HEARING OF THE HEALTH SUBCOMMITTEE OF THE HOUSE COMMITTEE ON ENERGY AND COMMERCE; SUBJECT: COMPREHENSIVE HEALTH REFORM DISCUSSION DRAFT, DAY THREE; CHAIRED BY: REPRESENTATIVE FRANK PALLONE, JR. (D-NJ); WITNESSES: PANEL I: GLENN M. HACKBARTH, CHAIR, MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC); DANIEL R. LEVINSON, INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; PANEL II: TED D. EPPERLY, M.D., PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS; M. TODD WILLIAMSON, M.D., PRESIDENT, MEDICAL ASSOCIATION OF GEORGIA; KARL J. ULRICH, M.D., CLINIC PRESIDENT AND CEO, MARSHFIELD CLINIC; JANET WRIGHT, M.D., VICE PRESIDENT, SCIENCE AND QUALITY, AMERICAN COLLEGE OF CARDIOLOGY; KATHLEEN M. WHITE, PH.D., CHAIR, CONGRESS ON NURSING PRACTICE AND ECONOMICS, AMERICAN NURSES ASSOCIATION; PATRICIA GABOW, M.D., CHIEF EXECUTIVE OFFICER, DENVER HEALTH AND HOSPITAL AUTHORITY NATIONAL ASSOCIATION OF PUBLIC HOSPITALS; DAN HAWKINS, SENIOR VICE PRESIDENT, PUBLIC POLICY AND RESEARCH, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS; BRUCE T. ROBERTS, R.PH, EXECUTIVE VICE PRESIDENT AND CEO, NATIONAL COMMUNITY PHARMACISTS ASSOCIATION; BRUCE YARWOOD, PRESIDENT AND CEO, AMERICAN HEALTH CARE ASSOCIATION; ALISSA FOX, SENIOR VICE PRESIDENT, OFFICE OF POLICY AND REPRESENTATION, BLUE CROSS BLUE SHIELD ASSOCIATION; PANEL III: KELLY CONKLIN, OWNER, FOLEY-WAITE CUSTOM WOODWORKING, MAIN STREET ALLIANCE; JOHN ARENSMEYER, FOUNDER AND CEO, SMALL BUSINESS MAJORITY; GERALD M. SHEA, ASSISTANT TO THE PRESIDENT, AFL-CIO; DENNIS RIVERA, HEALTH CARE CHAIR, SEIU; JOHN CASTELLANI, PRESIDENT, BUSINESS ROUNDTABLE INSTITUTE FOR CORPORATE ETHICS; JOHN SHEILS, SENIOR VICE PRESIDENT, THE LEWIN GROUP; MARTIN REISER, MANAGER OF GOVERNMENT POLICY, XEROX CORPORATION, NATIONAL COALITION ON BENEFITS; PANEL IV: HOWARD A. KAHN, CHIEF EXECUTIVE OFFICER, L.A. CARE HEALTH PLAN; KAREN L. POLLITZ, PROJECT DIRECTOR, HEALTH POLICY INSTITUTE, GEORGETOWN PUBLIC POLICY INSTITUTE; KAREN IGNAGNI, PRESIDENT AND CEO, AMERICA'S HEALTH INSURANCE PLANS; JANET TRAUTWEIN, EXECUTIVE VICE PRESIDENT AND CEO, NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS; LOCATION: 2123 RAYBURN HOUSE OFFICE BUILDING, WASHINGTON, D.C.

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June 25, 2009 Thursday

Section: CAPITOL HILL HEARING

Length: 66149 words

Body

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REP. PALLONE: (Sounds gavel.) The Subcommittee on Health will reconvene our hearing on comprehensive health care ***reform*** on the discussion draft. And we have actually four ***panels*** today. And we are going to get started.

So our ***first panel*** is on Medicare payment. And let me introduce our two witnesses. ***First***, on my left is Glenn M. Hackbarth, who is the chair of the Medicare Payment Advisory Commission, better known as MedPAC. And then, next to him, is the Honorable Daniel R. Levinson who is the inspector general for the U.S. Department of Health and Human Services.

