud you for doing this. I  
4743 think it is the right step in the right direction.

4744 Mr. {Gordon.} Don't applaud me. Let us just move on  
4745 and tell me why it is good.

4746 Dr. {Epperly.} Oh, okay.

4747 Mr. {Gordon.} No, no, no, no, tell me why. Please tell  
4748 me why it is good.

4749 Dr. {Epperly.} Oh, okay. I think it is a step in the  
4750 right direction. If there is not a relationship with  
4751 patients, the default is to do more to patients, not less so

4752 that you cover yourself. That is why the relationship is  
4753 critical. If we don't get reform in place, then people that  
4754 don't have that relationship will continue to order every  
4755 test known to man to try to diagnose the problem.

4756 Dr. {Williamson.} I agree completely. I think the  
4757 costs are hidden but they are very, very real and I think  
4758 they are gigantic. Physicians order expensive tests to rule  
4759 out conditions that they don't suspect but might occur  
4760 randomly in one in several thousand, and if someone gets \$10  
4761 million from a lawsuit and it occurs in an incidence of one  
4762 in 10,000, if you don't screen for that you are statistically  
4763 going to lose money. And so you are exactly on target here.  
4764 We must have real medical liability reform. I will tell you  
4765 in Georgia in 2005, we enacted a very effective tort package.  
4766 The number of suits in Georgia are down by 40 percent now.  
4767 We only had three professional liability carriers in Georgia.  
4768 We now have something like in the teens, and we have a cap on  
4769 non-economic damages, not total damages but only non-economic  
4770 damages so that economic--

4771 Mr. {Gordon.} We are not talking about caps here. We  
4772 are thinking about things less than that.

4773 Dr. Ulrich?

4774 Dr. {Ulrich.} I would agree with what both gentlemen  
4775 before me said. The reality is that, you know, having to pay

4776 some dollars out in those unfortunate circumstances is an  
4777 actual cost and without some relief from that we will  
4778 continue to bear those costs.

4779 Mr. {Gordon.} Dr. Wright?

4780 Dr. {Wright.} I also agree. I think the burden of this  
4781 is quite large and I particularly like the idea that you  
4782 would test various options, various approaches to controlling  
4783 the tort problem.

4784 Mr. {Gordon.} What we want to do is give incentives for  
4785 States to experiment and let us find out what might work.

4786 Dr. White?

4787 Ms. {White.} The American Nurses Association does have  
4788 some concerns about caps. They have a position statement  
4789 that--

4790 Mr. {Gordon.} Okay. We are not talking about caps. I  
4791 said practices short of caps.

4792 Ms. {White.} Okay. Well, they have a position  
4793 statement that they can make available to the committee.

4794 Mr. {Gordon.} But they would support malpractice reform  
4795 short of caps? You raised your hand earlier.

4796 Ms. {White.} Yes. I mean, it--

4797 Mr. {Gordon.} Dr. Gabow?

4798 Dr. {Gabow.} As a governmental entity, we have  
4799 governmental immunity. In the broader discussion, I think

4800 that it is very important to do malpractice reform and I  
4801 think your idea of experimenting with health courts is a very  
4802 good one.

4803 Mr. {Gordon.} Mr. Hawkins, earlier you said you weren't  
4804 personally affected but that is not the question, it is for  
4805 the system overall.

4806 Mr. {Hawkins.} Yeah, and as a matter of fact, if I can,  
4807 one important thing that--a couple of members of the  
4808 committee here have sponsored legislation to extend the  
4809 Federal Tort Claims Act, FTCA coverage, that health center  
4810 clinicians get today to clinicians who volunteer at health  
4811 centers.

4812 Mr. {Gordon.} Well, that will be a part of the bill in  
4813 terms of emergency rooms. I think they should be considered  
4814 as first responders.

4815 Mr. {Hawkins.} Yes, I would just say we know for a  
4816 fact--

4817 Mr. {Gordon.} And Mr. Yarwood--oh, I am sorry. Okay.  
4818 You are saying you know for a fact that it helps?

4819 Mr. {Hawkins.} That many local physicians and  
4820 clinicians would volunteer time at a health center if this  
4821 issue were addressed.

4822 Mr. {Gordon.} Mr. Roberts?

4823 Mr. {Roberts.} I think from a pharmacy's perspective,

4824 it is not as large an issue but still we would be supportive.

4825 Mr. {Gordon.} Mr. Yarwood?

4826 Mr. {Yarwood.} It is a huge issue. We talked about  
4827 this before.

4828 Mr. {Gordon.} Ms. Fox?

4829 Ms. {Fox.} We absolutely agree.

4830 Mr. {Gordon.} And if I could go back, since I have a  
4831 little more time, concerning those individuals that have the  
4832 hospitals. Are you finding it a problem now to get  
4833 specialists to come into the emergency room because of the  
4834 medical malpractice problem? Yes, ma'am, go ahead.

4835 Dr. {Gabow.} Because of medical malpractice, we aren't  
4836 because we have governmental immunity and our physicians are  
4837 employed so we have no problem getting coverage and we don't  
4838 pay extra for that coverage.

4839 Mr. {Gordon.} But it is because they are already  
4840 covered? Yes. Okay. My time is up and I thank you for your  
4841 advice.

4842 Mrs. {Capps.} [Presiding] The Chair now recognizes Mr.  
4843 Shadegg for questions.

4844 Mr. {Shadegg.} Thank you, Madam Chair.

4845 Dr. Wright, I want to begin with you. I also want to  
4846 follow up with Dr. Ulrich because he mentioned a word that I  
4847 think is very important. He talked about the incentives in

4848 the current policy or health care system. Under the tax code  
4849 in America today, businesses can buy health insurance tax-  
4850 free. Individuals have to buy it with after-tax dollars,  
4851 making it at least 30 percent more expensive. You were just  
4852 asked, and I want to follow up, a question by Mr. Pitts about  
4853 transparency. I guess my concern about transparency is that  
4854 until we enable consumers, individual people, to buy health  
4855 insurance on the same tax-free basis that businesses can do  
4856 it, I don't see how a consumer has the motivation to look at  
4857 transparency, that is, to say if my employer provides me with  
4858 health care and he or she pays for it, I don't see what the  
4859 motivation is for me to go research the cost of a particular  
4860 procedure at one hospital versus another or one doctor for  
4861 another or the quality outcomes. Because I agree with you, I  
4862 think that both cost and quality are things consumers want to  
4863 know but only if they are a part of a marketplace where those  
4864 factors can make a difference to them. Would you agree?

4865 Dr. {Wright.} I am not a pricing expert. I am barely a  
4866 quality-of-care expert. I understand your point. I am  
4867 greatly concerned about the number of people who are not  
4868 covered at this point in time.

4869 Mr. {Shadegg.} Me too.

4870 Dr. {Wright.} I know you are, and so I guess most of my  
4871 priority in terms of getting this fixed has been directed at

4872 them.

4873           Mr. {Shadegg.} Dr. Ulrich, is that one of the  
4874 incentives that concerns you?

4875           Dr. {Ulrich.} Yes, certainly, and if I can expand on  
4876 that just briefly?

4877           Mr. {Shadegg.} Please.

4878           Dr. {Ulrich.} If we look at the quality equation, that  
4879 is the outcomes of patient care and the patient-physician  
4880 interaction being the numerator, costs being the denominator,  
4881 quality being the end product of that, the concern I have is  
4882 this, is that currently we don't pay for that. We absolutely  
4883 need to move to that model, but what hinders us now is the  
4884 fact that patients don't understand necessarily what quality  
4885 is. We did some market research, and what patients tell us  
4886 is that look, you guys are all the same. You all went to  
4887 medical school, you all did residencies so there is really  
4888 very little to pick between you. When in fact for those of  
4889 that work in the industry, there are differences, so the  
4890 question before us, how do we now educate our patients so  
4891 that they can make fully informed decisions relative to that  
4892 quality equation.

4893           Mr. {Shadegg.} Dr. Williamson, I think if I gather your  
4894 testimony correctly, you think that is exactly the point. If  
4895 we empowered or allowed, just permitted people to buy their

4896 own health insurance policy and therefore to shop for it and  
4897 to be involved in the selection of the plan and the selection  
4898 of the doctor, they would be motivated to use transparency,  
4899 cost data, quality data, and make the market much more  
4900 competitive, bringing down costs and causing quality to go  
4901 up?

4902 Dr. {Williamson.} Absolutely, and I think it would  
4903 raise quality on two levels. It would raise quality on the  
4904 national level in terms of saving money in the entire system  
4905 and it would raise the quality that the individual patient  
4906 perceives. Even though patients may not be able to judge  
4907 scientific quality, they do vote with their feet, and I think  
4908 if we had transparency, I think doctors are going to have to  
4909 compete with each other, and if we can do what you have  
4910 suggested which is to empower patients to buy with the same  
4911 tax advantage that employers have now, their own health  
4912 insurance policies and control that, they then control their  
4913 medical decision making and that is the best way to keep  
4914 costs down and ensure good patient care.

4915 Mr. {Shadegg.} The health care policy I have advocated  
4916 says that we should tell every American that has employer-  
4917 provided health care that they can keep it and they can keep  
4918 the exclusion, but every American that doesn't have employer-  
4919 provided health care would get a tax credit. Those Americans

4920 who can't afford to buy their own health care would get a  
4921 refundable and advancable tax credit to go out in the market  
4922 and buy what they want. We would then bring consumer choice  
4923 to the entire health care industry.

4924 I would like every member of the panel to tell me what  
4925 other thing in our society somebody else buys for us. I  
4926 mean, I struggle with this question, and I don't understand  
4927 it. Our employers buy our health care insurance. They don't  
4928 buy our auto insurance, they don't buy our homeowners  
4929 insurance, they don't buy our suits. I don't buy my  
4930 employees lunch. But why in health care do we decide that  
4931 only employers can buy it? Is there something else that  
4932 somebody on the panel can remember or can think of that is of  
4933 that dimension where your employer buys it for you and you  
4934 are just kind of a pawn in the whole system? Dr. Williamson?

4935 Dr. {Williamson.} I can't answer the question but I can  
4936 tell you where it came from, and it came from the notion of  
4937 pooling risk. Patients realize that if I get really sick, I  
4938 am going to need a lot of money, and so they went together  
4939 and they pooled their money and then what happened is, over  
4940 time they have lost control of that pool of money and that is  
4941 where all this is coming from. The patients have turned over  
4942 to others the ability to make their health care decisions for  
4943 them by allowing them to pay for it.

4944 Mr. {Shadegg.} So if we empower them to be able to buy  
4945 their own health care if choose it from their employer or out  
4946 on the market and we empower poor people to do that who can't  
4947 afford it by giving them a refundable tax credit, we would  
4948 also need to create new pooling mechanisms, would we not?

4949 Dr. {Williamson.} I completely agree with you.

4950 Mr. {Shadegg.} Thank you very much.

4951 Mrs. {Capps.} Thank you very much, and we will turn to  
4952 Mr. Green for his questions, and I will just say probably  
4953 this is our last series of questions because the vote has  
4954 been called and your panel can be excused. You really set a  
4955 record for endurance. I have to thank each of you.

4956 Mr. {Green.} Madam Chairman, some of us were here last  
4957 night at 7:00. Well, you were too, I think, and we started  
4958 at 9:30 yesterday morning and finished some time after 7:00.

4959 Mrs. {Capps.} Be thankful you weren't on that last  
4960 panel.

4961 Mr. {Green.} Yes, you will at least get out before  
4962 dark.

4963 Mr. Hawkins, you and I have been working with  
4964 Representative Tim Murphy since we reauthorized community  
4965 health centers program last year on a bill we introduced, the  
4966 Family Health Care Accessibility Act of 2009. The bill would  
4967 extend Federal Tort Claim Act coverage to volunteers by

4968 deeming these volunteer practitioners at health centers as  
4969 employees of the federal government. These volunteers would  
4970 have to be licensed physician or licensed clinical  
4971 psychologists and unpaid in order to qualify. This seems  
4972 like an easy solution to the lack of primary care physicians  
4973 in some areas, especially in medically underserved areas  
4974 where community health centers are located. Yesterday the  
4975 GAO released a report stating that the lack of Federal Tort  
4976 Claims Act coverage for volunteer practitioners can be a  
4977 barrier for volunteers who wish to dedicate their time at a  
4978 federally qualified health center. Can you elaborate on how  
4979 the extension of the FTCA coverage to licensed physicians or  
4980 other licensed practitioners would help increase the number  
4981 of volunteers at federally qualified health centers?

4982 Mr. {Hawkins.} Sure, Mr. Green, and thank you for  
4983 raising that issue. In fact, just a couple of minutes ago we  
4984 were discussing the issue of malpractice and I--

4985 Mr. {Green.} I thank my colleague, Congressman Murphy,  
4986 for bringing it up.

4987 Mr. {Hawkins.} That is okay. I specifically alluded to  
4988 this legislation which you and Mr. Murphy have collaborated  
4989 on in the past and continue to collaborate on. I can't tell  
4990 you not only for primary care, Mr. Green, but even for  
4991 urologists, dermatologists. You know, the biggest

4992 frustration that health center clinicians who are virtually  
4993 all primary care today express is the barriers and difficulty  
4994 they face getting specialty care, diagnostics, even hospital  
4995 admits for the 7.5 million uninsured people we serve in  
4996 particular, not exclusively but in particular. Allowing FTCA  
4997 coverage to extend to individuals who, as you note, come into  
4998 the health center and donate their time, do not charge the  
4999 patient, don't charge the health center, would be a  
5000 phenomenal benefit and boon and would provide for much more  
5001 fully integrated care and better health outcomes.

5002         Mr. {Green.} And we discovered this problem in Texas  
5003 with Hurricane Katrina with all the evacuees. In our  
5004 federally qualified health centers, we had medical  
5005 professionals who couldn't volunteer in Texas because they  
5006 weren't covered, and we realize now that it is a way we can  
5007 provide for our federally qualified health centers.

5008         The discussion draft also addresses the issue of  
5009 residency training in offsite locations like FQHCs, but it  
5010 still allocates the funds to the hospitals and not to the  
5011 offsite locations. Do you believe the language in the draft  
5012 should make it easier for federally qualified health centers  
5013 and other offsite residency training programs to start up and  
5014 operate residency programs? And again, we have an example in  
5015 my district of a federally qualified health center has a

5016 partnership with Baylor College of Medicine in Houston, and  
5017 they do it, and what I would like to do is see if we can get  
5018 a number of medical schools, because I want primary care  
5019 physicians to know they can make a living at a federally  
5020 qualified health center in a community-based setting.

5021         Mr. {Hawkins.} Not only that, Mr. Green, but I am  
5022 honored to be part of a panel today that includes Denver  
5023 Health, a community health center, as well as a public  
5024 hospital--

5025         Mr. {Green.} Congresswoman DeGette has preached to me  
5026 for years about Denver Health.

5027         Mr. {Hawkins.} And the great work that Dr. Gabow has  
5028 done. Also, residency training program, Marshfield Clinic,  
5029 which has a community health center embedded in it, doing  
5030 residency training and Ted Epperly, Dr. Epperly, whose family  
5031 medicine residency training program in Boise, Idaho, is also  
5032 a federally qualified health center. Perfect examples. Now,  
5033 all are working locally with their medical schools and with  
5034 teaching hospitals to ensure, because those residents, even  
5035 family medicine, have to have med-surg residency inpatient  
5036 based so it can't be done independently. At the same time,  
5037 the vast bulk of family medicine residency training,  
5038 pediatric residency training, even general internal medicine  
5039 residency training can be done in an ambulatory care site.

5040 More than 300 health centers today across the country are  
5041 engaged in residency training programs. They have rotations  
5042 of residents through them and everyone is willing to step up  
5043 and do more. All that is needed is the resources to be able  
5044 to do so.

5045 Mr. {Green.} And if we know we have chronic need for  
5046 primary care doctors, then this is a way we can do that and  
5047 hopefully expand it.

5048 One last question in my last 6 seconds. The discussion  
5049 draft includes additional funding through the Public Health  
5050 Investment Fund, and as many on the committee know, we have  
5051 been asking for additional funds for federally qualified  
5052 health clinics for years. How do you intend to use the new  
5053 funds when you provide more services like dental and mental  
5054 health and would it also help build more FQHCs? Because we  
5055 know we need that in our country.

5056 Mr. {Hawkins.} I think there are two or three quick  
5057 points to make on that. Just last month, the Government  
5058 Accountability Office, GAO, issued a report that pointed out  
5059 that almost half of federally designated medically  
5060 underserved areas in this country have no health centers, not  
5061 a one. There are 60 million people out there today across  
5062 this country, some of whom have insurance and yet do not have  
5063 a regular source of preventive and primary care, no family

5064 doctor, no medical or health care home. So the need is  
5065 great. It runs in tandem with the extension of coverage that  
5066 this bill would provide but takes it that one step further,  
5067 turning the promise of coverage into the reality of care  
5068 through providing a health care home. The expansion of  
5069 coverage to serve more people as you noted very importantly  
5070 the expansion of medical care to include oral health and  
5071 mental health services so crucially important, all of that  
5072 will be afforded through the new resources in this bill.

5073 Mr. {Green.} Thank you.

5074 Mrs. {Capps.} Thank you again to the panelists, and we  
5075 are in recess for the next panel to begin after this series  
5076 of votes. It is eight votes, but after the first one  
5077 apparently is 2 minutes per vote so it should go fairly  
5078 quickly hopefully. Thank you very much.

5079 [Recess.]

5080 Mr. {Pallone.} The Subcommittee on Health will  
5081 reconvene, and our next panel is on employer and employee  
5082 views. Let me introduce the panel, from my left is Kelly  
5083 Conklin, Mr. Conklin, who is the owner of Foley-Waite Custom  
5084 Woodworking, Main Street Alliance, and then we have John  
5085 Arensmeyer, who is founder and CEO of Small Business  
5086 Majority. We have Gerald M. Shea, who is the assistant to  
5087 the president of the AFL-CIO, Dennis Rivera, who is the

5088 health care chair for the SEIU, John Castellani, who is  
5089 president of the Business Roundtable Institute for Corporate  
5090 Ethics, John Sheils, who is senior vice president for the  
5091 Lewin Group, and Martin Reiser, who is manager of government  
5092 policy for Xerox Corporation, I guess representing the  
5093 National Coalition on Benefits. And you know, we ask you to  
5094 speak for about 5 minutes, your written testimony becomes  
5095 part of the record and then we will have questions from the  
5096 panel.

5097           So I will start with Mr. Conklin. Thank you for being  
5098 here.

|  
5099 ^STATEMENTS OF KELLY CONKLIN, OWNER, FOLEY-WAITE CUSTOM  
5100 WOODWORKING, MAIN STREET ALLIANCE; JOHN ARENSMEYER, FOUNDER  
5101 AND CEO, SMALL BUSINESS MAJORITY; GERALD M. SHEA, ASSISTANT  
5102 TO THE PRESIDENT, AFL-CIO; DENNIS RIVERA, HEALTH CARE CHAIR,  
5103 SEIU; JOHN CASTELLANI, PRESIDENT, BUSINESS ROUNDTABLE; JOHN  
5104 SHEILS, SENIOR VICE PRESIDENT, THE LEWIN GROUP; AND MARTIN  
5105 REISER, MANAGER OF GOVERNMENT POLICY, XEROX CORPORATION,  
5106 NATIONAL COALITION ON BENEFITS

|  
5107 ^STATEMENT OF KELLY CONKLIN

5108 } Mr. {Conklin.} Thank you, Chairman Pallone, Ranking  
5109 Member Deal and other members of the committee for inviting  
5110 me to appear today. My name is Kelly Conklin and I co-own  
5111 with my wife, Kit, an architectural woodworking business in  
5112 Bloomfield, New Jersey. My purpose today is to explain how  
5113 the House tri-committee's health reform proposals might  
5114 affect small companies like ours.

5115 To start, I think the draft legislation is right on  
5116 target. I believe it will receive broad support in the small  
5117 business community. Before I go any further, let me provide  
5118 some background. My wife and I opened Foley-Waite in 1978 in  
5119 a 700-square foot shop in Montclair, New Jersey. In 1985 we

5120 expanded, hired four employees and started offering health  
5121 insurance. The premiums were about 5 percent of payroll and  
5122 we paid it all. Today we employ 13 people, occupy 12,000  
5123 square feet of space and serve some of the most influential  
5124 people in the world, and we fork over \$5,000 a month in  
5125 health insurance premiums, close to 10 percent of payroll and  
5126 one of the largest single expenses in our budget.  
5127 Practically speaking, we offer coverage to attract and retain  
5128 skilled employees but like the majority of small companies,  
5129 we do so because it is the right thing to do for our workers  
5130 and if we don't offer coverage, we are just passing our  
5131 obligation and our share of the cost on to someone else.

5132 Cost is by far the single most important driver in  
5133 making basic decisions regarding health care. That applies  
5134 whether it is a small firm like mine or the United States  
5135 Congress, and no system that tends to dance around the cost  
5136 issue can succeed.

5137 April is the month I dread, not for taxes but for health  
5138 insurance renewal nightmares. Every year is worse--  
5139 unpredictable rate hikes, unaffordable premiums, an  
5140 administrative tangle that is our system. In 3 years, we  
5141 have had three different insurance companies. Most recently,  
5142 Horizon Blue Cross Blue Shield raised our rates 25 percent.  
5143 Now we have Health Net. That means new primary care

5144 physicians, and for my wife, who has a chronic illness, a new  
5145 doctor who knows nothing of her medical history. It is very  
5146 frustrating. There are no quality, affordable health care  
5147 options available for small businesses.

5148         In reading the discussion draft, it is apparent the  
5149 committee is determined to control cost. Responsible  
5150 employers understand we will all be better off in a system  
5151 where employers and individuals contribute a reasonable  
5152 amount toward assuring our common health and well-being.  
5153 That is why I support the draft provisions requiring  
5154 employees and individuals to pay their fair share. For too  
5155 long, the small business community has paid too much for too  
5156 little. We sacrifice growth, financial security and the  
5157 peace of mind of our employees and their families in the name  
5158 of protecting private insurers from meaningful competition.  
5159 The private health insurance market has failed to contain  
5160 costs, enhance efficiency or improve outcomes. It fails to  
5161 provide coverage to millions. Half measures warmed over,  
5162 more of the same second chances for the health insurance  
5163 industry won't fill the yawning gaps in our patchwork  
5164 coverage. We need a guarantee that individuals and small  
5165 companies will have real choices and affordable coverage  
5166 options.

5167         I commend the committee for including a strong public

5168 health insurance option in this legislation. With a public  
5169 option, small businesses will have leverage, real bargaining  
5170 power and guaranteed backup and greater transparency. Most  
5171 importantly, by creating genuine competition and restoring  
5172 vitality to the market dynamic, this proposal will bring  
5173 about the kind of broad-based changes in the private  
5174 insurance industry Main Street is clamoring for. For a small  
5175 business like mine, bringing down health insurance premiums  
5176 can be the difference between growth and sitting tight. Two  
5177 years ago we were interested in buying a building. It  
5178 represented growth potential, financial security and long-  
5179 term equity. We were looking at around \$5,000 a month in  
5180 mortgage payments as opposed to our rent of around \$3,500.  
5181 If our health insurance premiums had been closer to our rent  
5182 and not the future mortgage, we might be in that building  
5183 today. We work in a competitive marketplace. All the time  
5184 there are new competitors looking to take business away. We  
5185 find savings, improve efficiency, invest in equipment and  
5186 personnel. That is how it is for us and that is how it will  
5187 be for the health insurers if a public option is available.

5188       Transparency is critical. It is time for the insurance  
5189 companies to come clean and in plain English explain where  
5190 our premium money goes, to say up front what is covered and  
5191 what is not. It is time to put a halt to cost containment by

5192 denial, copays and hidden charges. The draft discussion  
5193 addresses this need by creating a health insurance exchange  
5194 to offer real coverage choices to allow us to actually know  
5195 where our premium dollars are being spent. We can provide  
5196 access to both preventive and therapeutic care for everyone.  
5197 We are encouraged by the provisions reforming common  
5198 practices in the current insurance market. Ending lifetime  
5199 and annual benefit limits, discriminatory coverage and rating  
5200 policies and creation of a basic benefit are all important  
5201 and necessary parts of a complete reform package. These are  
5202 full measures designed to provide real relief. If enacted,  
5203 they will represent a watershed for American health care and  
5204 a godsend to the small business community.

5205         This committee working with its counterparts to develop  
5206 the tri-committee proposal has done yeoman's work taking on  
5207 and meeting an extremely complex set of issues. I will not  
5208 be alone in supporting this extraordinary effort. I am a  
5209 member of the New Jersey Main Street Alliance, a coalition of  
5210 over 450 small businesses working for health reform that will  
5211 finally give us access to quality health care we can afford.  
5212 I have canvassed small businesses, and when I say ``and we  
5213 support a public option,'' they take the pen out of my hand  
5214 and the New Jersey MSA has a new member. Small businesses  
5215 have seen your leadership and with this document you have

5216 delivered. Now the real fight begins. We need you to enact  
5217 this proposed legislation and bring about health reform that  
5218 works for us and our employees this year so we can do our  
5219 part for economic recovery. Thank you, Mr. Chair.

5220 [The prepared statement of Mr. Conklin follows:]

5221 \*\*\*\*\* INSERT 13 \*\*\*\*\*

|

5222 Mr. {Pallone.} Thank you, Mr. Conklin.

5223 Mr. Arensmeyer.

|  
5224 ^STATEMENT OF JOHN ARENSMEYER

5225 } Mr. {Arensmeyer.} Thank you, Chairman Pallone, Ranking  
5226 Member Deal and members of the committee. Small Business  
5227 Majority appreciates this opportunity to present the small  
5228 business perspective on the House tri-committee draft health  
5229 care reform plan. We support the effort to move this  
5230 legislation through Congress expeditiously, and thank you for  
5231 bringing a proposal forward in such a timely manner.

5232 Small Business Majority is a nonprofit, nonpartisan  
5233 organization founded and run by small business owners and  
5234 focused on solving the biggest single problem facing small  
5235 businesses today, the skyrocketing cost of health care. We  
5236 represent the 27 million Americans who are self-employed or  
5237 own businesses of up to 100 employees. Our organization uses  
5238 scientific research to understand and represent the interests  
5239 of all small businesses. I have been an entrepreneur for  
5240 more than 20 years including 12 years owning and managing an  
5241 Internet communications company. Together with the other  
5242 senior managers in our organization, we have a total of 70  
5243 years running successful small businesses ranging from high  
5244 tech to food production to retail. We hear stories every day  
5245 from small business owners who can't get affordable coverage

5246 and for whom health care is a scary, unpredictable expense.  
5247 Louise Hardaway, a would-be entrepreneur in Nashville,  
5248 Tennessee, had to abandon her business stream after just a  
5249 few months because she couldn't get decent coverage. One  
5250 company quoted her a \$13,000 monthly premium for her and one  
5251 other employee. Others such as Larry Pearson, owner of a  
5252 mail order bakery in Santa Cruz, California, struggle to do  
5253 the right thing and provide health care coverage. Larry  
5254 notes that, ``The tremendous downside to being uninsured can  
5255 be instant poverty and bankruptcy, and that is not something  
5256 my employees deserve.'' Our polling confirms that  
5257 controlling health care costs is small business owners'  
5258 number one concern. Indeed, on average, we pay 18 percent  
5259 more than big businesses do for health care coverage.

5260 An economic study that we released earlier this month  
5261 based on research by noted M.I.T. economist Jonathan Gruber  
5262 found that without reform, health care will cost small  
5263 businesses \$24 trillion over the next 10 years. As such, we  
5264 are pleased to see that the House bill addresses key cost  
5265 containment measures such as expanded use of health IT,  
5266 transparency, prevention, primary care and chronic disease  
5267 management.

5268 Our polling shows that 80 percent of small business  
5269 owners believe that the key to controlling costs is a

5270 marketplace where there is healthy competition. To this end,  
5271 there must be an insurance exchange that is well designed and  
5272 robust. We are very pleased that the committee's bill  
5273 proposes a national insurance marketplace with the option for  
5274 state or regional exchanges that adhere to national rules.  
5275 Moreover, we encouraged by the committee's proposal that  
5276 there be standardized benefit packages along with guaranteed  
5277 coverage without regard to preexisting conditions or health  
5278 status, a cap on premiums and out-of-pocket costs and  
5279 marketplace transparency.

5280         We understand that a balanced set of reforms will  
5281 require everyone to participate. Sixty-six percent of small  
5282 business owners in our recent polls in 16 States for which we  
5283 released preliminary data this week support the idea that the  
5284 responsibility for financing a health care system should be  
5285 shared among individuals, employers, providers and  
5286 government. It should be noted that respondents to our  
5287 surveys included an average of 17 percent more Republicans at  
5288 40 percent than Democrats at 23 percent while 28 percent  
5289 identified as independent.

5290         According to the results of the economic modeling done  
5291 for us by Professor Gruber, comprehensive reform that  
5292 includes even modest cost containment measures and a well-  
5293 designed structure for employer responsibility will offer

5294 vast improvement over the status quo. A system with  
5295 appropriate levels of tax credits, sliding scales and  
5296 exclusions will give small businesses the relief they need,  
5297 potentially saving us as much as \$855 billion over the next  
5298 10 years, reducing lost wages by up to \$339 billion and  
5299 restoring job losses by up to 72 percent. We are very  
5300 pleased that the committees have addressed some of the  
5301 affordability concerns of the smallest businesses. Professor  
5302 Gruber has modeled specific scenarios described in detail in  
5303 our report and we look forward to working with you to ensure  
5304 the best balance between the need to finance the system and  
5305 our ability to pay.

5306 Finally, another issue of great concern to us is the  
5307 unfair tax treatment of the 21 million self-employed  
5308 Americans. Under the current tax code, self-employed  
5309 individuals are unable to deduct premiums as a business  
5310 expense and are required to pay an additional 15.3 percent  
5311 self-employment tax on their health care costs. We encourage  
5312 that this inequity be rectified in the final bill passed by  
5313 the House.

5314 In closing, health care premiums have spiraled out of  
5315 control, placing our economy and the fortunes of small  
5316 business in peril. Health care reform is not an ideological  
5317 issue, it is an economic and practical one. We are

5318 encouraged by the overall approach of this bill and look  
5319 forward to working with you to make it a reality this year.

5320 Thank you.

5321 [The prepared statement of Mr. Arensmeyer follows:]

5322 \*\*\*\*\* INSERT 14 \*\*\*\*\*

|

5323 Mr. {Pallone.} Thank you, Mr. Arensmeyer.

5324 Mr. Shea.

|  
5325 ^STATEMENT OF GERALD M. SHEA

5326 } Mr. {Shea.} Good afternoon, Chairman Pallone and  
5327 Congresswoman Capps. I really appreciate the opportunity to  
5328 share the views of the AFL-CIO on this critically important  
5329 issue.

5330 I want to start by saying a hearty congratulations on  
5331 producing a very good draft bill. I think you really  
5332 responded to what the American people have asked for, and we  
5333 look forward to working with you over the coming weeks to get  
5334 that bill enacted.

5335 You have decided to build health reform based on the  
5336 current system, therefore based largely on the employment-  
5337 based system, since that is the backbone of our health  
5338 coverage and health financing, and I want to direct my  
5339 remarks to that today, and I hope that the experience I  
5340 bring, which is the experience of unions that bargain  
5341 benefits for 50 million workers each year, will be of some  
5342 benefit to you. And the main thing I have to say is, if you  
5343 are going to proceed down this path, and we certainly support  
5344 it, then job number one is stabilizing employment-based  
5345 coverage. It has proved remarkably resilient in the face of  
5346 high cost pressures but it is in fragile shape today. From

5347 2000 to 2007, we lost five full percentage points on the  
5348 number of 18- to 64-year-old working Americans who were  
5349 covered, and the underinsured rate, people who have insurance  
5350 but really can't afford to get care under it, shot up from 16  
5351 percent to 25 percent in the last 4 years. So despite the  
5352 fact that it is still hanging on, employment-based coverage  
5353 is really eroding very rapidly, and to stabilize that  
5354 coverage, we would suggest that you focus first of all on  
5355 cost, secondly on having everyone involved in coverage and in  
5356 the system, and thirdly, and I don't mean these in rank  
5357 order, they are really all important, thirdly, reform of the  
5358 delivery system.

5359         Let me start with participation because in some ways  
5360 that is the simplest. If you are going to base this on  
5361 employment-based coverage, we think it makes simple sense, as  
5362 you have done in your bill, to require that everyone, every  
5363 individual participate and take responsibility to some  
5364 extent, certainly responsibility for their own health status,  
5365 and every employer to participate, and that is included in  
5366 your bill, and the benefits of this are simple. It helps  
5367 bring people into the system, it does stabilize the  
5368 employment-based coverage, it helps reduce the amount of  
5369 federal tax dollars that you have to spent because everybody  
5370 who is covered by an employer plan will not be dependent on

5371 monies that you have to raise and put into this bill for  
5372 subsidies. It levels the playing field between employers who  
5373 now do provide and those who don't. And there really are  
5374 just three categories of workers in terms of their insurance  
5375 coverage. The vast majority, as you know, get insurance  
5376 coverage at work, some 92 percent of the employers of 50 or  
5377 above workers provide health insurance. There are some  
5378 employers who don't provide insurance but certainly are well  
5379 enough off to do that. The example of the Lobby Shop in  
5380 Washington comes to mind. And then there are a group of low-  
5381 wage, small employers who really need a lot of help to do  
5382 this. Our suggestion is that everyone be included in this, no  
5383 exemptions, because once you start exempting people, we think  
5384 you are going to run into distortions in the marketplace as  
5385 now exist, but we do think it is appropriate, as you have  
5386 done, to provide tax subsidies for employers with low wage  
5387 and small numbers of employers and I would emphasize that we  
5388 don't think there are just small numbers of employees, it  
5389 actually it is some measure of the financial stability or  
5390 success of the firm that should be taken into account.