We are starting fresh today. If you had been here at 7 o'clock last night, it wouldn't have been as -- we would have all ***looked*** very tired. But now, we are all fresh. So, you know the drill, we ask you to talk about five minutes and your complete testimony becomes part of the record and then we will have questions. And so, we will start with Chairman Hackbarth.

MR. HACKBARTH.: Thank you, Chairman Pallone and Ranking Member Deal, members of the subcommittee. I appreciate the opportunity to talk about the Medicare Payment Advisory Commission's recommendations for improving the Medicare program.

As you know, MedPAC is a non-partisan Congressional advisory body. Our mission is to support you, the Congress, in assuring Medicare beneficiaries have access to high quality care, while protecting the taxpayers from undue financial burden.

MedPAC has 17 commissioners. Six of the commissioners are trained as clinicians. Seven of the commissioners have experience, either as executives or board members of health care providers or health plans. Three commissioners have high-level experience in congressional support agencies or CMS. And we have four researchers, who add to intellectual regulatory work. And some commissioners have more than one of these credentials. In addition to that, we have a terrific staff headed by Mark Miller, the executive director.

I want to emphasis the credentials of the commissioners to emphasize that we are from the health care system in no small measure. As such, MedPAC commissioners recognize the talent and commitment of the professionals who serve within the health care system. We are not outsiders, critics who have no appreciation of the challenges of being on the frontline.

MedPAC recommendations may be right, they may be wrong. The issues are complex and rarely are they clear cut. But if we are wrong, it isn't because we are inexperienced or lack a stake in the success of the system. We also ***take*** pride in our ability to reach consensus on even complex and sensitive issues. For example, on our March 2009 report, we voted on 22 different recommendations. On those 22 recommendations, there were roughly 300 yes votes and only 4 no votes and 3 abstentions.

All of the MedPAC commissioners agree that Medicare is an indispensable part of our health care system. Not only has it financed care for many millions of senior citizens and disabled citizens, it's helped finance investments in health care delivery that have benefited all Americans.

But we also know that Medicare is unsustainable in its current form. We must slow the increase in costs even while maintaining or improving quality of care and access. We believe accomplishing that task will in turn require both restraint and payment increases under Medicare's current payment systems and a major overhaul of those payment systems.

Medicare's payment systems, and I would add, those used by most private payers, reward volume and complexity without regard to the value of the care for the patient. Moreover, those payment systems facilitate siloed or fragmented practice, whereby providers caring for the very same patient too often work independently of one another.

When care is well-integrated and coordinated, it is usually testimony to the professionalism of the clinicians involved.

That coordination and integration is too rarely supported or rewarded by our payment systems. The resulting fragmented approach to care is not only expensive, it's dangerous, especially for complex patients of which there are many in the Medicare program.

It's MedPAC's belief that we need payment ***reform*** that rewards the efficient use of precious resources and the integration and coordination of care. But it's not enough to simply change how we pay health care providers. We also must engage Medicare beneficiaries in making more cost conscious choices, while being sensitive to the complex nature of the decisions that must be made and the limited financial means of many beneficiaries. It is our belief that the cost challenge facing the Medicare program, and indeed the country, is so great that we need to engage everyone -- patients, providers, and insurers -- in striving for a more efficient system.

In the last several years, MedPAC has recommended a series of changes in the Medicare program that we believe would help improve the efficiency of the care delivered, while maintaining or improving quality. Let me just quickly mention a few of those recommendations. ***First*** is increased payment for primary care services, and perhaps a different method of payment as well. Abundant research has shown that a strong system of primary care is a keystone of a well-functioning health care system.

Second, we've recommended that the Congress ***take*** a number of steps to increase physician and hospital collaboration including gain sharing that would encourage collaboration between physicians and hospitals in reducing cost and improving quality. Third, we've recommended reduced payment for hospitals experiencing high levels of potentially avoidable readmissions. As you know, about 18 to 20 percent of all Medicare admissions are followed by a readmission within 30 days, a cost of roughly $15 billion a year to the Medicare program.

Next, we've recommended a pilot of bundling whereby payment for hospital and physicians services provided during admission would be combined into a single payment and perhaps combined with payment for post acute services as well. Next, we've recommended ***reform*** of the Medicare Advantage program so that participating private plans are engaged in promoting high performance in our health care system instead offering plans that mimic Medicare.