5391         Secondly, in terms of controlling costs, the most  
5392 important thing we can do is to change the delivery system.  
5393 If the Institute of Medicine estimate of 30 percent waste in  
5394 the system is anywhere near correct, we could easily pay for

5395 health reform and cover all of the uninsured if we can get a  
5396 substantial amount, not all of that but a substantial amount  
5397 of that waste out of the system. So that is the most  
5398 important thing, and your bill includes a number of good  
5399 provisions on that. We are working with your staff because  
5400 we think they could be strengthened in a number of areas but  
5401 we think you have made a very good start. However, in the  
5402 short term, that is really not going to do the job. You are  
5403 going to need to do something else, and there are only two  
5404 options in our view as to how to do this in the short term.  
5405 One is to do it by regulation. You could do global budgets  
5406 or set rates, and the other is to introduce competition into  
5407 the marketplace that now doesn't exist, and you have chosen  
5408 the idea of competition through a public health insurance  
5409 plan and we strongly support that. I would just point out  
5410 that there is an additional advantage of a public health  
5411 insurance program in that it can be a leader in reform of the  
5412 system as Medicare is now. I deal with a lot of employers  
5413 and a lot of unions who have wanted to change the delivery  
5414 system for the better over the past few years but it wasn't  
5415 until Medicare started to change their payment rates that  
5416 this really started to happen.

5417           And then lastly, looking at the delivery system, I  
5418 think, as I said, that there is plenty of money in it to pay

5419 for reform, but we are not going to get that money back very  
5420 quickly and some people are talking about having to pay for  
5421 reform totally out of the current money in the system, which  
5422 we think is just very unrealistic. We think you have to look  
5423 outside for additional monies, and if you take the view that  
5424 you have to look inside, you may well get to the very  
5425 dangerous territory of the Senate Finance Committee talking  
5426 about taxation of benefits, which we think would be a  
5427 disastrous approach. It is unfair to the people involved  
5428 since they already pay an arm and a leg, many of them, for  
5429 health coverage, and it is unfair in terms of the inequities  
5430 built into this, workers who are older, groups that have  
5431 families, groups that have more retirees will have much  
5432 higher costs. And then there is the simple political dynamic  
5433 of this. If you want to throw a monkey wrench into public  
5434 support to health reform, this would be the perfect way to do  
5435 it because in the process you would really, really turn the  
5436 apple cart upside down in employment-based coverage.

5437 Thank you, Mr. Chairman.

5438 [The prepared statement of Mr. Shea follows:]

5439 \*\*\*\*\* INSERT 15 \*\*\*\*\*

|

5440 Mr. {Pallone.} Thank you, Mr. Shea.

5441 Mr. Rivera.

|  
5442 ^STATEMENT OF DENNIS RIVERA

5443 } Mr. {Rivera.} Thank you. I am chair of SEIU Health  
5444 Care, the 1.2 million health care workers who are committed  
5445 to reforming our Nation's broken health care system. We  
5446 represent members like Pat DeJong of Libby, Montana, who  
5447 works as a home care aide. Pat and her husband Dan were  
5448 ranchers but had a hard time finding affordable coverage and  
5449 were uninsured when he was diagnosed with Hodgkin's lymphoma  
5450 in the year 2000. The medical bills piled up for Pat and  
5451 Dan, eventually forcing them to sell the land they loved and  
5452 that has been in Dan's family for generations. Dan succumbed  
5453 to cancer and Pat remains uninsured. This is America. We  
5454 can and we must do better for hardworking families like the  
5455 DeJongs. Americans are ready to fix health care and they  
5456 know that this is the year it must happen. Now it is up to  
5457 you to deliver Pat and the millions who face the consequences  
5458 of our broken health care system with a real choice of  
5459 affordable, quality, private and public health care coverage.  
5460 SEIU's 1.2 million health care workers in hospitals, clinics,  
5461 nursing homes and in homes in communities are at the bedside  
5462 every day witnessing high-price families pay for the delay  
5463 and skip medical treatments. The uninsured are not just a

5464 statistic. They are hardworking people, people such as Pat,  
5465 who despite caring for those who cannot care for themselves,  
5466 cannot afford health care coverage for herself.

5467         The discussion draft includes many essential elements  
5468 that would promote coverage and access, cost containment and  
5469 improve quality and value for American families. A strong  
5470 public health insurance option is vital to ensuring consumer  
5471 choice and access. The public plan will drive down the cost  
5472 of insurance by competing with private insurance and lowering  
5473 overall costs.

5474         Medicaid expansion--we support increase in Medicaid  
5475 eligibility for families up to 133 percent of federal  
5476 poverty. The discussion draft will also improve Medicaid  
5477 payments to primary care practitioners to address concerns  
5478 about access to needed services by Medicaid beneficiaries.  
5479 We caution the committee that safety-net providers and  
5480 systems must be protected to provide access and support to  
5481 low-income communities and to maintain a mission that  
5482 includes trauma care and disaster preparedness. Special  
5483 payment to these facilities such as the disproportionate  
5484 share payments must be maintained as coverage expands. In  
5485 addition, essential community providers must be included in  
5486 insurance plans that serve Medicaid beneficiaries and  
5487 individuals eligible for health care credits.

5488 Health care reform needs to work for everyone including  
5489 the 4 million American citizens who reside in Puerto Rico,  
5490 and we urge Congress to include Puerto Rico and all the  
5491 territories in all parts of health care reform. SEIU is  
5492 pleased to see that the committee has recognized the need to  
5493 improve the treatment of Puerto Rico and the territories  
5494 under Medicaid by increasing the caps and federal matching  
5495 rates. While this is an important step in the right  
5496 direction, it falls short of resolving the longstanding  
5497 inequities in federal health care programs that have been  
5498 hurting the people of Puerto Rico for decades.

5499 Shared responsibility. Employers, individuals and  
5500 government must all do their part to make sure we have a  
5501 sustainable and affordable system that covers everybody. For  
5502 employers that do not provide meaningful coverage to their  
5503 employees, they must pay into a fund. This pay-or-play  
5504 requirement is necessary to ensure individuals can meet their  
5505 responsibility to obtain affordable coverage with special  
5506 support provisions to provide small businesses with tax  
5507 credits and access to an insurance exchange to help them  
5508 purchase coverage for their employees.

5509 Affordability. Individuals' responsibility must be  
5510 augmented by measures to ensure affordability. We commend  
5511 the committee for offering federal financial assistance to

5512 individuals and families with low and moderate income and  
5513 those with high health care costs relative to their income to  
5514 guarantee affordability.

5515           Eliminating disparities--We congratulate the committee  
5516 for recognizing disparities in access to quality health care.  
5517 No one should be discriminated for preexisting conditions.  
5518 No one should be discriminated for being low income,  
5519 minority, disabled or aged.

5520           Workforce. As coverage grows, so much the health care  
5521 workforce. Today there are chronic shortages in almost every  
5522 area of health care from primary care physicians to nurses to  
5523 long-term-care workers. Health care reform to be effective  
5524 must include a diverse, well-trained workforce that is  
5525 working in the appropriate setting across the delivery system  
5526 and is well distributed in both urban and rural areas.

5527           This is your moment, your moment to ensure that Pat  
5528 DeJong and millions of other hardworking Americans do not  
5529 have to wait any longer in America for quality, affordable  
5530 health care coverage. The time is now. We cannot wait.

5531           [The prepared statement of Mr. Rivera follows:]

5532 \*\*\*\*\* INSERT 16 \*\*\*\*\*

|  
5533 Mr. {Pallone.} Thank you, Mr. Rivera.

5534 I wanted to apologize to Mr. Castellani because I said  
5535 that you represented the Business Roundtable Institute for  
5536 Corporate Ethics, and apparently it is just the Business  
5537 Roundtable.

5538 Mr. {Castellani.} I am president of the Business  
5539 Roundtable. I am a member of the board of directors of the  
5540 Business Roundtable Institute for Corporate Ethics. That is  
5541 probably--

5542 Mr. {Pallone.} Oh, I see. Okay. Well, thanks for  
5543 clarifying that.

|  
5544 ^STATEMENT OF JOHN CASTELLANI

5545 } Mr. {Castellani.} Thank you, Mr. Chairman. I am here  
5546 on behalf of the members of the Business Roundtable who are  
5547 the chief executive officers of America's leading  
5548 corporations. Collectively, they count for more than \$5  
5549 trillion in annual revenues and 10 million employees but most  
5550 importantly they provide health care for 35 million  
5551 Americans. I appreciate the invitation to testify and I  
5552 share the urgency of this committee and the fellow panelists  
5553 that health care reform must be addressed now.

5554 Today I want to focus on key three messages. First, we  
5555 need to get health care costs under control. Second, we must  
5556 preserve the coverage for those 132 million Americans who  
5557 receive that coverage from their employer. And third, we  
5558 need a reformed insurance marketplace so that individuals and  
5559 small employers can afford and find affordable coverage.

5560 Let me address the draft legislation that you have  
5561 before the committee. First, let me thank you and the  
5562 committee of moving forward on health care reform. We view  
5563 that as very positive and necessary and we want to be  
5564 constructive in what we believe will work and what we believe  
5565 will not. We support the provisions that reform the

5566 insurance market so that there are more affordable coverage  
5567 options. The bill also includes a requirement that all  
5568 Americans get health insurance coverage and includes auto-  
5569 enrolling for individuals into SCHIP or Medicaid if indeed  
5570 they are eligible. We support both of those provisions and  
5571 also support offering subsidies to low-income Americans who  
5572 cannot afford coverage. The changes that you have included  
5573 in the Medicare programs and other efforts to make our health  
5574 care system more efficient are very positive. Medicare  
5575 payments do need to be adjusted and we will provide the  
5576 committee with comments on these and other issues.

5577         We do, however, have significant concerns about two  
5578 major issues in the draft legislation and hope that the  
5579 committee will consider some revisions. First, ERISA should  
5580 not be changed if reforms are to be built on the employer-  
5581 based system. The proposal before you would change some of  
5582 the ERISA rules. For example, it would impose minimum  
5583 benefit packages on our employees. Large employers design  
5584 innovative plans including wellness and prevention  
5585 initiatives that have been tremendously successful in helping  
5586 employees take greater control over their own health and yet  
5587 such programs which we believe are critical to the success of  
5588 health care reform would be jeopardized by a new federally  
5589 mandated benefit law.

5590           Second, we are very concerned about public plan  
5591 proposals that would compete in the private marketplace. As  
5592 large employers, we are concerned that our employees will  
5593 suffer from additional cost shifting that come from  
5594 inadequate government repayment to the providers. For that  
5595 reason, we are concerned that the kind of cost shifting that  
5596 we are dealing with now would be exacerbated. Further, the  
5597 government plan could erode existing worker coverage if  
5598 employees seek subsidized lower priced public option that  
5599 would diminish the people in our plans and would leave  
5600 employer-sponsored coverage with more expenses, most cost for  
5601 both employers and employees.

5602           Innovation, which we think is the key to modernizing our  
5603 health care system and getting our costs under control,  
5604 benefits improvements and how best to care for patients, we  
5605 believe come best from the private marketplace. We need to  
5606 preserve the energy and the commitment to improve our health  
5607 care market and we are concerned that government plans cannot  
5608 do that as well as the private sector. We urge the committee  
5609 to instead create even stronger rules to make the private  
5610 insurance marketplace more competitive and we want to help in  
5611 that effort.

5612           Business Roundtable believes that the search for  
5613 bipartisan consensus can begin by honoring the principles

5614 that we have outlined in our written testimony and by  
5615 crafting reform that is consistent with the uniquely American  
5616 principles that drive our economy: competition, innovation,  
5617 choice and a marketplace that serves everyone. On behalf of  
5618 our members, we pledge to work with you and all the members  
5619 of the committee to find workable solutions that let people  
5620 keep what they have today in a reformed health care system  
5621 that works better for everyone. Thank you.

5622 [The prepared statement of Mr. Castellani follows:]

5623 \*\*\*\*\* INSERT 17 \*\*\*\*\*

|

5624 Mr. {Pallone.} Thank you.

5625 Mr. Sheils.

|  
5626 ^STATEMENT OF JOHN SHEILS

5627 } Mr. {Sheils.} Hello. Good afternoon, Mr. Chairman. My  
5628 name is John Sheils. I am with the Lewin Group, and I have  
5629 specialized over the years in estimating the financial impact  
5630 of health reform proposals. We got your bill on Friday and  
5631 immediately went about doing some preliminary estimates on  
5632 coverage and the impact on provider incomes. Allison is  
5633 going to help me with some slides.

5634 [Slide.]

5635 The first slide, the system that the bill would  
5636 establish begins with, we have new health insurance exchange.  
5637 The exchange would provide a selection of coverage  
5638 opportunities. Most of them are private coverage that we are  
5639 familiar with but it would also offer a new public plan. The  
5640 impact that this program will have on coverage is going to be  
5641 drive by the groups that you are permitted to enroll. The  
5642 program would allow individuals, self-employed and small  
5643 firms, at least in the first year, to go through the exchange  
5644 to obtain their coverage. In the third year, the newly  
5645 established commissioner would have the authority to open the  
5646 exchange to firms of all sizes. The new public plan, we  
5647 predict, will attract a great many people because the

5648 premiums in the public plan will be much lower than for  
5649 private insurance, and because of that, we think that a great  
5650 many people are going to be attracted to it. Let us discuss  
5651 that a little bit.

5652 [Slide.]

5653 On the next slide, we summarize some of the payment  
5654 rates on the left side. You are using the Medicare hospital  
5655 reimbursement methodology, and under Medicare, payments are  
5656 equal to about 68 percent of what private payers have to pay  
5657 for the same services. For physicians' care, you pay about--  
5658 well, Medicare pays about 81 percent of what private  
5659 insurance pays. You are going to be adding another 5 percent  
5660 to that, so we are looking at about 85 percent of private  
5661 payers. And we also have some information here on what  
5662 happens to insurance administrative costs in the exchange.  
5663 The public plan will not have to worry--need an allowance for  
5664 profits and it will not pay commissions for brokers and  
5665 agents.

5666 [Slide.]

5667 The next chart shows what happens to premiums. For  
5668 family coverage for the enhanced benefits package described  
5669 in your legislation, in the private sector it would cost  
5670 about \$917 per family per month. Under the public plan, it  
5671 would cost about \$738 per family per month. That is savings

5672 of about \$2,200 a year, and we think that is going to draw a  
5673 lot of people into the public plan. Next page.

5674 [Slide.]

5675 On the right-hand side, we illustrate what happens to  
5676 coverage when the plan is open to all firms. The program  
5677 would reduce the number of uninsured by about 25 million  
5678 people. There would be an increase in Medicaid enrollment of  
5679 about 16 million people but we find 123 million people going  
5680 into the public plan. That is a reduction in private  
5681 coverage of about 113.5 million people. That is about 66  
5682 percent of all privately insured persons. This of course is  
5683 if and when the plan is opened up to firms of all sizes. If  
5684 it is limited to just firms less than 10 workers as in the  
5685 first year, you still get a reduction of about 25 million  
5686 people uninsured, still 16 million people with Medicaid  
5687 coverage but private coverage would drop by about 20 million  
5688 people. The public plan coverage would be 29 million people.  
5689 Next chart, please.

5690 [Slide.]

5691 This chart summarizes what happens to provider incomes  
5692 under the plan. On the right-hand side, we have the scenario  
5693 where all firms are eligible to participate in the program.  
5694 Hospital margin, which is hospital profit, net income  
5695 basically, would be reduced by about \$31 billion because of

5696 that. That is about a 70 percent reduction in hospital  
5697 margin. Physician net income would go down by about \$11  
5698 billion. That comes to, in terms of net income, that is an  
5699 average of about \$16,000 per year reduction in net income per  
5700 physician. On the left-hand side, we show what is happening  
5701 in the small firms, and this is really interesting because  
5702 under this scenario provider incomes actually go up. For  
5703 instance, hospital margin goes up by about \$17 billion. Much  
5704 of this has to do with the fact that we will have reduced  
5705 uncompensated care and they will be paid for services they  
5706 were providing for free before, and there will be new  
5707 services they will provide to newly insured people. The  
5708 physician net income would go up by about \$10 billion, and  
5709 the increase in income there is largely driven by the fact  
5710 that you are going to increase payments for primary care  
5711 under the Medicaid program.

5712 That sums it up, and I am out of time so I will turn it  
5713 over to my colleague here.

5714 [The prepared statement of Mr. Sheils follows:]

5715 \*\*\*\*\* INSERT 18 \*\*\*\*\*

|  
5716 ^STATEMENT OF MARTIN REISER

5717 } Mr. {Reiser.} Mr. Chairman and members of the  
5718 committee, I want to thank you for the opportunity to testify  
5719 about proposals to reform the U.S. health care system. I am  
5720 here today on behalf of the National Coalition on Benefits, a  
5721 coalition of 185 business trade associations and employers  
5722 that have joined together to work with Congress to strengthen  
5723 the employment-based system.

5724 The NCB supports health care reform that improves health  
5725 care quality and reduces costs. The NCB recently wrote  
5726 President Obama applauding his commitment to comprehensive,  
5727 bipartisan health care reform. We expressed our shared view  
5728 that a strategy to control costs must be the foundation of  
5729 any effort to improve the health care system. I have  
5730 included that letter in my written testimony.

5731 For many years, the American people have sent two clear  
5732 messages to elected officials. First, Americans want to see  
5733 change and improvements in both cost and access to health  
5734 care, and second, Americans like the health benefits they  
5735 receive through their employer. The NCB believes the  
5736 American people are right on both points. We do need change,  
5737 however, such change should not erode the part of the health

5738 care system that is working. The employer-sponsored model  
5739 works well because it allows the pooling of risks and because  
5740 group purchasing lowers health care costs, enabling those who  
5741 are less healthy to secure affordable coverage for themselves  
5742 and their families. ERISA and its federal framework allows  
5743 employers to offer equal, affordable and manageable benefits  
5744 regardless of where the employees live and work and without  
5745 being subject to the confusing patchwork of mandates,  
5746 restrictions and rules that vary from State to State.

5747         Yet as good as it is, the system is increasingly at  
5748 great risk. As President Obama has said, soaring health care  
5749 costs make our current course unsustainable. The National  
5750 Coalition on Benefits completely agrees. Unfortunately, we  
5751 are concerned that the legislative proposal released last  
5752 week does not provide meaningful cost savings for the overall  
5753 system. In an effort to expand coverage, cost containment  
5754 has not received the priority it demands. For several years,  
5755 employers have worked to make clear the issues that health  
5756 care reform must properly address to preserve the employment-  
5757 based system, control costs and lead to our support. To  
5758 date, we have not seen legislative proposals where each of  
5759 these core issues have been adequately resolved. I will  
5760 briefly discuss our concerns on ERISA, the employer mandate  
5761 and the public plan.

5762           If the objective is to build upon the employer-based  
5763 system that successfully covers more than 170 million  
5764 Americans, then employers must have the ability to determine  
5765 how best to meet the needs of their employees. Legislation  
5766 should not include changes to ERISA or other laws that would  
5767 risk hurting those who are highly satisfied with the health  
5768 care coverage they currently receive. The NCB opposes  
5769 provisions that alter the federal ERISA law remedy regime.  
5770 The existing structure encourages early out-of-court  
5771 resolution of disputes and provides a national uniform legal  
5772 framework to provide both employers and employees with  
5773 consistency and certainty. The draft of the legislation  
5774 would replace the successful structure with differing remedy  
5775 regimes depending on where the employers and employees attain  
5776 health coverage. All these differing bodies of law are  
5777 likely to result in contradictory decisions about plan  
5778 determination and would expose employers who obtain coverage  
5779 to the exchange to unlimited state law liability. In other  
5780 words, these legislative provisions would weaken the  
5781 employer-based system.

5782           We are also concerned about proposals that would limit  
5783 the flexibility of employers at a time when our country needs  
5784 employers to create jobs and invest in future growth.  
5785 Employer mandates including requirements to pay or play are

5786 not the answer to the health care problem because they  
5787 undermine our ability to address 2 key goals of health care  
5788 reform, coverage and affordability. On the public plan, we  
5789 do not believe a public plan can operate on a level playing  
5790 field and compete fairly if it acts as both a payer and a  
5791 regulator. A public plan that would use government-mandated  
5792 prices would result directly in a cost shift to other payers  
5793 and thus would do nothing to address the underlying problems  
5794 that make health coverage unaffordable for many. We already  
5795 experience that cost shift today as Medicare, the largest  
5796 payer in the United States, consistently underpays providers.

5797 In summary, we remain concerned about any provisions  
5798 that would make health care more costly for employers and  
5799 employees, to stabilize our employer-based system of health  
5800 coverage or restrict the flexibility of employers to provide  
5801 innovative health plans that meet the needs of their  
5802 employees. As Congress moves forward to formal consideration  
5803 of the legislation, we want to continue to work with all  
5804 members of Congress to enact reforms that not only allow  
5805 Americans to keep the coverage they have today if they like  
5806 it, and for most Americans that means their employer-based  
5807 coverage, but make it possible for them to count on it being  
5808 there tomorrow when they need it.

5809 [The prepared statement of Mr. Reiser follows:]

5810 \*\*\*\*\* INSERT 19 \*\*\*\*\*

|

5811           Mr. {Pallone.} Thank you, and thank you all. I am  
5812 going to start, and I am going to try to get a lot in in my 5  
5813 minutes here so bear with me if you don't mind. Mr. Shea,  
5814 you expressed concern about taxing health care benefits. And  
5815 you know, and you acknowledge in your testimony, this came  
5816 from the Senate, not from the President, not from the House,  
5817 needless to say. My concern is that, you know, a stated  
5818 purpose of this reform is to let people keep what they have  
5819 and to keep what they have, and of course that implies  
5820 employer, not only for employer benefits, but whoever has an  
5821 insurance policy that they have. So I mean if you just want  
5822 to tell me briefly what the consequences would be. I mean I  
5823 know everything is on the table, but this is something that I  
5824 am concerned about. Just briefly.

5825           Mr. {Shea.} What was it that somebody said about some  
5826 things are moving off the table, but we hope this is in that  
5827 category. The main thing that would happen is destabilized  
5828 employment coverage which, as I said, is exactly the opposite  
5829 direction for where we need to go because it would change the  
5830 relationship between employees and employers around this very  
5831 important part of their compensation. Some employees who are  
5832 younger might say, well, gee, I really don't need to be part  
5833 of the group plan. I am going to go off since it is now

5834 taxed money. Secondly, it would penalize certain groups of  
5835 workers because of their health status essentially. We  
5836 looked at health funds--

5837 Mr. {Pallone.} I am going to stop you because, you  
5838 know, I appreciate what you are saying but I got to ask Mr.  
5839 Rivera a question. He stressed the pay to play requirements  
5840 for businesses and, of course, we get criticisms of this,  
5841 and, you know, a suggestion that, you know, it is going to  
5842 hurt business. Why do you think the pay to play requirement  
5843 is necessary for, you know--why do you think it is a good  
5844 idea basically?

5845 Mr. {Rivera.} Because we believe at this moment some of  
5846 the employers--the employers who basically are providing  
5847 health care are basically subsidizing those who are not  
5848 providing health care. For example, on average health  
5849 insurance is about between \$1,300 to \$1,500 more for the cost  
5850 of a family insurance, and those who don't provide health  
5851 care coverage to their employees are basically on the free  
5852 ride here. That is basically it.

5853 Mr. {Pallone.} Okay. And what about the public option?  
5854 You know, you said you are supportive of it. Obviously, it  
5855 is in the discussion draft. Are insurance market performance  
5856 enough to drive down costs and ensure coverage for all or do  
5857 you think the public option is an essential piece of the

5858 reform?

5859 Mr. {Rivera.} We believe that it is an essential part  
5860 of the reform, sir, and we believe that it will be a very  
5861 important contribution to lowering the cost of health care.  
5862 And basically this is America where we all can compete and  
5863 this is another way of competing to lower the cost, sir.

5864 Mr. {Pallone.} Okay. Mr. Sheils, I am going to you  
5865 last here. I got about 2 minutes left. You criticize the  
5866 public option and just for purposes of full disclosure the  
5867 study you mentioned, my understanding, and tell me if I am  
5868 wrong, is it was completely funded by an insurance company.  
5869 You said in your written testimony you are the senior vice  
5870 president of the Lewin Group and your group is--my  
5871 understanding is your group is 100 percent funded by United  
5872 Health Group, one of the largest insurance companies in the  
5873 country. Is that accurate?

5874 Mr. {Sheils.} We are owned by United Health. We have a  
5875 36-year tradition of doing--

5876 Mr. {Pallone.} But it is 100 percent owned by United  
5877 Health.

5878 Mr. {Sheils.} I would like to finish.

5879 Mr. {Pallone.} Well, let me get to the next thing and  
5880 you can probably can respond to it--

5881 Mr. {Sheils.} Anyway, about 2 years ago and at that

5882 point we were--but our work is completely independent. We  
5883 have complete editorial control over our work.

5884 Mr. {Pallone.} But I mean the group is 100 percent  
5885 funded by United Health, right?

5886 Mr. {Sheils.} Well, we are a consulting firm. We are  
5887 funded by the work we negotiate with the clients, so I work  
5888 for the Commonwealth Fund, I work for Families, USA, I work  
5889 for Blue Cross/Blue Shield.

5890 Mr. {Pallone.} Well, what about this study?

5891 Mr. {Sheils.} This study?

5892 Mr. {Pallone.} Yeah.

5893 Mr. {Sheils.} This study was done on our own nickel.

5894 Mr. {Pallone.} But who funded it?

5895 Mr. {Sheils.} Well, we just did our own nickel. We did  
5896 it out of our firm's overhead.

5897 Mr. {Pallone.} Did United Health directly or indirectly  
5898 pay for it because they are funding you? I am just trying to  
5899 get an answer to that.

5900 Mr. {Sheils.} You could say it that way but United  
5901 Health did not review any of our materials.

5902 Mr. {Pallone.} Okay. The only reason I mentioned it is  
5903 our committee conducted an investigation of United Health and  
5904 we found that the company had incredible profitability. In  
5905 2004 their net income was \$2.6 billion, 2005 it grew to \$3.3

5906 billion, 2007 it went up to \$4.7 billion. Even last year at  
5907 the height of the financial collapse, the company's net  
5908 income was \$3 billion. And then in 2005 the CEO of United  
5909 Health, William McGuire, was the third highest paid CEO in  
5910 the country according to Forbes magazine. He resigned in  
5911 2006 after the SEC launched an investigation involving the  
5912 back dating of stock options, but United Health gave him a  
5913 severance pay of \$1.1 billion, which was stunning to me. I  
5914 mean do you think it is appropriate for United Health to pay  
5915 the CEO more than a billion dollars severance?

5916         Mr. {Sheils.} I don't have--if I were at the pay level  
5917 where I would even know this stuff, it would be a much  
5918 different spot. We were a firm that was bought by Genex  
5919 which is owned by United Health. We don't get involved in  
5920 anything like that and there is nobody in our firm who ever  
5921 sees income of that type. You can only imagine how surprised  
5922 we were when 2 years ago we were bought. They quickly  
5923 assured us that they wanted us to maintain editorial control  
5924 of our work to continue our 36-year tradition of non-biased,  
5925 objective, non-partisan work.

5926         Mr. {Pallone.} All right. Thank you.

5927         Mr. {Sheils.} That is all I am about.

5928         Mr. {Pallone.} I appreciate that. Thank you. Mr.  
5929 Whitfield.

5930           Mr. {Whitfield.} Thank you, Mr. Chairman. And I want  
5931 to thank all of you on the witness panel for being with us  
5932 today. We genuinely appreciate your testimony as all of us  
5933 attempt to get through this legislation and understand as  
5934 best we can what the ramifications and implications of the  
5935 legislation will be. We hear a lot of discussion about the  
5936 public plan, the public option, and I know some of you are  
5937 opposed to it, some of you support it. What I hear most of  
5938 all from members of the committee the concern is that if you  
5939 have a public plan many people will leave the private plan,  
5940 their employer plan, and go join that plan because the costs  
5941 are lower, which is certainly understandable. But eventually  
5942 you can basically destroy the employer plans because everyone  
5943 is going to leave and then you will end up with one big  
5944 government plan.

5945           And maybe that is okay except the Medicare system can be  
5946 criticized in many ways, particularly because of the cost  
5947 escalations and I am saying that because Medicare is  
5948 basically a U.S. government plan and if this public option  
5949 goes the way some people will say that is going to be a big  
5950 government plan. And I will make one comment. In 1965 when  
5951 they started the Medicare program the Congressional Budget  
5952 Office did a forecast that in 1990 that plan would cost \$9  
5953 billion. It turned out to be almost \$200 billion by 1990, so

5954 that is an astronomical miscalculation. So, Mr. Shea, you  
5955 represent the AFL-CIO?

5956 Mr. {Shea.} Yes, sir.

5957 Mr. {Whitfield.} Okay. Well, tell me, the argument  
5958 that I made that if it is less expensive more people are  
5959 going to move over there and it is going to weaken the  
5960 private system. Does that concern you or do you think that  
5961 that argument has merit?

5962 Mr. {Shea.} Well, as I said, Congressman, we start out  
5963 saying that we need to address cost containment just like  
5964 others on the panel said that is job number 1. If we don't  
5965 control these costs nothing else is going to be done in  
5966 health care. So how do you do that? Well, there is several  
5967 ways to do it but the public health insurance plan is one.  
5968 You can calibrate the rates in the public insurance plan.  
5969 This plan proposes Medicare rates. You could do Medicare  
5970 plus 10 percent or you could do halfway between private.  
5971 That would all affect this. But the notion is to put some  
5972 competition in the insurance market that now doesn't display  
5973 any competition. What we have are really close relationships  
5974 in my view between insurers and providers, and that is the  
5975 problem that we have to change. It was what Mr. Conklin was  
5976 talking about. We are just trapped by this. So there are  
5977 other ways to do it but this is what the competitive model

5978 is--

5979 Mr. {Whitfield.} Okay. Thank you. There are other  
5980 ways to do it. Mr. Reiser, will you make a comment on the  
5981 argument that I put out there that people are making?

5982 Mr. {Reiser.} The concern that we have about the public  
5983 plan option is Medicare currently underpays, and there is a  
5984 significant cost shift onto the private employers which is a  
5985 big problem in the current system. A public plan option, we  
5986 believe, would exacerbate that, particularly a public plan  
5987 option as outlined in the proposal that would pay Medicare  
5988 rates so that would just exacerbate the system. The second  
5989 problem that we see with it is if people do leave the  
5990 employer pool, that is going to weaken our risk pool and lead  
5991 to higher costs for the remaining employees, and over time  
5992 will weaken and potentially destroy the employment-based  
5993 system.

5994 Mr. {Whitfield.} Yes, sir, Mr. Rivera.

5995 Mr. {Rivera.} One of the things that we have in New  
5996 York State a health care plan which provides health care for  
5997 health care workers in the greater New York metropolitan  
5998 area, and we pay about \$8,500 for family insurance. Upstate  
5999 New York where only one of the insurance companies basically  
6000 dominates the market, we pay close to \$17,000 so basically  
6001 the idea of the public plan is to come into markets where

6002 basically are concentrated by only one insurance company, and  
6003 there is a case of Maine, New Hampshire, and you can see high  
6004 cost areas where basically the lack of competition that  
6005 basically insurance companies don't come into those areas and  
6006 the cost of health care goes up.

6007           Mr. {Whitfield.} Mr. Castellani, I know the Business  
6008 Roundtable is comprised of very large companies but what are  
6009 your views on the pay or play provisions of this bill?

6010           Mr. {Castellani.} Well, pay or play is almost an  
6011 academic issue for us because indeed on the surface all of  
6012 our members provide health care, and we want to continue  
6013 providing it. The problem that we see with the concept of  
6014 pay or play is that we need to bring into the healthcare  
6015 system all those people who are currently not covered or  
6016 can't afford to be covered because we are paying for them  
6017 through the kind of cross subsidies that Mr. Reiser referred  
6018 to. We do not see the merit of forcing companies to buy  
6019 something that they cannot afford, particularly the small  
6020 businesses. And so pay or play we think can be dealt with if  
6021 we provide the kind of competition that both Mr. Rivera and I  
6022 think all of us would agree on but we think it is best  
6023 provided through reforms in the insurance market because in  
6024 addition to what Mr. Reiser said, that is, the public option  
6025 plan exacerbates the cost shift. It potentially erodes our

6026 risk pool and causes younger, healthier people to leave,  
6027 quite frankly, and get a lower premium.

6028         But it also does something else that hurts what we all  
6029 want and we all talk about, and that is we see much more  
6030 innovation in terms of delivery, in terms of wellness, in  
6031 terms of prevention, in terms of quality, in terms of  
6032 information technology, the kinds of things that will reduce  
6033 costs and increase quality coming out of the private sector.  
6034 We are concerned that a government run program as we see now  
6035 in Medicare and Medicaid just doesn't have the ability to  
6036 innovate, so we also lose out on the ability to gain from  
6037 those innovations.

6038         Mr. {Whitfield.} Thank you. I think my time has  
6039 expired.

6040         Mr. {Pallone.} Ms. Capps, our vice chair.

6041         Mrs. {Capps.} Thank each of you for your presentations.  
6042 It has been a good panel. You waited a long time, many of  
6043 you, because it has been a very long day of presentation and  
6044 different panels on this topic of health care reform. I have  
6045 questions for two of you because there is not enough time,  
6046 only 5 minutes, and my first question will be for Mr. Rivera  
6047 with SCIU. In your testimony, Mr. Rivera, you expressed that  
6048 individual responsibility must be augmented by measures to  
6049 ensure affordability. It seems fair to think that our health

6050 care system should meet hard-working Americans halfway. For  
6051 this reason, SCIU supports affordability credit for families  
6052 between 133 percent and 400 percent of the federal poverty  
6053 line. Why do you believe it is necessary to offer these  
6054 credits for families up to 400 percent of the poverty level?

6055 Mr. {Rivera.} Part of the problem that we have is the  
6056 incredible cost of health care these days. For example, in  
6057 the case of SEIU almost 50 percent of the members of our  
6058 union basically live on very meager means, less than \$35,000,  
6059 so when you take into account on one hand the high cost of  
6060 health care and the disposable income you can see that  
6061 basically in order to make it meaningful you have to have  
6062 subsidies.