REP. PALLONE: Mr. Hackbarth, I want you to finish but I just want you to know you're a minute over, so --

MR. HACKBARTH: Okay. I am to the last step, Mr. Chairman.

Let me just close with two cautionary statements. One is that changing payment systems -- and we must change them -- and doing so with some speed is going to require more resources and broader discretion for CMS than it now has.

The second caution is that while we need to ***reform*** payment, it's going to ***take*** some time. And in the meantime we need to continue pressure on the prices under our existing payment systems in the Medicare program. Thank you.

REP. PALLONE: Thank you very much for what is really important in terms of what we are trying to accomplish here. I appreciate it.

Mr. Levinson.

MR. LEVINSON: Good morning, Chairman Pallone, Ranking Member Deal and members of the subcommittee.

REP. PALLONE: Your mike may not be on, or maybe it is not close enough. Try to move it -- no, I think you've got to press it -- when the green light is on it's -- green light on?

MR. LEVINSON: It is.

REP. PALLONE: Now you're fine.

MR. LEVINSON: Okay, thank you.

Chairman Pallone, Ranking Member Deal, members of the subcommittee, good morning. I thank you for the opportunity to discuss the Office of Inspector General's work at this very important time of deliberations over health care ***reform***.

Based on our experience and expertise our office has identified five principles that we believe should guide the development of any national health care integrity strategy. And consistent with these principles, OIG has developed specific recommendations to better safeguard federal health care programs. My office has provided technical

assistance, as requested, to staff from the committee, and we welcome the fact that many of OIG's recommendations have been incorporated into the ***House*** tri-committee health ***reform*** discussion draft.

Principle one, enrollment, scrutinize those who want to participate as providers and suppliers prior to their enrollment in the federal health care programs. Provider enrollment standards and screening should be strengthened making participation in federal health care programs a privilege, not a right.

As my written testimony describes, a lack of effective provider and supplier screening gives dishonest and unethical individuals access to a system that they can easily exploit. Heightened screening measures for high-risk items and services could include requiring providers to meet accreditation standards, requiring proof of business integrity or surety bonds, periodical recertification and onsite verification that conditions of participation have been met, and full disclosure of ownership and control interests.

Principle two, payment. Establish payment methodologies that are reasonable and responsive to changes in the marketplace. Through extensive audits and evaluations, our office has determined that Medicare and Medicaid paid too much for certain items and services. When pricing policies are not aligned with the marketplace, the programs and their beneficiaries bear the additional cost. In addition to wasting health care dollars, these excessive payments are a lucrative target for unethical and dishonest individuals. These criminals can reinvest some of their profit and kickbacks thus using the program's funds to perpetuate the fraud schemes.

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

Principle three, compliance. Assist health care providers in adopting practices that promote compliance with program requirements. Health care providers can be our partners in ensuring the integrity of our health care programs by adopting measures that promote compliance with program requirements.

The importance of health care compliance programs is well recognized. In some health care sectors, such as hospitals compliance programs are widespread and often very sophisticated. New York requires providers and suppliers to implement an effective compliance program as a condition of participation in its Medicaid program.

Medicare Part D prescription drug plan sponsors are also required to have compliance programs. Compliance programs are an important component of the comprehensive integrity strategy and we recommend that providers and suppliers should be required to adopt compliance programs as a condition of participating in Medicare and Medicaid.

Principle four, oversight. Vigilantly monitor the programs for evidence of fraud, waste, and abuse. The health care system compiles an enormous amount of data on patients, providers and the delivery of health care items and services. However, federal health care programs often fail to use data and technology effectively to identify improper claims before they are paid, and to uncover fraud schemes. For example, Medicare should not pay a clinic for HIV infusion when the beneficiary has not been diagnosed with the illness or paid twice for the same service.

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

As fraud schemes evolve and migrate rapidly, access to real-time data and the use of it -- and the use of advanced data analysis to monitor claims and provider characteristics are critically important.