6063 Mrs. {Capps.} So you are talking about your work force,  
6064 hard-working men and women with raising a family and trying  
6065 to have a quality of life in this country, not at all  
6066 luxurious, but still they are doing essential work in their  
6067 communities and they should have a decent health care system,  
6068 and so you are wanting to provide--

6069 Mr. {Rivera.} As a matter of fact, the overwhelming  
6070 majority of Americans who don't have health care coverage are  
6071 working people who make more money than to qualify for  
6072 Medicaid and are not enough to qualify for Medicare and then  
6073 the question that they have--

6074 Mrs. {Capps.} Which shows you one of the disparities  
6075 that the premiums are so expensive that you really--if you  
6076 are going to have your own private insurance plan, self-  
6077 employed or whatever, you have to be upper middle class or  
6078 wealthy in order to pay for it, and that is one of the major  
6079 challenges that we face in this country right now. I am sure  
6080 you would say that. Are there some other protections? We  
6081 are talking about middle class, right, or at least what we  
6082 want to consider as the middle class, the working class, the  
6083 hard-working people who keep this country going whether in  
6084 small businesses or in large companies providing labor or  
6085 providing management. What other projections do you believe  
6086 are necessary to make health care more affordable for the  
6087 middle class? This is a big question, but I want to also  
6088 move on to another subject.

6089 Mr. {Rivera.} I think the fundamental question that we  
6090 have is that we are spending 17-1/2 percent of our gross  
6091 domestic product on health care, and if we do not--and I  
6092 think my colleague, Mr. Shea, was talking about it, if we  
6093 don't resolve the problem of the cost controls we are not  
6094 going--

6095 Mrs. {Capps.} I see other people nodding your heads.  
6096 Is this sort of a given that this is one of the major  
6097 challenges that--and one of the reasons that you are

6098 participating is because we need reform to deal with this in  
6099 some aspect. I appreciate that. You are a very diverse  
6100 group, I might add. I think there is quite a cross section  
6101 here. That is interesting. I would like to now turn for the  
6102 last couple minutes to you, Mr. Sheils, just some particular  
6103 questions about what you were talking about. Your analysis  
6104 suggested a public option can get lower premiums than private  
6105 plans. Some of our colleagues are making the--come to the  
6106 conclusion that this disparity--that a private plan is not  
6107 even going to be able to compete with the public option.  
6108 Does your model assume that private insurers and large  
6109 employer purchases are simply price takers with no ability to  
6110 add value or change behavior in a competitive market? In  
6111 other words, it is so monolithic in that private world that  
6112 there is no ability to compete?

6113 Mr. {Sheils.} Well, we don't conclude that they cannot  
6114 compete. We conclude that there are only certain types of  
6115 plans that could survive, and those would be integrated  
6116 delivery systems like some of the better HMO type models. I  
6117 would like to explain that though because there are some key  
6118 issues here. Right now a lot of the insurers get price  
6119 discounts with providers.

6120 Mrs. {Capps.} Right.

6121 Mr. {Sheils.} Having to do with the fact that they make

6122 volume discounts. They say to a hospital I will bring you  
6123 all 100,000 of my people for their hospital care if you will  
6124 give me a break. Now if everybody goes to the public plan  
6125 and the private health plan only has 10,000 people left in  
6126 it--

6127 Mrs. {Capps.} The public plan is not going to be able  
6128 to offer that, is it? That is pretty competitive.

6129 Mr. {Sheils.} I wanted to finish my--my point is if  
6130 there is only 10,000 people left in the private insurance  
6131 plan then they are not going to be able to negotiate  
6132 discounts that are as deep as what they can get today.

6133 Mrs. {Capps.} And that is the only way they can be  
6134 competitive.

6135 Mr. {Sheils.} Right.

6136 Mrs. {Capps.} I would hope that there would be a lot  
6137 more creativity within the private sector. I will get to you  
6138 but--but you said I could have a little more time because of  
6139 that terribly disruptive moment there. Anyway, maybe you or  
6140 someone else would comment about some of the larger markets  
6141 like Los Angeles, New York City, private plans sitting below  
6142 Medicare fee for service levels. How do you factor that into  
6143 it and then I will open it up if there is time?

6144 Mr. {Sheils.} Well, there are places where there are  
6145 smaller disparities between Medicare and private, and then

6146 there are places where there is much larger disparity. In  
6147 those areas where you have large disparities, we get quite a  
6148 bit of shake up. In areas where there is little disparity it  
6149 doesn't really show us very much of a change.

6150 Mrs. {Capps.} Another comment on this with the other--

6151 Mr. {Shea.} Just on the whole dynamic. I think what is  
6152 important to bear in mind about the Lewin analysis is that it  
6153 is based on the prices. Your point is just price taking.  
6154 Employers, and you could ask people on this panel, employers  
6155 make decisions based on more than price in health care. This  
6156 is a very--

6157 Mrs. {Capps.} Is that a valid point? May I ask for  
6158 corroboration?

6159 Mr. {Pallone.} One more and then I think we got to move  
6160 on.

6161 Mrs. {Capps.} Okay. I would hope so because I would  
6162 hope that we would have a little more creativity in the  
6163 private market. We actually need that competition because  
6164 this is too big for anyone's response. Many of us feel that  
6165 way, and I think that is a feature of the public option is  
6166 that it will be competition and it will be a competitive  
6167 market place. In my congressional district it isn't  
6168 competitive at all. It is rural and there is only one  
6169 private provider. So, you know, this is a thoroughly needed

6170 situation. I will yield back, Mr. Chairman.

6171 Mr. {Pallone.} Mr. Gingrey.

6172 Mr. {Gingrey.} Mr. Chairman, thank you. Let me direct  
6173 my question to Mr. Castellani of the Business Roundtable.  
6174 Mr. Castellani, could you explain to us how the public plan  
6175 proposals would undermine the private insurance industry that  
6176 many Americans are very happy with, and I am not--quite  
6177 honestly, I have read some of your testimony, and I am not  
6178 sure where you are on this public plan proposal. In the  
6179 interest of full disclosure, I am concerned about it so that  
6180 is the reason for my question.

6181 Mr. {Castellani.} Yes, sir. What we are concerned  
6182 about is not that it would undermine although it would the  
6183 private insurance but it would undermine our ability as  
6184 employers to provide health care for our employees through  
6185 the private insurance market. And it is for the reasons that  
6186 we have discussed here and it is primarily three. We do  
6187 agree with competition. What Congresswoman Capps was  
6188 addressing is what we think is part of the solution. We need  
6189 greater competition, but that competition has to be on a  
6190 level playing field. If a government plan exists and it has  
6191 all the elements of a private plan except it is not required  
6192 to pay its investors back a fair return on their investment,  
6193 the taxpayers in this case, then it can and will by

6194 definition have a lower premium cost. So the first effect is  
6195 we would lose people who could qualify and would move to that  
6196 lower premium from our plan.

6197 As a result of that, they will tend to be younger and  
6198 tend to be healthier employees. Our costs go up because we  
6199 would lose that spectrum of our risk pool that allows us to  
6200 provide an affordable product for all of our employees.

6201 Mr. {Gingrey.} Now, Mr. Castellani, you are speaking  
6202 from the perspective of the Business Roundtable?

6203 Mr. {Castellani.} From the payers, yes.

6204 Mr. {Gingrey.} From the Business Roundtable?

6205 Mr. {Castellani.} Correct.

6206 Mr. {Gingrey.} And we are talking about the payers and  
6207 there are probably 270 million lives covered through  
6208 employer-provided health insurance. My numbers here say most  
6209 of the 177 million Americans who have employer-based coverage  
6210 say they are happy with the coverage they receive. President  
6211 Obama, God bless him, has promised to ensure that those folks  
6212 can keep what they have. I think that is almost a quote. He  
6213 likes the word folks. Those folks can keep what they have.  
6214 I have heard him say it many times. Do you think that the  
6215 public plan could lead to Americans losing their current  
6216 coverage because of an unfair playing field that would be  
6217 established by a public plan?

6218 Mr. {Castellani.} Yes, I think it runs that risk.

6219 Mr. {Gingrey.} All right. Well, I tend to agree with  
6220 you. Now describe for the committee and for everyone in the  
6221 room what are some of the unfair aspects that could be  
6222 attributed to a public plan that we are concerned about, that  
6223 you are concerned about, that the Business Roundtable is  
6224 concerned about?

6225 Mr. {Castellani.} Well, as I had answered previously, a  
6226 lower premium cost would be attractive to some of our own  
6227 employees for which we provide coverage now. If they leave  
6228 the system, we have a reduced risk pool and the nature of  
6229 that risk pool, the nature of our employees could leave us  
6230 with a more costly and fewer number of lives to cover. The  
6231 second thing that it does is by its design in this draft  
6232 legislation it does not fully reimburse for cost, so another  
6233 large player in addition to Medicare and Medicaid that does  
6234 not fully reimburse for cost because it is a situation, for  
6235 example, you are a hospital. The government is not going to  
6236 pay any more, Medicare and Medicaid is not going to pay any  
6237 more, the uninsured can't pay any more. There is only one  
6238 person left paying and that is the employers, so it  
6239 exacerbates the cost shift, makes our cost potentially  
6240 greater rather than what we are all trying to achieve which  
6241 is more affordable health care at lower cost trajectories

6242 than we have now.

6243           The third thing it does is it hurts us in the long term  
6244 and that is that fundamentally government programs are not  
6245 able to innovate at the kind of rates and with the kind of  
6246 creativity that we see in the private sector with  
6247 competition, and we need that kind of innovation to bring  
6248 down the trajectory of cost so it hits us 3 ways in raising  
6249 our--

6250           Mr. {Gingrey.} I had one more, Mr. Chairman. I can't  
6251 see the clock.

6252           Mr. {Pallone.} It keeps going off. Go ahead.

6253           Mr. {Gingrey.} Okay. Thank you, Mr. Chairman. I  
6254 appreciate your indulgence. Just one more question, Mr.  
6255 Castellani. Under this draft proposal, a tri-committee draft  
6256 proposal, did you see anywhere that describes what would  
6257 happen if the public plan did not set the premiums and the  
6258 cost-sharing high enough to cover its cost? Was there a  
6259 provision that described what happens if the public plan--if  
6260 their reserves are not high enough, for example, and indeed  
6261 was there anything in the draft that describes where those  
6262 reserves would come from and how they would compare with the  
6263 reserves that were required of the private insurance, health  
6264 insurance plans, that they are competing with.

6265           Mr. {Castellani.} I don't believe they were--at least

6266 in my reading of it and analysis of it, they weren't  
6267 specified. They say there are reserves. Reserves would be  
6268 provided for. But the one thing that is missing even  
6269 whatever levels they would be provided at and the networks  
6270 would be provided at in the public plan the one thing that is  
6271 missing is a fair return on the people who invest in the  
6272 capital that allows that public option to exist. If you  
6273 don't have that, you always have accost advantage.

6274 Mr. {Gingrey.} Well, I thank you very much, and I am  
6275 sure my time has probably already expired. Mr. Chairman,  
6276 thank you for your indulgence. I appreciate it, and I yield  
6277 back.

6278 Mr. {Pallone.} Thank you. I think that is the end of  
6279 our questions. Thank you very much. We appreciate it. I  
6280 know it keeps getting later. We have one more panel. You  
6281 may get, as I think you know, you may get some additional  
6282 written questions within the next 10 days and we would ask  
6283 you to get back to us on those. Thank you very much. And we  
6284 will ask the next panel to come forward. I think our panel  
6285 is seated. And I know the hour is late, but we do appreciate  
6286 you being here, and I am told we may also have another vote  
6287 so we will see. We will try to get through your testimony.  
6288 This is the panel on insurer views. And beginning on my left  
6289 is Howard A. Kahn, who is Chief Executive Officer for L.A., I

6290 assume that is Los Angeles, Care Health Plan. L.A. Okay.  
6291 Karen L. Pollitz, who is Project Director for the Health  
6292 Policy Institute at Georgetown Public Policy Institute, Karen  
6293 Ignagni, who is President and CEO of America's Health  
6294 Insurance Plans, and Janet Trautwein, who is Executive Vice  
6295 President and CEO of the National Association of Health  
6296 Underwriters. I don't think I have to tell anyone here that  
6297 we try to keep it to 5 minutes, and your written testimony  
6298 will be included complete in the record. I will start with  
6299 Mr. Kahn.

|  
6300 ^STATEMENTS OF HOWARD A. KAHN, CHIEF EXECUTIVE OFFICER, L.A.  
6301 CARE HEALTH PLAN; KAREN L. POLLITZ, PROJECT DIRECTOR, HEALTH  
6302 POLICY INSTITUTE, GEORGETOWN PUBLIC POLICY INSTITUTE; KAREN  
6303 IGNAGNI, PRESIDENT AND CEO, AMERICA'S HEALTH INSURANCE PLANS;  
6304 AND JANET TRAUTWEIN, EXECUTIVE VICE PRESIDENT AND CEO,  
6305 NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS

|  
6306 ^STATEMENT OF HOWARD A. KAHN

6307 } Mr. {Kahn.} Thank you, Chairman Pallone, members of the  
6308 committee. Thank you. The need for national health care  
6309 reform has never been greater. As the CEO of L.A. Care  
6310 Health Plan, America's largest public health plan, I am here  
6311 to provide information about our model and how a public  
6312 health option has worked in California for more than a  
6313 decade. L.A. Care is a local public agency and health plan  
6314 that provides Medicaid managed care services. We opened our  
6315 doors in 1997 as the local public plan competing against a  
6316 private health plan, Health Net of California, Inc. L.A.  
6317 Care strongly supports the concept that public plans can  
6318 provide choice, transparency, quality, and competition. L.A.  
6319 Care competes on a level playing field against our private  
6320 competitor. Plans must have enough funding to endure

6321 provider payments and operate under the same set of rules.

6322 L.A. Care has always been financially self-sustaining  
6323 and has never received any government bailout or special  
6324 subsidy. L.A. Care serves over 750,000 Medicaid  
6325 beneficiaries and has 64 percent of the Medicaid market share  
6326 in Los Angeles. The competition between L.A. Care and Health  
6327 Net has resulted in better quality and system efficiencies.  
6328 For example, as part of our efforts to distinguish ourselves  
6329 in the market place, L.A. Care attained an excellent  
6330 accreditation from NCQA, validation that it is possible to  
6331 provide quality care to the poorest and most vulnerable in  
6332 our communities. There are 7 other public plans like L.A.  
6333 Care in California providing health coverage to Medicaid  
6334 beneficiaries. In all of these counties, the public plans  
6335 compete against private competitors.

6336 Two and a half million Medicaid beneficiaries are  
6337 provided health services through this model. California has  
6338 other public plan models as well. Congresswoman Eshoo, a  
6339 member of this subcommittee, is very familiar with the  
6340 enormously successful county organized health system which  
6341 she and I helped create within her district. Our provider  
6342 network includes private and public hospitals and physician  
6343 groups, non-profits, for-profits, federally qualified health  
6344 centers, and community clinics. Our subcontracted health

6345 plan partners include some of the biggest private health  
6346 plans, Anthem Blue Cross and Kaiser Permanente, as well as  
6347 smaller local plans. In addition to Medicaid, L.A. Care  
6348 operates a CHIP program, Medicare Advantage special needs  
6349 program, and a subsidized product for low income children.

6350         What makes L.A. Care or public health plan different?  
6351 L.A. Care conducts business transparently. We are subject to  
6352 California's public meeting laws so all board and committee  
6353 meetings are open to the public. L.A. Care answers to  
6354 stakeholders, not stockholders. Its 13-member board includes  
6355 public and private hospitals, community clinics, FQHCs,  
6356 private doctors, Los Angeles County officials and enrollees.  
6357 Our enrollees actually elect 2 of our board members resulting  
6358 in a strong consumer voice. Part of our mission is to  
6359 protect the safety net. When Medicaid managed care began  
6360 there was fear that FQHCs and public hospitals would lose  
6361 out. Through several strategies over 20 percent of L.A.  
6362 Care's enrollees have safety net providers as their primary  
6363 care home. In Los Angeles large numbers of people will  
6364 remain uninsured under even the most ambitious health care  
6365 reform proposals, and the safety net will continue to need  
6366 our support.

6367         Local public plans like L.A. Care protect consumer  
6368 choice. Since we started, 3 private health plans serving

6369 this population in Los Angeles have gone out of business.  
6370 L.A. Care's stability has ensured that Medicaid beneficiaries  
6371 continue to have continuity and choice. Local public plans  
6372 raise the bar on performance and quality in their local  
6373 communities. L.A. Care offers a steady calendar of provider  
6374 education, opportunities that improve provider practices and  
6375 the quality of care. Our family resource center serves over  
6376 1,200 people most of whom are not our plan members. While  
6377 defining a public plan option is still underway, we recommend  
6378 against creating a monolithic national public plan. Health  
6379 care is, and will continue to be, delivered to local markets  
6380 which vary in terms of population and competition,  
6381 infrastructure, community need, and medical culture.

6382 California recognized years ago the need to lower cost  
6383 and improve quality and develop local plan options for  
6384 Medicaid that have been supported by each successive  
6385 Administration, both Democrat and Republican. With regard to  
6386 the health insurance exchange, L.A. Care supports allowing  
6387 states to create their own exchange. We appreciate the  
6388 recognition that Medicaid beneficiaries have special needs  
6389 and so are not included at first. However, we strongly  
6390 recommend excluding Medicaid beneficiaries completely as they  
6391 are among the most vulnerable to care for and present unique  
6392 challenges. California's local public plans are successful

6393 local model that should be considered. Let us build on what  
6394 is working in health care and focus on fixing what is broken.