OIG is using innovative technology to detect and deter fraud and we continue to develop our efforts to support a data driven anti fraud approach. However, more must be done to ensure that we and other government agencies are able to access and utilize data effectively in the fight against health care fraud.

Final principle, response. Respond swiftly to the detected fraud, impose sufficient punishment to deter others, and promptly remedy program vulnerabilities. Health care fraud attracts criminals because the penalties are lower than those for other criminal offenses. There are low barriers to entry. Schemes are easily replicated and there is a perception of a low risk of detection. We need to alter the criminal's cost/benefit analysis by increasing the risk of swift detection and a certainty of punishment.

As part of this strategy, law enforcement is accelerating our response to fraud schemes. The HHS-DOJ Medicare Fraud Strike Force model described in my written testimony is a powerful anti-fraud tool and represents a tremendous return on investment. These strike forces have proven highly effective in prosecuting criminals, recovering payments for fraudulent claims and preventing fraud through a powerful sentinel effect.

In conclusion, our experiences and results in protecting HHS programs and beneficiaries have applicability to the current discussions on health care ***reform***. We believe that our five principle strategy provides the framework to identify new ways to protect the integrity of the programs, meet the needs of beneficiaries, and keep federal health care programs solvent for future generations.

We appreciate the opportunity to work with the committee. We welcome your questions. Thank you.

REP. PALLONE: Thank you. Thank you both. I'm going to ask my questions of Mr. Hackbarth, but not because what you said is not important, Mr. Levinson. I think this whole issue of enforcement, fraud and abuse is really crucial.

But I -- yesterday, Mr. Hackbarth, I asked basically the same question of Secretary Sebelius. In other words, you know, on the one hand we are talking about reductions in payments for certain Medicare and Medicaid programs. On the other hand, we are talking about enhancements, and you know, actually spending more on other aspects of Medicare and Medicaid. For example, Medicare Part D, filling up the doughnut hole. And you do both.

In other words, my understanding is that, you know, your recommendations which we -- many of which are incorporated in this discussion draft accomplish both purposes. So what I wanted to do though is, I think, there is more media attention on cuts than there is on what you do to enhance programs.

So I wanted you to talk a little bit about what motivates MedPAC to ***propose*** some of the reductions we are contemplating, you know, like the Medicare Advantage, the home health rebasing productivity into payment updates and the rest. But why is it that the MedPAC sees these as important policy ***proposals*** on their own terms, not because of, you know, cost savings?

MR. HACKBARTH: Well, Mr. Chairman, we believe that pressure on the prices in the Medicare payment system is important to force the system towards more efficiency. As you and the other members of the committee know, Medicare has administered price systems that are set through a government process as opposed to market prices.

We believe that what we have to do with that administered price system is mimic, so far as possible, the sort of pressure that exists in a completive marketplace. The taxpayers who finance the Medicare program face relentless pressure often from international competition, for example, forcing the firms that they work for to lower their costs day in and day out.

We think the health care system must experience the same sort of pressure.

REP. PALLONE: And then the solvency of the trust fund is extended and premiums are reduced and the program is maintained for future generations, so that is the ultimate goal?

MR. HACKBARTH: Absolutely.

REP. PALLONE: And let me ask you another question about, you know, we get this argument from some -- and not too many, but some employers and providers complain about alleged cost shifting for Medicare to the private sector.

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

MR. HACKBARTH: Yeah. Well, let me start by saying that we believe that Medicare payment rates are adequate, we don't believe that there are too low. We don't believe that they should be increased. And we -- let me focus on hospital service that is -- as an example of that. We ***look*** at the data in several different ways. We've ***looked*** at time series data, and you see there is a pretty consistent relationship.

In periods where private payments are generous Medicare margins become negative and it's is our belief that that is because when the private payment are generous, hospitals have more money to spend and they spend it. It's a largely not-for-profit industry if they get revenue, they will spend it.

And then we see the same pattern, when we ***look*** at individual hospitals. So what we have identified is a group of hospitals that don't have a lot of generous payment from private payers. They have constrained resources. Those institutions lower their costs, and actually have a positive margin on Medicare business. They don't have the luxury of additional private money flowing into their institutions. They are forced to control costs and they do control costs as a result.

REP. PALLONE: And so you disagree with claims that Medicare is responsible for high health insurance premiums.

MR. HACKBARTH: No, I -- if institutions -- clearly the rates paid by Medicare and private payers are different, and private payers pay higher rates, it does not follow from that however, if you increase Medicare rates that the private rates would fall.

REP. PALLONE: Okay. Then let me just one more thing about access. You know, we hear about in some parts of the country that, you know, Medicare enrollees say that they can't find a doctor willing to accept new patients. Based on your research, do you have any reason to believe that we have a crisis of access in Medicare that basically providers are not ***taking*** Medicare in a significant way?

MR. HACKBARTH: Each year we do a careful study of access for Medicare beneficiaries, asking both the patients and physicians. Our most recent patient survey, which was done in the fall of 2008, found that Medicare beneficiaries are more satisfied with their access to care than private patients -- privately insured patients in the 50 to 64 age group.

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

REP. PALLONE: Which was one of the things we are trying to address in this discussion here. Thank you.

Mr. Deal.

REP. NATHAN DEAL (R-GA): Mr. Hackbarth, let me follow up on one of your comments about your ***look*** at those hospitals that have higher ratios of Medicare patients and lower ratios of private paying patients. And I believe your statement was that they are able to make a profit and in fact be more profitable than some of the ones who have lower volume of Medicare patients. Don't those hospitals receive DSH payments as a general rule?

MR. HACKBARTH: Some of them may, yeah.

REP. DEAL: Does your recommendation in any way address whether DSH payments should continue or be abolished?

MR. HACKBARTH: We have had some discussion, Mr. Deal about refocusing DSH payments. We have not recommended abolishing them.

REP. DEAL: Okay.

Mr. Levinson, the draft talks about expanding Medicaid coverage and providing federal payment of 100 percent for some of this expansion of new populations, so that the states don't have to pick up even their matching share in their Medicaid formula. If that is the case, if the federal government picks up 100 percent of this cost, are you concerned that states will no longer have the incentive to ***look*** for the waste, and the fraud, and the abuse because they don't really have any state dollars in that pot. Is that a concern from your standpoint?

MR. LEVINSON: Well, it is certainly always a concern about what is occurring with the federal share of Medicaid, and indeed, as we ***look*** for a larger share of that on the federal side, it becomes of greater interest to us at the federal level. It's an issue actually that I, as a member of the Recovery Act Accountability and Transparency Board, is already dealing with, with my colleagues on the board because the ARRA does include a significant increase in the federal share funding to alleviate states of some of the Medicaid burden.

And in some of the states, particularly, in the South Central part of the United States we are approaching a level where states give little, if any, contribution to Medicaid. So we are focusing on ensuring that there are controls in place to make sure that, you know, the Medicaid dollar is protected. But as the federal involvement becomes greater, the need for more federal monitoring of those dollars also becomes greater.

REP. DEAL: Because the states have been the primary enforcement -- the ***first*** line of enforcement against fraud and abuse with oversight from the federal. So you're saying that there may be a need for more federal oversight?

MR. LEVINSON: That is correct. Historically, the Medicaid fraud control units, which exist in nearly every State of the Union, have been really the ***first*** protectors, as it is, of the Medicaid program.

We have provided oversight. In the last several years though, the Congress has provided us additional funding to be more involved in the monitoring of those Medicaid dollars as the federal share has increased.

REP. DEAL: Mr. Hackbarth, in your testimony you make reference, I think, to the fact that about 60 percent of beneficiaries now buy supplemental policies to cover part of their Medicare costs. That seems to me a little bit inconsistent with your conclusion that the Medicare reimbursement rates are adequate.

I know one is from the provider standpoint and the other being from the patient standpoint. Do you foresee from the patient standpoint that if we model everything after the Medicare reimbursement rates in the Medicare model that there is going to be a need for even more purchasing of supplemental insurance by individual patients?

MR. HACKBARTH: Well, as you say, Mr. Deal, there are two distinct issues. One is the adequacy of payment rates to providers and we believe those payment rates are adequate. The Medicare benefit package is probably not designed the way any of us would design it.