6395 Thank you.

6396 [The prepared statement of Mr. Kahn follows:]

6397 \*\*\*\*\* INSERT 20 \*\*\*\*\*

|  
6398           Mr. {Pallone.} Thank you. Now let me mention that we  
6399 do have votes, but I would at least like to get one or  
6400 possibly two of the testimony in, so let us see how it goes.  
6401 Ms. Pollitz next.

|  
6402 ^STATEMENT OF KAREN L. POLLITZ

6403 } Ms. {Pollitz.} All right. Thank you, Mr. Chairman,  
6404 members of the committee. First, I would like to  
6405 congratulate you on the tri-committee draft proposal. It  
6406 contains the key elements necessary for effective health care  
6407 reform and at this time I am sure you are going to get the  
6408 job done. The proposal establishes strong new market reforms  
6409 for private health insurance with important consumer  
6410 protections, a minimum benefit package, guaranteed issue,  
6411 modified community rating, elimination of pre-existing  
6412 condition exclusion periods. These rules apply to all  
6413 qualified health benefit plans including those purchased by  
6414 mid-size employers with more than 50 employees. Today, mid-  
6415 size firms have virtually no protection against  
6416 discrimination. When a group member gets sick premiums can  
6417 be hiked dramatically at renewal forcing them to drop  
6418 coverage and with no guaranteed issue protection finding new  
6419 coverage is not an option.

6420 I commend you for not including in the bill exceptions  
6421 to the employer non-discrimination rule that would allow  
6422 employers and insurers to substantially vary premiums and  
6423 benefits for workers through the use of so-called wellness

6424 programs. Clearly, wellness is an important goal but ill-  
6425 advised regulations issued by the Bush Administration  
6426 cynically hid behind it to allow discrimination against  
6427 employees who are sick through the use of non-bona fide  
6428 wellness programs that penalize sick people but do nothing  
6429 else to promote good health. Another good feature of the  
6430 tri-committee bill is the requirement of minimum loss ratios  
6431 of 85 percent, which will promote better value in health  
6432 insurance. The bill grants broad authority to regulators to  
6433 demand data from health plans in order to monitor and enforce  
6434 compliance with the rule, and it creates a health insurance  
6435 ombudsman that will help consumers with complaints and report  
6436 annually to the Congress and insurance regulators on those  
6437 complaints.

6438 Another key feature in the bill is the creation of a  
6439 health insurance exchange and organized insurance market with  
6440 critical support services for consumers. The exchange will  
6441 provide comparative information about plan choices and help  
6442 with enrollment appeals and applications for subsidies. The  
6443 exchange will negotiate with insurers over premiums to get  
6444 the best possible bargain and importantly consumers and  
6445 employers who buy coverage in the exchange will also have  
6446 that choice of a new public plan option. I know you have  
6447 talked today about the cost containment potential of such an

6448 option. It is all important that a public option would offer  
6449 consumers an alternative to private health plans that for  
6450 years have competed on the basis of discrimination against  
6451 people when they are sick. Just last week, your committee  
6452 held a hearing on health insurance rescissions that discussed  
6453 people who lost their coverage just as they started to make  
6454 claims.

6455         At the Senate Commerce Committee hearing yesterday, a  
6456 former officer of Cigna Insurance Company testified on common  
6457 industry practices of purging employer groups from enrollment  
6458 when claims costs get too high. I would like to submit his  
6459 testimony for your hearing record today. When consumers are  
6460 required to buy coverage having a public option that doesn't  
6461 have a track record of behaving in this way will give many  
6462 peace of mind. And I left the rest of my statement in the  
6463 folder. Isn't that terrible? There we are. I got it. I  
6464 got it. I am so sorry. Second, a public plan will promote  
6465 transparency in health insurance market practices. In  
6466 addition to data reporting requirements on all plans with a  
6467 public plan option you will be able to see directly and in  
6468 complete detail how one plan operates and if private insurers  
6469 continue to dump risk after reform it will be much easier to  
6470 detect and sick people will have a secure coverage option  
6471 while corrective action is taken.

6472 Mr. Chairman, in my written statement I offer several  
6473 recommendations regarding the draft bill and will briefly  
6474 describe just a few of them for you now. First, the benefit  
6475 package, the benefit standard in your bill does not require a  
6476 cap on patient cost sharing for care that is received out of  
6477 network and it really needs one. Also, the benefit standard  
6478 does not specifically reference as a benchmark that Blue  
6479 Cross/Blue Shield's plan that most members of Congress enjoy.  
6480 Many have called on health reform to give all Americans  
6481 coverage at least as good as what you have. It is not clear  
6482 whether your essential benefits package meets that standard  
6483 but if it doesn't, it should, and if that raises the cost of  
6484 your reform bill, it will be a worthwhile investment to raise  
6485 that standard.

6486 Over the next decade, our economy will generate more  
6487 than \$187 trillion in gross domestic product and we will  
6488 spend a projected \$33 trillion on medical care. The stakes  
6489 are high and it is important to get this right. The second  
6490 rules governing health insurance must be applied equally to  
6491 all health insurance. As drafted in your bill, some of the  
6492 rules that will apply in the exchange might not apply outside  
6493 of the exchange. Further, there is no requirement that  
6494 insurers who sell both in and out of the exchange to offer  
6495 identical products at identical prices. If the rules aren't

6496 parallel risk segmentation can continue. As an extra measure  
6497 of protection, the tri-committee bill provides for added  
6498 sanction on employers if they dump risks into the exchange  
6499 and similar added sanctions should apply to insurers.

6500 Another problem with non-parallel rules is the exemption  
6501 for non-qualified health benefit plans and limited benefit  
6502 policies called accepted benefits. Health care reform is  
6503 your opportunity to end the sale of junk health insurance and  
6504 you should do it. And, finally, Mr. Chairman, with regard to  
6505 subsidies, the bill creates sliding scale assistance so that  
6506 middle income Americans with incomes up to 400 percent of the  
6507 poverty level won't have to pay more than 10 percent of  
6508 income towards their premiums. But as charts in my written  
6509 statements show, some consumers with income above that level  
6510 could still face affordability problems especially those who  
6511 buy family coverage and baby boomers who would face much  
6512 higher premiums under the 2 to 1 A trading. I hope you will  
6513 consider phasing out the A trading and also setting  
6514 affordability premium cap so that no one has to spend more  
6515 than 10 percent of income on health insurance. Thank you.

6516 [The prepared statement of Ms. Pollitz follows:]

6517 \*\*\*\*\* INSERT 21 \*\*\*\*\*

|  
6518           Mr. {Pallone.} Thank you. I don't want to cut you  
6519 short, Ms. Ignagni, so you can all wait until we come back.  
6520 Hopefully, we won't be too long. I would say 20 minutes or  
6521 so. Thank you.

6522           [Recess.]

6523           Mr. {Pallone.} The hearing will reconvene, and we left  
6524 off with Ms. Ignagni. Thank you for waiting.

|  
6525 ^STATEMENT OF KAREN IGNAGNI

6526 } Ms. {Ignagni.} Thank you, Mr. Chairman, members of the  
6527 committee. It is a pleasure to be here, and having watched  
6528 the hearing all day I just want to congratulate you. It is a  
6529 wonderfully diverse group of people that you have assembled  
6530 and you all should be congratulated. It was terrific to  
6531 watch it. I think in the interest of time recognizing you  
6532 have been here all day, I want to make just a couple of  
6533 points. First, on behalf of our industry, we believe that  
6534 the nation needs to pass health reform this year. We don't  
6535 believe that the passionate debate on which direction or form  
6536 that should take in any way should deter getting this done.  
6537 It needs to happen. And to that end, I think it is somewhat  
6538 disappointing that the focus generally in the press and here  
6539 in Washington had been almost exclusively on the question of  
6540 whether to have a government-sponsored plan or not. And I  
6541 think in many ways one could say that it is obscuring the  
6542 broad consensus that exists and indeed that I believe you  
6543 built on in the legislation in several important areas.

6544 First, we see several important areas. First, we see a  
6545 consensus on improving the safety net and making it stronger.  
6546 Second, providing a helping hand for working families.

6547 Third, a complete overhaul of the market rules. We have  
6548 proposed an overhaul. You have imbedded it in this  
6549 legislation. We firmly support it and congratulations for  
6550 it. We think it is time to move in a new direction and we  
6551 are delighted you are doing that. Next, a responsibility to  
6552 have coverage. We think that is very important because, in  
6553 fact, the market and many of the questions today about how  
6554 the market works today really can be answered because until  
6555 Massachusetts passed legislation requiring everybody to  
6556 participate the industry grew up with the rules that are no  
6557 longer satisfactory to the American people, and the  
6558 opportunity to get everyone in and participating is an  
6559 opportunity to charge a new course.

6560 Next, the concept of one-stop shopping for individuals  
6561 and small employers. Next, investments in prevention and  
6562 chronic care coordination. Next, addressing disparities.  
6563 Bending the cost curve. A number of the witnesses have  
6564 talked about that today. We believe it is integral to moving  
6565 forward. And, finally, improving the work force creating new  
6566 opportunities and looking at where we have deficits and  
6567 attending to them. The committee's draft contains many and  
6568 all--actually all of these elements, and we commend you for  
6569 it. Moreover, we feel that we have to seize the moment as a  
6570 country and build on this consensus that will accomplish what

6571 has eluded the nation for more than 100 years and that is to  
6572 pass health care reform.

6573         The government-sponsored plan shouldn't be a roadblock  
6574 to reform, and the key concept of introducing a government-  
6575 run plan is that it would compete on a level playing field,  
6576 but that is not what would happen. And, Mr. Chairman, as I  
6577 sat here today, I thought of an analogy, and just to reduce  
6578 it to a clear and hopefully very direct way to explain our  
6579 concerns, I want to make an analogy to a race between 2  
6580 people, one that makes the rules and at the same time says to  
6581 the other competitor this is my 50-pound backpack and I want  
6582 you to carry it. Cost-shifting for Medicare and Medicaid is  
6583 that backpack for our health plans and we can't take it off  
6584 in this race. The government plan will run without that  
6585 encumbrance. Moreover, it will add weight to the backpack.  
6586 We now pay hospitals 132 percent on average nationally of  
6587 costs about 46 percent above Medicare rates. That has  
6588 implications for preserving the employer-based system. We  
6589 believe you cannot under those circumstances implications for  
6590 hospitals and physicians who have long expressed concerns  
6591 about Medicare rates and the adequacy or not adequacy--not  
6592 being adequate, and the implications for the deficit which  
6593 are not being taken into account.

6594         We believe that the most important message we can convey

6595 is that we have tools and skills to provide. Indeed, we have  
6596 pioneered disease management and care coordination. We  
6597 pioneered opportunities for individuals to be encouraged when  
6598 their physician finds it acceptable to substitute generic  
6599 drugs. We are recognizing high quality performance in  
6600 hospitals and physicians, and we are moving down a path of  
6601 showing results. Imbedded in our testimony are some of those  
6602 results, which are very specific and very measurable about  
6603 what we are doing and how we are doing a better job. We can  
6604 help with traditional Medicare. We can bring more of those  
6605 tools, but we hope that you will recognize the 50-pound  
6606 backpack and the weight as we explain our concerns with a  
6607 government-sponsored program.

6608         The most important message I can convey to you today is  
6609 not to let what people disagree on threaten the ability to  
6610 pass reform this year. Our members have proposed and are  
6611 committed to a comprehensive overhaul of the current system.  
6612 We have appreciated the opportunity to discuss key features  
6613 of the bill with your staff, and we pledge our support to  
6614 work to achieve legislation that protects consumers and  
6615 provides health security to patients. Thank you very much.

6616         [The prepared statement of Ms. Ignagni follows:]

6617 \*\*\*\*\* INSERT 22 \*\*\*\*\*

6618

|

Mr. {Pallone.} Thank you. Ms. Trautwein.

|  
6619 ^STATEMENT OF JANET TRAUTWEIN

6620 } Ms. {Trautwein.} Thank you very much. And being the  
6621 last witness of the day, I will try to not repeat everything  
6622 that everyone else has said. What I would like to do is I  
6623 agree with everything Ms. Ignagni has just said except that I  
6624 do want to say one thing, and that is that the details  
6625 matter. And one of the things that our members do for a  
6626 living is we look at a lot of the details, and I feel it  
6627 incumbent to bring up a couple of those because I think we do  
6628 need to make sure that we get these things straightened out  
6629 before we move forward. I do want to stress that we don't  
6630 want to not move forward. We want health reform and we want  
6631 it done correctly. I do want to mention a couple of things  
6632 to illustrate to you that we have got to get some of these  
6633 things that may appear to be small straight because they  
6634 could have huge implications.

6635 First of all, I want to mention the rating provisions in  
6636 the bill, and I want to stress I am not talking about the no  
6637 pre-existing conditions. I am not talking about the no  
6638 health status rating. I am not talking about anything like  
6639 that. I am talking about specifically the modified community  
6640 rating provisions. Currently the bill uses something called

6641 an age band of 2 to 1. I am not going to go into details  
6642 about that except to tell you that it is too narrow. And,  
6643 Mr. Chairman, I would like to use your own state for an  
6644 example of it being too narrow. New Jersey recently went to  
6645 3-1/2 to 1 age bands because what they had was too narrow  
6646 already and it wasn't affordable for people. The gentleman  
6647 on the last panel that talked about New Jersey rates of  
6648 \$13,000, they are in a situation of 2 to 1 age bands, and  
6649 that is one of the reasons why it is too expensive. So we  
6650 want to make sure that we establish bands that allow wide  
6651 enough adjustments to make it affordable for more people so  
6652 that we don't end up losing a lot of the young person  
6653 participation.

6654 In addition, one of our very specific concerns has to do  
6655 with the fact that this bill tends to lump all groups that  
6656 are what we call fully insured together, whether they are a  
6657 group of 10 people, 50 people, or 200 people, and the  
6658 modified community rating provisions apply to all of them.  
6659 Today, groups of over 50 on a gradual basis use their own  
6660 claims experience, and when I talk about claims experience, I  
6661 don't mean perspective health status ratings where they fill  
6662 out a health statement in advance. I mean that the group  
6663 develops community rates based on the experience of their own  
6664 group of employees. It is very cost effective. It allows

6665 them to keep their rates low over time, and I would point out  
6666 this is not a market that has problems today. These are not  
6667 the people that are knocking on your doors telling you that  
6668 they have a problem.

6669         And I would encourage you to not eliminate that ability  
6670 for them to do that because the rate shock to the employers  
6671 in that category will be fairly significant. I would also  
6672 like to point out that the grandfathering provisions really  
6673 need to be improved, and there are a couple of areas that I  
6674 am thinking are probably just mistakes, it is a draft, inside  
6675 the bill that ought to be changed. The provision, first of  
6676 all, is too strict for individuals. It only allows them to  
6677 add family members and frequently these policies are reviewed  
6678 on an annual basis and other minor adjustments need to be  
6679 made. For example, a person that has an HAS qualified plan  
6680 has a legal adjustment to be made relative to the deductible  
6681 on an annual basis, and the bill doesn't really allow for  
6682 that. And then groups, of course, are not really  
6683 grandfathered. They have a phase-in period over 5 years, and  
6684 we would be hopeful that groups could keep their coverage  
6685 longer than that period of time.

6686         The one thing I want to talk about that I don't think  
6687 anyone else has mentioned has to do with risk adjustment.  
6688 This is something that we look at a lot. We are very

6689 involved with risk adjustment and reinsurance plans to make  
6690 sure that they are stable. I am very concerned that the risk  
6691 adjustment that is suggested is not adequate for starting up  
6692 this program.

6693         The risk adjustment suggested is more something you  
6694 would do once your exchange had been in effect for a period  
6695 of time and it would adjust risks among the plans inside the  
6696 exchange. It doesn't account for what is going to happen  
6697 initially when we have lots of people entering the system,  
6698 many of whom may have serious health conditions. For  
6699 example, the way that your bill is written today on day one  
6700 of guarantee issue every single person in this country that  
6701 is in a high risk pool will come immediately into that pool,  
6702 so we got to have something to mitigate the cost of those  
6703 high risks coming in so that you don't end up with something  
6704 you don't want which is a pool that results in costs that are  
6705 higher instead of lower, so again these details are important  
6706 that we get them straightened out correctly.

6707         I would be remiss if I didn't say something else about  
6708 the public program. Like many of the people that have talked  
6709 here today, we are very worried about a government run public  
6710 program. I want to talk specifically about the cost  
6711 shifting. There are a lot of things that we have concerns  
6712 about but we do definitely see the impact of cost shifting.

6713 We all have heard the statistic but I think it bears  
6714 repeating again. Almost \$1,800 a year for the average family  
6715 of 4 is a direct result of today's cost shifting without a  
6716 new public program. And I want to mention one other thing.  
6717 I see that I am out of time but I want to mention this very  
6718 quickly. We have heard state premium taxes mentioned here  
6719 many times today, but I want to kind of put a face on that  
6720 because in New Jersey alone state premium taxes are \$503  
6721 million annually to the state and they are not dedicated to  
6722 insurance. They have gone to other programs.