If we're starting with a clean piece of paper, the design could be streamlined and that process may reduce the need for beneficiaries to buy supplemental coverage. For example, if we were to add catastrophic coverage, a key missing component on Medicare that might reduce the perceived need for supplemental coverage.

REP. DEAL: Okay.

MR. HACKBARTH: We've begun ***looking*** at that redesign issue.

REP. DEAL: Real quickly. You were going through your principles that you have recommended and you got through most of them, I think. In the very short time that I have left, are there any of those principles that, you are concerned, are not being addressed in this discussion draft in particular any that you have great concern about?

MR. HACKBARTH: Off the top of my head, Mr. Deal, I can't think of one.

REP. DEAL: Okay.

Thank you, Ms. Chairwoman.

REP. LOIS CAPPS (D-CA): The chair now recognizes Mr. Murphy for his questions.

REP. CHRIS MURPHY (D-CT): Thank you very much, Madame Chair.

And Mr. Hackbarth, thank you so much for all the work that you've done guiding this Congress on this issue of moving away from a volume- based system to a system that attempts to really reward outcome and performance. And I think I for one am worried that if we don't ***take*** advantage of this moment in time with this health care ***reform*** debate to make those changes that we may never be able to make them.

And so, I know Mr. Deal just asked you a general question about whether there were points of ***reform*** that you've pushed that aren't in this bill. But I wanted to ask specifically on this issue of payment ***reform***. Have you ***taken*** a ***look*** at this bill with regard to payment ***reform***, and how do you think it measures up versus what you think could be potentially done through this ***reform*** act with regard to transforming our payment system?

MR. HACKBARTH: Well, as I indicated to Mr. Deal, I think that the bill's provisions on Medicare are pretty comprehensive and address the major issues that MedPAC has raised about the Medicare program. Having said that, some of the provisions -- let me ***take*** an example, accountable care organizations we are bundling, you know, the bill provides for pilots of these new ideas, and in fact that's what MedPAC has recommended. These are complex ideas that will ***take*** time to develop and refine, so the bill includes provisions.

We shouldn't assume from that that, oh, it's a done deal. There is lots of work that needs to be done in CMS in particular to make these things a reality.

REP. MURPHY: Well, and that was going to my second question. You've had a lot of experience in pilot programs and I think one of the things that some of us worry about is that it's -- that there has been a lot of research done on, for instance, the issue of accountable care organizations and bundling, and I think the majority of evidence is that they work that they get good outcomes and they can reduce costs. And so if we are going to go into a bill that pilots these, how do we make sure that if the pilots turn up with the outcomes that pretty much every other -- all other work on these payment ***reforms*** have done, how do we make sure then that becomes a system wide ***reform***?

MR. HACKBARTH: Yes, this is an issue that I think we discussed last time I was with the committee. The pace at which we make changes, ***reform*** the Medicare payment system is way too slow. And one of the things that we've recommended is a broader use of pilots as opposed to demonstrations.

And the difference in our mind is that under a pilot, the secretary has the authority to move to implementation if a pilot achieves a stated objective. It doesn't have to come back through the legislative process.

And we think that's a very important step, and again I'd emphasize CMS needs more resources to do these things both quickly and effectively. They are operating on a shoestring and the work is too important, too complex to allow that to continue.

REP. MURPHY: And let me ask then specifically about this issue of accountable care organizations. And it seems to me that one of the ways that you expand out to a system of outcome based performance is that you try to encourage physicians to join in and collaborate. And we've put in an enormous amount of money in the stimulus bill into giving physicians and hospitals the information technology to create those -- and those interactions in that coordination.

And I guess I would ask you, what are the ways that we need to be ***looking*** at in order to try to provide some real incentives for physicians to coordinate, become part of multi-specialty groups, enter into cooperative agreements? And then should we be ***looking*** at only incentives or should we be ***looking*** at something tougher than incentives to try to move more quickly to a system by which physicians aren't operating in their own independent silos?

MR. HACKBARTH: Well, the fact that we have a fragmented delivery system, I believe, is the result of how we've paid for medical care, not just in Medicare but also in private insurance programs for so many years.

We basically enabled the sort of siloed independent practice without coordination. The most important step we can ***take*** is change the payment systems so that services are bundled together and physicians of various specialties and various types of providers must work together. And there is abundant evidence that when they do that, we not only get lower costs, we get better quality.

REP. MURPHY: Thank you very much, Madame Chair.

REP. CAPPS: Thank you.

The chair now recognizes Congressman Burgess for his questions.

REP. MICHAEL BURGESS (R-TX): Thank you, Madame Chair.

Mr. Hackbarth, always good to see you.

MR. HACKBARTH: Good to see you.

REP. BURGESS: And I have several questions that I'm going to submit in writing because time is so short during these Q-and-A's, but -- and I was going to reserve all my questions in fact for the inspector general, but I just have to pick on a point that was just expressed.

And under the accountable care organization within Medicare, just within the Medicare system with Medicare being an entirely federal system -- it is not a state system. It is a federal system, so we don't have state mandates in Medicare. It functions across state lines. If we were to provide an incentive that is a backstop on liability under the Federal Tort Claims Act for doctors practicing within the Medicare system who practice under the guidelines of whatever we decide the accountable care organization -- the proper accountable care organization should be, would that not be the type of incentive that we could offer to physicians that would not require increase in payments, but yet would bring doctors -- increase their interest in practicing within these accountable care organizations?

MR. HACKBARTH: Yeah. Dr. Burgess, MedPAC is not -- ***looks*** specifically at the malpractice issue. We principally focus on federal issues, you know, that's our -- REP. BURGESS: But if I could -- we could make liability a federal issue within the Medicare system because defensive medicine does cost the federal system additional dollars as Dr. McClellan's great article from 1996 showed.

MR. HACKBARTH: Right. And in -- my point is that there is no MedPAC position on malpractice issues. As you know though I've been -- I am -- formerly a CEO of a very large medical group, so I've a lot of experience working with physicians and I know how large malpractice looms in the minds of physicians.

Because I have not studied the issue in detail, I don't have the specific recommendation, but I think addressing physician concerns by malpractice is a reasonable thing to do --

(Cross talk.)

REP. BURGESS: Well, one of the things that really bothers me about these discussions in this committee, you have so many people who have never, never run a medical practice as you have, and as some of us have. Doctors tend to be very goal-directed individuals. That is why the fee-for-service system has worked for so long because you tell us what to do and what the rules are and we make a living at it.

I'm not a big fan of bundling. I don't trust hospital administrators as a general rule and I would not trust them to appropriately apportion out the payments, so not a big fan there, but are there -- there ought to be other ways to tap into the goal- directed nature of America's physicians to achieve the goals that you're trying to get. And right now, I don't think, at least from what I've seen, we're quite there. I'm going to actually go to Mr. Levinson, because what you have talked about is so terribly important and let me just ask a question.

Right now, within the discussion draft we're talking about, I don't think the numbers are filled in as far as the budget, the numbers -- the dollar numbers that are going to be there. What do you need today in order to do your job more effectively?

MR. LEVINSON: While we certainly need the resources that we have been given by the Congress and by the executive and it is certainly being used I think in an optimum way, but as the mission get larger, the need for greater resources also is there.

REP. BURGESS: And I'm going to interrupt you, that's an extremely important point because we've increased the FMAP on -- and so in the stimulus bill and some of the other things that we're talking about doing, is that not going to increase the burden, the pressure that's placed on you and your organization in order to provide the proper oversight?

MR. LEVINSON: Certainly, our mission has been heading north for the last few years and we are really pressed to enlist really the best investigators, evaluators, lawyers, and auditors we can find to handle, you know, a much larger budget than historically we ever have had before.

REP. BURGESS: It is not just you, because my understanding from talking to folks back home in the Dallas, Fort Worth area, from within the HHS Inspector General's shop, and within the Department of Justice's jurisdiction, there's actually a deficit of prosecutorial assets or actually assets have been -- been had to use for other things, homeland security, narcotics trafficking. And there is not the prosecutors to devote to the cases that you all develop to bring those cases to trial.