6723 We have programs in North Carolina, Connecticut,  
6724 Kentucky, Pennsylvania, North Dakota that were state premium  
6725 taxes from firefighter programs. They buy equipment to fight  
6726 fires and so these funds, I don't think the states can do  
6727 without this revenue source. It is another example of how we  
6728 are not going to have a level playing field and we need to  
6729 think this through a little bit more carefully. And I have  
6730 additional information but I am out of time so I will go  
6731 ahead and stop now.

6732 [The prepared statement of Ms. Trautwein follows:]

6733 \*\*\*\*\* INSERTS 23, 24 \*\*\*\*\*

|  
6734           Mr. {Pallone.} Thank you. And, as I mentioned earlier,  
6735 I think I did, that whatever your written testimony is or  
6736 data that is attached to it, we will put in the record in its  
6737 entirety. I wanted to--let me start with Ms. Pollitz. The  
6738 discussion draft takes the step of prohibiting discrimination  
6739 in insurance based on a person's health status, things such  
6740 as disability, illness or medication history. However, you  
6741 know, as we are trying to close the door on that with this  
6742 bill, some are proposing others, and I am not entirely sure  
6743 what you said, but I know that you said that, or at least in  
6744 your written testimony, that insurers should--I am talking  
6745 about Ms. Trautwein now, that insurers should continue to be  
6746 able to alter premiums based on a person's past claims  
6747 experience, and the way I understand it that employers would  
6748 be permitted to change a person's premium not necessarily on  
6749 their health status but on certain activities like wellness  
6750 programs and those kind of things. I don't want to put words  
6751 in your mouth.

6752           Ms. {Trautwein.} What I meant is not what I--

6753           Mr. {Pallone.} Sure. Go ahead.

6754           Ms. {Trautwein.} We want health status rating to go  
6755 away for individuals.

6756           Mr. {Pallone.} Right, but you said that the employers--

6757 Ms. {Trautwein.} But we are talking about employer  
6758 groups there they look at all of their employees, de-  
6759 identified information, and they calculate what their  
6760 anticipated claims are for the next year. This is done all  
6761 the time. And then they figure out how much they need for  
6762 reserves and things like that and they develop a rate based  
6763 on their particular group and it is a very, very cost  
6764 effective way of doing it. It results in lower rates for the  
6765 employees, not higher. That is why we were asking for that.

6766 Mr. {Pallone.} I just want to make sure, and I am not  
6767 trying to put words in your mouth, Ms. Trautwein. I am just  
6768 trying to understand that I want, you know, employers be able  
6769 to have wellness programs certainly but it just seems to me  
6770 we have to insure the persons who are, you know, unable to  
6771 achieve a specific physical or other goal and not penalize  
6772 and therefore somehow health status comes back again. But I  
6773 am not just talking about Ms. Trautwein's testimony. I am  
6774 just talking about in general that we are trying to eliminate  
6775 a lot of these things. Let me just ask you this, Ms.  
6776 Pollitz. Can you discuss the role of employer wellness  
6777 program and what sort of protections we can be sure to  
6778 include to promote the positives without allowing this  
6779 discrimination and what it would mean for people if insurers  
6780 were able to use claims experience and ratings. Again, I am

6781 not entirely clear on what Ms. Trautwein was saying so maybe  
6782 this is not fair, but hopefully between the two of you, you  
6783 can answer my question.

6784 Ms. {Pollitz.} I think those are 2 separate things.

6785 Mr. {Pallone.} Okay.

6786 Ms. {Pollitz.} Just very quickly on the wellness  
6787 programs. You are right. I think there is a lot of  
6788 interest. At Georgetown there are a lot of great programs,  
6789 sponsored walks, time off, free exercise classes in the  
6790 building, stuff like that, so I think there is a great deal  
6791 of creativity and good intentions and good results in a lot  
6792 of employer-sponsored wellness programs. But there are other  
6793 programs that even take on the name incentive care that all  
6794 they do is just apply health screenings, make you take  
6795 certain health tests, and if you flunk them, that is it.  
6796 Your benefits get cut, your deductible gets raised, or your  
6797 premium gets hiked by a lot, and there is nothing else.  
6798 There is no classes. There is no help. There is no nothing.  
6799 So I think a return to the original notion under the old  
6800 Clinton Administration regs for non-discrimination establish  
6801 some standards for bona fide wellness programs, you know,  
6802 some indication that there actually is wellness promotion,  
6803 disease prevention activities going on, opportunities to  
6804 participate, giving employees opportunities to participate

6805 that doesn't kind of come out of their hide.

6806 Privacy considerations, employers are not covered  
6807 entities under HIPA privacy rules. All that health screen  
6808 information that goes in, people are very worried about that.  
6809 And so that is the first thing, and then whatever rewards  
6810 there are, I think it is important to just keep that separate  
6811 from the health plan because otherwise it--

6812 Mr. {Pallone.} Do you agree with her, Ms. Trautwein,  
6813 because if you do then I don't need to pursue this any  
6814 longer.

6815 Ms. {Trautwein.} Well, I sort of agree with her. The  
6816 plan that she talked about that is not a real wellness  
6817 program, we are not in favor of those. That is not what we  
6818 are talking about.

6819 Mr. {Pallone.} Okay.

6820 Ms. {Trautwein.} We are talking about very unique  
6821 programs where each person designs their own goals. Somebody  
6822 might be in a wheelchair and the other person might be a  
6823 marathon runner.

6824 Mr. {Pallone.} Okay.

6825 Ms. {Trautwein.} That would be silly.

6826 Mr. {Pallone.} I don't want to prolong it. I think we  
6827 have--

6828 Ms. {Trautwein.} I think we agree. I do think you

6829 could have some incentives relative to people meeting the  
6830 goals that they have established for themselves though.

6831 Mr. {Pallone.} Okay. Now let me ask Karen the second  
6832 question, and then I will quit. Mr. Shadegg, he is not here,  
6833 I hate to mention him with his not being here, but I am, Mr.  
6834 Shadegg and others have suggested that it would make sense to  
6835 allow insurers to get licensed in one state and sell those  
6836 license products and others. I have always been worried  
6837 about that, and I know insurance commissioners don't like it.  
6838 Can you tell me under this new national market place what  
6839 would your thoughts be on a proposal like that? Did I say  
6840 Karen? Either one of you. I meant Ms. Pollitz but you can  
6841 answer it too, Ms. Ignagni.

6842 Ms. {Ignagni.} Thank you, Mr. Chairman. I didn't mean  
6843 to step in. I thought you were directing--

6844 Mr. {Pallone.} No, go ahead.

6845 Ms. {Ignagni.} Actually just on the last question, I do  
6846 think there is a combination as you are suggesting. I do  
6847 think it makes a great deal of sense to have a permissible  
6848 corridor of activities that could be done in the context of  
6849 wellness and I think you are right to pursue it. There have  
6850 been some major advances in the employer context that I think  
6851 we could take advantage of and if you would like, Ms.  
6852 Pollitz--

6853 Mr. {Pallone.} No, go ahead. Why don't you start with  
6854 Ms. Pollitz and then we will come back to you.

6855 Ms. {Pollitz.} I will be happy to answer.

6856 Mr. {Pallone.} All right. This idea that you allow  
6857 insurers to get licensed in one state and sell the products  
6858 in another, I have always thought that was a dangerous thing,  
6859 you know.

6860 Ms. {Pollitz.} The experience has been that that is a  
6861 dangerous thing in association health plans. This is where  
6862 you see this happening a lot and it is very dangerous and it  
6863 creates opportunities for fraud.

6864 Mr. {Pallone.} But in addition now we have this  
6865 national proposal in the draft so how does that all fit in  
6866 with that?

6867 Ms. {Pollitz.} Well, now you have got a national  
6868 proposal, but in your proposal a requirement to sell anywhere  
6869 outside or inside of the exchange the first requirement that  
6870 is listed is that you have to be state licensed, so you still  
6871 need to--you have to have a license. You need to work with  
6872 licensed agents. You need to meet solvency standards. All  
6873 of those things are established at the state level. You  
6874 don't need to replace those at the federal level and you  
6875 haven't in your bill, but I think you need that close  
6876 accountability so someone need to be watching the health

6877 plans all the time, otherwise, there is great nervousness  
6878 about selling back and forth. Just the last thing I would  
6879 mention, and I think it was mentioned in some of the written  
6880 testimony, I think there may be a little bit of drafting  
6881 imprecision about sort of what are the federal rules that  
6882 apply across the board and then what other sort of state  
6883 rules or rules under the old HIPAA structure that apply and  
6884 that you probably need to straighten out a little bit in the  
6885 next draft, but you don't want a situation where a health  
6886 plan can be licensed in one state and operate under one set  
6887 of rules but then be able to sell somewhere else under a  
6888 different set of rules. If your national rules become  
6889 completely across the board always the same, you still need  
6890 to be state licensed but then this whole notion of selling  
6891 across state laws I think won't matter.

6892 Mr. {Pallone.} And if you want to comment on--

6893 Ms. {Ignagni.} Thank you, Mr. Chairman. I think this  
6894 is a tremendous opportunity to look very carefully at the  
6895 regulatory structure and take a major leap forward. Having  
6896 everyone in allows the complete overhaul that is baked into  
6897 the proposal now, guarantee issue, no pre-existing  
6898 conditions, no health status rating. We ought to specify  
6899 those guidelines at the federal level, have uniformity and  
6900 consistency, not re-regulate them at the state level, which

6901 is causing a great deal of confusion now in the market with  
6902 same function regulated at different levels by different  
6903 entities. We should take this opportunity to make it clear  
6904 so that consumers can feel protected and know that the health  
6905 plans will be accountable. We are very comfortable with  
6906 that. We would have this enforced at the state level.  
6907 States have done a very good job at maintaining solvency  
6908 standards, consumer protections, et cetera. We think that is  
6909 the right balance.

6910 We don't believe that--and we have some advice in our  
6911 testimony but the drafting of the legislation in terms of  
6912 these regulatory responsibilities. We think it is absolutely  
6913 clear and key for consumers to understand how they will be  
6914 protected, where they will be protected, and what the  
6915 standards are. And we have such duplication and confusion  
6916 now in the system it is very, very difficult for consumers to  
6917 feel protected, so I think this is an opportunity to take a  
6918 major step forward and really respond to that.

6919 Mr. {Pallone.} Okay. Thank you. Mr. Burgess is next.

6920 Mr. {Burgess.} Let me just be sure I understand  
6921 something now. The new public government run program is  
6922 going to have to be licensed in all 50 states? I guess that  
6923 is a maybe. This new public plan, this new government plan--

6924 Ms. {Pollitz.} I would defer to your own staff on that.

6925 It is a federal program.

6926 Mr. {Burgess.} Right. Medicare is a federal program.

6927 It is sold across state lines and it is not licensed

6928 individually to every state.

6929 Ms. {Pollitz.} I don't see the requirement that it has

6930 to be licensed by states. It is a federal program.

6931 Mr. {Burgess.} Right. So it seems to me that if Ms.

6932 Ignagni's group wants to develop something that meets certain

6933 criteria that it ought to be afforded the same courtesy to be

6934 sold in every state.

6935 Ms. {Pollitz.} Well, I don't know that that is a

6936 courtesy. I think it is just an administrative faculty.

6937 Mr. {Burgess.} The same administrative faculty then,

6938 but we will not call it a courtesy. It just strikes me as we

6939 have got 2 sets of rules here, one for the public sector and

6940 one for the private. That seems inherently unfair. This is

6941 not what I intended to talk about but I am not following.

6942 Where is the inherent fairness in the--Ms. Ignagni has

6943 already talked about carrying a 50-pound weight on her back

6944 because she has got to carry the freight, the cross

6945 subsidization from the federal programs, the freight they are

6946 not paying in the first place and then on the other hand are

6947 we creating a product that is just by definition she can't

6948 compete with it because it is something that could be sold

6949 without regard to state insurance regulation. Ms. Ignagni,  
6950 is that your understanding? Is that your understanding of  
6951 this new public plan?

6952 Ms. {Ignagni.} I know the remedies. I would yield to  
6953 counsel but I understand that the remedies are federal  
6954 remedies, and I think the entity is chartered at the federal  
6955 level but I wouldn't want to be presumptuous in that regard.

6956 Mr. {Burgess.} Ms. Trautwein, you are the national  
6957 organization. Do you have an opinion about this?

6958 Ms. {Trautwein.} Oh, yes, sir. We have a very--that is  
6959 what I said in my testimony that we are very concerned about  
6960 the fact that a playing field would never be level. On one  
6961 is the payment, which I spoke about in my oral testimony.  
6962 The other is the rules. Its regulation at the state level is  
6963 what we have to meet. Having state premium taxes, state  
6964 regulation, state remedy. That is not the way the bill reads  
6965 at present.

6966 Mr. {Burgess.} Maybe I will figure out a way to say  
6967 this more clearly and submit it in writing. Ms. Ignagni, I  
6968 just have to say maybe I am a little bit disappointed after  
6969 the group of six met down at the White House, and I know my  
6970 own professional organization was part of that. And we came  
6971 out of there with, what was it, a trillion dollars, 2  
6972 trillion dollars in saving over 10 years, and part of those

6973 savings was administrative streamlining, which presumably is  
6974 one claim form instead of 50 or 60, which we have to deal  
6975 with now. I did see it reported, but I am also going to  
6976 assume that perhaps there is one credential form rather than  
6977 filling out 50 different credentialing forms every January  
6978 and taking 2 or 3 full-time equivalents to have them do that  
6979 in a 5-doctor practice. Why the hell didn't we do that a  
6980 long time ago?

6981 Ms. {Ignagni.} Well, sir, that is a fair point, and we  
6982 have been working now over a 4-year period. As you probably  
6983 know, we set up a separate entity to actually take on this  
6984 issue of simplification in the ways the banks took on the ATM  
6985 technology. We have worked with physicians. We have worked  
6986 with all the specialty societies. We have worked with  
6987 hospitals, the different types of hospitals to make sure that  
6988 we were going to get the language right. We have taken our  
6989 time doing it to make sure we had that language right in a  
6990 way that physicians, physician groups, and hospital felt  
6991 satisfied that we are actually solving the problem. So now  
6992 that we did that, we were able to step forward and say we are  
6993 not only taking the responsibility of moving forward, we are  
6994 not going to be doing it voluntarily. We are very committed  
6995 to legislation. We have said that. We want to make sure it  
6996 is uniform across our industry. We are comfortable with

6997 that, and we will help you draft it.

6998           Mr. {Burgess.} Let me ask you because you have been up  
6999 here a long time and you know the rules we live under with  
7000 the Congressional Budget Office, and a \$2 trillion score,  
7001 whatever it is, over 10 years, the Congressional Budget  
7002 Office is going to look at that and say if this is something  
7003 you were supposed to be doing anyway then we just calculate  
7004 it into the base line and there in fact is no new money to  
7005 spend. How are you going to deal with that?

7006           Ms. {Ignagni.} This is a very important question you  
7007 are asking. First, until we made the announcement no one  
7008 said from our industry that we were going to be regulated for  
7009 this, that it would be not only committed to legislation, we  
7010 would support it and help draft it, so that is a material  
7011 difference, number 1. Number 2, for the \$2 trillion goal to  
7012 be achieved, as you know well, it is going to take an  
7013 interdependence among all the stakeholders to achieve that.  
7014 There are 4 key areas of savings if we are going to bend the  
7015 curve as a nation, we have to take seriously. One is  
7016 administrative simplification. We need to make sure that not  
7017 only everything we have committed to, but where we go in the  
7018 future is the right direction for hospitals and physicians  
7019 that they can achieve--

7020           Mr. {Burgess.} You have no argument from me about that.

7021 I do wonder how we are actually going to get the dollars  
7022 savings scored by--we all know, we talked about the Medicare  
7023 prescription drugs. It is much more cost effective to treat  
7024 something at the front end. Then when the target is  
7025 destroyed and yet the Congressional Budget Office is never  
7026 going to score that as an actual savings. It actually scores  
7027 it as an expense because you are going to be treating more  
7028 people by virtue of the fact you are treating disease at an  
7029 earlier point.

7030 Ms. {Ignagni.} Well, we have some ideas on both. Let  
7031 me just quickly--

7032 Mr. {Burgess.} We are about out of time. I am going to  
7033 submit some other questions in writing. I would just say  
7034 this. You see what a fluid situation this is, and please  
7035 forgive me, Mr. Chairman, just close your ears for a minute.  
7036 Pay no attention to the man behind the curtain. Things are  
7037 in such flux. Don't be quick to give things up. By all  
7038 means, work with us, but don't go to the White House waving  
7039 the white flag as the first volley. In fact, it can be  
7040 counterproductive. It is just my opinion. I will return it  
7041 to the chairman.

7042 Ms. {Ignagni.} Sir, if you will allow me to just--Mr.  
7043 Chairman, just a quick point.

7044 Mr. {Pallone.} Sure.

7045 Ms. {Ignagni.} I will be delighted to--you have some  
7046 very important technical questions. I will be delighted to  
7047 submit that for the record, but you ask now, the last point  
7048 you have made is more in the category of right road, wrong  
7049 road, so let me give you a very direct answer. If you look  
7050 at the Council of Economic Advisors report unless we truly  
7051 bend the cost curve in a sustainable way not only will we not  
7052 be able to afford the new advances we want to make in getting  
7053 everybody covered, we won't be able to afford the current  
7054 system. We participated in an effort with the hospitals, the  
7055 physicians, as you know, with the SEIU, farm and the device  
7056 companies to take our seat at the table to say as  
7057 stakeholders, as private sector entities, we could take part  
7058 of the responsibility of stepping up and saying we have  
7059 skills we can bring to the table to get this problem solved.

7060 That is what our plans do. That is the point that we  
7061 are making here. Ms. Capps had asked a question earlier to  
7062 Mr. Castellani about what is the legacy of the private  
7063 sector. The legacy of the private sector is that we have  
7064 brought disease management care coordination. We are now  
7065 recognizing physicians and hospitals, as you know,  
7066 recognizing high quality performance. We brought the skills  
7067 to do that. Patient decision support, personal health  
7068 records, helping physicians not have to sort through loads of

7069 paperwork. We are proud of that. We pioneered those tools.  
7070 We are implementing it. And similarly with administrative  
7071 simplification, we are the key domino to make that happen.  
7072 We have taken that very seriously, which is why we  
7073 participated in this effort to try to contribute to this  
7074 major goal.

7075 Mr. {Pallone.} That sounds like a good--

7076 Mr. {Burgess.} Briefly reclaiming my time.

7077 Mr. {Pallone.} You don't have any left.

7078 Mr. {Burgess.} It is obvious that there have not been  
7079 people willing to work with you on that for the last 7 years  
7080 that I have been here. I just cannot tell you how distressed  
7081 I am that there was never this willingness to work when our  
7082 side was in power, when a different president was in the  
7083 White House. I feel personally affronted by this, and it is  
7084 ironic that you were just at the point now where your  
7085 industry is going to be delivering on the promise that we all  
7086 knew it could do, and I don't know what the future holds for  
7087 you, because there are many people, we have heard it over and  
7088 over again in this committee this week, that a single payer  
7089 system is what is down the road for the United States of  
7090 America.

7091 Mr. {Pallone.} All right, let us get moving.

7092 Mr. {Burgess.} And all of the things that you have done

7093 with care and coordination disease management, that may be  
7094 something you have developed only to find it is never really  
7095 fully implemented to use in the private sector.

7096 Mr. {Pallone.} All right, Dr. Burgess.

7097 Mr. {Burgess.} We could have done a much better job  
7098 with this. I yield back.

7099 Mr. {Pallone.} I don't want to be tough because I kind  
7100 of like the dialogue, but we need to move on. Ms. Capps.

7101 Mrs. {Capps.} I find it interesting too, but I really  
7102 want to commend you all for the last panel of the day and  
7103 think there ought to be some kind of medal. Do we design  
7104 medals for the last panel? This is our fourth day of  
7105 hearings too so if we seem a little kind of flat you will  
7106 understand, I hope. But this is one I wanted to state in  
7107 particular because you are so key in what you represent to us  
7108 getting this right, and that is the goal and that is exactly  
7109 where we all are. And, Ms. Ignagni, I appreciate you taking  
7110 us down saying we have got so much we can agree on unless at  
7111 least agree we don't agree. I don't agree with you on many  
7112 things, and you know that, but that is okay. We can talk. I  
7113 want to tell you, Ms. Pollitz, you hold the bar very high,  
7114 and we are going to try to get as close as we can to the  
7115 standards you are giving us. And, believe me, I have  
7116 constituents who are reminding me of that every single day

7117 when I go home, which is a good thing. This is all across  
7118 the map. But everybody's attention is now focused on health  
7119 care, and I salute that. It is about time.

7120 Mr. Kahn, I have suburban counties north of your region  
7121 but I am a big fan, as you know, because now I can boast that  
7122 each of the 3 counties, I represent part of the 3, now has a  
7123 county operated program, and that yesterday we were able to  
7124 get Mr. Freeland, who speaks very highly of you, to testify  
7125 as a provider. It is now called CenCal. And they were one  
7126 of the first to get a waiver and there are some really  
7127 exciting options that can be brought to the table now. Call  
7128 them what you want but they are going to help us deliver  
7129 care. I have a tough--I want to share what it is like to be  
7130 a member of Congress and have the phone ring and hear a  
7131 story, and you know this. But I just want to bring it out  
7132 and make sure that it is on the record. This panel gives me  
7133 the chance to relay the story of the constituent whose  
7134 situation really illustrates why we need to bring honest  
7135 competition into the insurance market. I represent a little  
7136 town called Carpinteria, a rural part of Santa Barbara  
7137 County.

7138 A young woman is a good member of part of a non-profit  
7139 community organization. She has a 12-year old daughter who  
7140 was born with spina bifida and needs surgery to replace a

7141 stent in her brain. Her mother's income places her mother  
7142 just over the threshold to--she is not able to qualify for  
7143 Medicaid. We call it the Healthy Families, the SCHIP  
7144 expansion, in California. Though her mother's employer does  
7145 provide coverage the young girl is covered under the plan but  
7146 this plan specifically states that it will not cover the  
7147 surgery she needs for her life because spina bifida is a pre-  
7148 existing condition. Ms. Ignagni, I am going to start with  
7149 you. I would like to have comment for as much time as I  
7150 have, and I don't want to go over time, but this plan that  
7151 this mother has in rural--parts of my district there is one  
7152 option in much of it, one private plan, and there are at most  
7153 in Santa Barbara County, I think 2, maybe 3, at the moment,  
7154 so she can't shop around very much.

7155 She called my office because she is beside herself.  
7156 This denial is for a condition that this young woman was born  
7157 with, and this surgery is needed to relieve the pressure of  
7158 fluid on her brain. People have been talking about pre-  
7159 existing conditions in the private sector for a very long  
7160 time. This is real time. This is happening today in my  
7161 constituency.

7162 Ms. {Ignagni.} And, Ms. Capps, I think there is no  
7163 legitimate answer to your question but to say this is why we  
7164 have worked so hard to propose change in the comprehensive

7165 proposal--

7166 Mrs. {Capps.} It hasn't happened yet.

7167 Ms. {Ignagni.} It has not happened yet because we have  
7168 a system now where people purchase insurance if they are  
7169 doing it individually when--

7170 Mrs. {Capps.} No, this is part of her employment, but  
7171 let me--

7172 Ms. {Ignagni.} If it is part of an employer then  
7173 guarantee issue--

7174 Mrs. {Capps.} A non-profit organization with very  
7175 minimal amount that they can spend for employee-covered care  
7176 but let me see what some other comment is. Maybe, Mr. Kahn,  
7177 if this young mom was working for this non-profit which  
7178 abounds in Los Angeles as well, what option might she have?

7179 Mr. {Kahn.} Well, Congresswoman, and, by the way, you  
7180 have a beautiful area that you cover. Your district is  
7181 beautiful and you did have the first of all the country  
7182 organized health systems there. The problem is a structural  
7183 one which is the way our regulations and our markets are set  
7184 up right now that an individual or if they are in a very  
7185 small group perhaps because usually pre-existing conditions  
7186 are not excluded from group coverage. It may be such a small  
7187 group, however, that it is. That could be--

7188 Mrs. {Capps.} Less than 10 employees.

7189 Mr. {Kahn.} So knowing the situation, that could be the  
7190 case. And under the current system, to be perfectly honest  
7191 with you, there is no good answer for that situation for the  
7192 individual or in a small group like that. That is the  
7193 problem with the system right now and why I think we all  
7194 agree we have to change the system. Now depending on our  
7195 income level, it is--

7196 Mrs. {Capps.} It is not very high.

7197 Mr. {Kahn.} Not very high. They could actually become  
7198 eligible for Medicaid if they spend down enough depending on  
7199 what her income level is.

7200 Mrs. {Capps.} Pretty big price to pay.

7201 Mr. {Kahn.} And it is a very big price to pay, but that  
7202 is the problem is that we have a broken system right now that  
7203 needs to be fixed, and that is why we are all here because of  
7204 those kinds of situations covered and not covered.

7205 Mrs. {Capps.} Our reform legislation being a remedy?

7206 Mr. {Kahn.} Absolutely. I think that the solutions  
7207 that are being addressed--

7208 Mrs. {Capps.} From both the private sector and this  
7209 public option of course.

7210 Mr. {Kahn.} Well, I think what we are talking about is  
7211 reform of the rules around coverage, and indeed you would  
7212 accomplish that because once everyone is covered then the

7213 pre-existing conditions issue should really go away. The  
7214 problem right now is that--and we don't do individual  
7215 coverage. We serve only low income people.

7216 Mrs. {Capps.} Right. Right.

7217 Mr. {Kahn.} But the problem with the system right now  
7218 is that where people are not covered, they decide once they  
7219 get sick they need coverage and that is why there is  
7220 underwriting. I am not defining it. It is just--there are  
7221 no bad guys in this play. Unfortunately, it is bad  
7222 structures. It is a bad system.

7223 Mrs. {Capps.} Right, which is why it calls for  
7224 intervention from us. I am not looking for support for that,  
7225 and I applaud this is finally the moment that all the stars  
7226 are aligned. I think we would all agree that we are going  
7227 to--not everybody is going to be maybe pleased with the  
7228 outcome, but we are going to make progress. And I am just so  
7229 hopeful that we can do it in a very bipartisan way.

7230 Ms. {Ignagni.} And, Ms. Capps, I would be happy if you  
7231 think it is appropriate to help with your office and see if  
7232 we can look into the case and see if there is anything that  
7233 can be done. As a mother, I would be delighted to do that.

7234 Mr. {Pallone.} Thank you. Mr. Whitfield.

7235 Mr. {Whitfield.} Thank you, Mr. Chairman, and thank you  
7236 all for your testimony. One of the common reasons given for

7237 having a public option is the fact that there is not  
7238 competition particularly in rural areas, and there is  
7239 probably an obvious reason for this that I don't understand  
7240 but in the prescription drug benefit under Part D of Medicare  
7241 in my rural district of Kentucky there were like 42 different  
7242 plans offered to Medicare beneficiaries, so why are there so  
7243 many plans offered as a prescription drug benefit but not  
7244 plans competing with each other on the other sector. Would  
7245 someone answer that for me?

7246 Ms. {Pollitz.} Prescriptions are a little different  
7247 just because you don't need the provider network. I mean if  
7248 there are pharmacies nearby or even mail order pharmacy it is  
7249 easier to ensure the costs of prescriptions.

7250 Mr. {Whitfield.} So it is the fact that there is a lack  
7251 of a provider network and putting that together?

7252 Ms. {Pollitz.} I would expect. I am not familiar with  
7253 your district but prescriptions are a more kind of national  
7254 market than other health care.

7255 Mr. {Whitfield.} Okay.

7256 Ms. {Ignagni.} I think, Mr. Whitfield, one of the  
7257 things that we have observed is that often there are products  
7258 available but in particularly rural areas if individuals  
7259 don't have a broker, for example, they haven't been presented  
7260 with the information, they don't know where to go, which is

7261 why one of the first things that we suggested is this concept  
7262 of having an organized display on a site, it could be a state  
7263 site, of the health plans that are available in every part of  
7264 every state and organized it so people can understand what is  
7265 available. That would be, I think, a major step forward.

7266 Mr. {Whitfield.} Mr. Kahn, would you want to say  
7267 something?

7268 Mr. {Kahn.} Thank you, Congressman. I would just add  
7269 that the challenge in rural communities beyond the pharmacy  
7270 situation is that if you are the one hospital in town, you  
7271 probably don't have to negotiate so it is not very attractive  
7272 for a health plan. That is why you don't have competition.  
7273 Now I will say though that in California we have a number of  
7274 our public plans that compete with private plans, and some of  
7275 those are in rural areas as well, Kern County, for example,  
7276 and so there is competition but again by the nature of that  
7277 market because all health care is local still and it probably  
7278 will be for the most part under the reform, so it depends on  
7279 that market. Ms. Ignagni and Mr. Trautwein, you all are both  
7280 involved in associations that represent companies that I am  
7281 sure provide a lot of group insurance plans to rather large  
7282 employers. Are you at all concerned that employers because  
7283 of this public option being available might just say, you  
7284 know, to save money we are just not going to provide health

7285 insurance anymore?

7286 Ms. {Ignagni.} We are concerned about that, sir, and we  
7287 are also concerned about employers seeing the differences in  
7288 the numbers. As I indicated in my oral testimony there would  
7289 be very little available or left in the private sector  
7290 because the incentives are so compelling, and I think there  
7291 is a strong value in having the best of both, doing a better  
7292 job in the safety net and then doing a better job as we have  
7293 talked about in proving the--

7294 Mr. {Whitfield.} Does this draft bill provide the  
7295 protection that is necessary to protect the private sector?

7296 Ms. {Ignagni.} Well, I think that it is not--we were  
7297 very concerned, as we indicated, that we would not see a  
7298 private sector sustained because the playing field isn't  
7299 level. If you pay at Medicare rates, it is such a major  
7300 differential that that there is no way to sustain a private  
7301 sector.

7302 Mr. {Whitfield.} Okay.

7303 Ms. {Pollitz.} But, Congressman, just to add, under the  
7304 bill if an employer buys through the exchange they have to  
7305 agree to let their employees pick the plan and if they elect  
7306 not to offer coverage and to pay the fee then the employees  
7307 still get to pick the plan so there is no way that employers  
7308 can opt to put people in any of the plans available in the

7309 exchange. It is always up to the individuals.

7310 Mr. {Whitfield.} Are you saying that employers cannot  
7311 just decide to refuse to offer a plan?

7312 Ms. {Pollitz.} Employers first make an election are  
7313 they going to play or pay. Are they going to offer a plan or  
7314 are they going to pay, and if they are outside of the  
7315 exchange they could offer a plan and they would only have the  
7316 choice of buying private plans, and then if they come into  
7317 the exchange it becomes kind of a defined contribution but  
7318 the employees get to pick the plan that are offered between  
7319 public and private.

7320 Mr. {Whitfield.} Ms. Trautwein.

7321 Ms. {Trautwein.} I just wanted to add to that there is  
7322 language in the bill that after a period of time even  
7323 employees that are a part of a program where there is an  
7324 employer-sponsored plan can elect to spin off of that plan to  
7325 go into the exchange. This is a direct threat to employer-  
7326 sponsored coverage. We are very concerned about this because  
7327 you have to maintain a decent participation level inside an  
7328 employer group to have that balance of risk that I was  
7329 talking about earlier. So I think that that is something  
7330 that we should really look at whether that is a good idea to  
7331 keep that in the bill language.

7332 Mr. {Whitfield.} I guess my time has expired. Can I

7333 just ask one other question? I know you have been here for  
7334 hours but just one other question. Ms. Trautwein, in your  
7335 testimony you talked about it is critical that there be a  
7336 financial backstop to accompany reforms of the individual and  
7337 group insurance markets, and I was curious what do you mean  
7338 precisely by backstop?

7339 Ms. {Trautwein.} Well, it could take many different  
7340 forms. It is kind of what I talked about earlier, this idea  
7341 of reinsurance. You know, some states today use a high risk  
7342 pool to backstop their individual market but it doesn't have  
7343 to be that. It is just something to make sure that we  
7344 address the cost of high risk individuals. This is a  
7345 particular problem during the first 5 years, I am  
7346 guesstimating that amount, because it is going to take us a  
7347 while to get the hang of this individual mandate and  
7348 enforcing it. We won't have everybody in overnight and so  
7349 there will still be initially adverse selection, the same  
7350 that we have today in this market, and we have got to do  
7351 something to make sure that those high cost cases don't make  
7352 the cost of coverage go up for everybody else so we are not  
7353 trying to wreck the proposal. We are saying you need to have  
7354 this thing in here to stabilize your proposal so you will not  
7355 have these unintended consequences.

7356 Mr. {Whitfield.} Thank you, Mr. Chairman.

7357 Mr. {Pallone.} Thank you. And I know different members  
7358 mentioned that they are going to submit written questions and  
7359 we ask them to get them to you within the next 10 days or so  
7360 and get back to us as soon as you can.

7361 Mr. {Burgess.} Mr. Chairman, I was also supposed to ask  
7362 unanimous consent that the Blue Cross/Blue Shield data be  
7363 made part of the record.

7364 Mr. {Pallone.} Yeah, let me see. I have something too  
7365 here. I am glad you mentioned it. I almost forgot. So you  
7366 have, what is this, Blue Cross/Blue Shield, you called it?

7367 Mr. {Burgess.} Yes. Ms. Fox testified--as part of her  
7368 testimony she--

7369 Mr. {Pallone.} I am told that it already has been but  
7370 if it hasn't, then we will do it. And I also have to submit  
7371 for the record this study by Health Care for America Now  
7372 showing that 94 percent of the country has a highly  
7373 concentrated insurance market. This is from the American  
7374 Medical Association so without objection we will enter both  
7375 of these in the record.

7376 [The information follows:]

7377 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

|  
7378           Mr. {Pallone.} Thank you very much. I thought this was  
7379 very worthwhile. It is a complex issue but we appreciate  
7380 your input and your optimism as well. It is very important  
7381 so thank you very much. And the 3-day marathon of the  
7382 subcommittee is now adjourned, without objection is  
7383 adjourned.

7384           [Whereupon, at 6:45 p.m., the Subcommittee was  
7385 adjourned.]