MR. LEVINSON: That's a very important point and sometimes it's overlooked how key it is to understand that the resources that are used to fight health care fraud really require a collaborative effort across several different government entities and if you have the Justice Department personnel but don't have the IG personnel --

REP. BURGESS: Right.

MR. LEVINSON: -- and vice versa, you really have a significant problem.

REP. BURGESS: And just one last point. I will submit several questions in writing. On the issue that we're hearing so much about in McAllen, Texas where the -- McAllen appears to be an outlier.

Many physicians from the Texas border area were in town yesterday. I don't represent the border area, but they discussed it with me. They are concerned obviously about the negative press that they have been getting over the report by Dr. Gawande in the New Yorker magazine.

Is there any special focus that you are putting on that area because of the possibility of diversion of Medicare or Medicaid dollars within other ancillary agencies, imaging, drugs, home health? Are -- is the possibility that this number is skewed not because of practitioners in the area, but because in fact the -- that we don't have the resources to devote to the investigation of the fraud, the prosecution of the fraud when it's uncovered?

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

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

REP. BURGESS: Is that on your radar screen to pull that into the investigative process?

MR. LEVINSON: I can only say that the entire nation is on our screen because we have such an extensive jurisdictional requirement.

REP. BURGESS: All right.

Thank you, Ms. Chairwoman.

REP. CAPPS: The chair now recognizes Mr. Green for his questions.

REP. GENE GREEN (D-TX): Thank you.

Mr. Hackbarth, in your testimony you cited a lack of care coordination, and a lack of incentive for writers to actually coordinate care as a cost burden and I agree. And we have several coordination bills pending before our committee. One is a RE-Aligning Care Act, which focuses on geriatric care coordination.

Your testimony cites geriatrics as an area in which care coordination is especially necessary. Can you elaborate on how geriatric care coordination can help lower health care costs, and again, we're dealing with Medicare, but maybe we could also deal with whatever we create as in -- in the national health care.

MR. HACKBARTH: Geriatricians, as you know, tend to focus on elderly patients who have very complex, multiple illnesses. And for those patients, not only is the potential for inappropriate unnecessary care large, the risk to the patient of uncoordinated care is very large, indeed. And so such patients really need somebody who is going to follow them at each step, not hand them off to specialists and then they are handed to another specialist and another -- they need somebody, as that home base, to integrate and coordinate the services.

REP. GREEN: And I know that's our goal is to talk about a medical home where someone did -- any of us -- a number of us had elderly parents who we've had to monitor the number of doctors visits simply because they also ***take*** lots of different medications that there is nobody coordinating that except maybe a family member.

MR. HACKBARTH: And the problem is, as you well know Mr. Green, is that Medicare really doesn't pay for that activity outside of the patient visit, the phone calls that need to be made to pull together the services so that they are well integrated. And so we made a series of recommendations to increase payment for primary care and the medical home which in addition to those fee-based payments has a per patient sum to support that sort of activity.

REP. GREEN: And since we're also concerned about the scoring, did MedPAC ***look*** at, by creating this benefit of coordinated care, could we save on the back end? Is there something we could quantify, say to the CBO, or someone could -- could say, we -- over a period of time let's -- we think we can save ultimately?

MR. HACKBARTH: Yeah, well, it's our hope and perhaps even our expectation that there would be savings, but what we've recommended and what the Congress has done is a large scale pilot so that -- in fact, we can hopefully document those savings and to have a resulting CBO score from it.

REP. GREEN: Okay. And I know we have your -- under current law, we have your Welcome to Medicare Exam that -- do you think that could fit in there with what we would call a geriatric assessment initially and then build on using that primary care?

MR. HACKBARTH: Potentially, because it gives the physician, hopefully a strong primary care physician, an introductory assessment of all of the patient's problems right from the outset.

REP. GREEN: Okay. And again I know there is a provision in the bill and a lot of us have that interest and that's one of the good things about this bill that we're dealing with, again, since we're ***looking*** at scoring, say, you know -- and it's hard to get CBO to say at the end we can save money -- not only save money but almost -- much more humane dealing with Medicare or any patient, in all honesty.

MR. HACKBARTH: What I can say, Mr. Green, is that, as I said in my opening comment, there is abundant evidence that systems that have strong primary care have lower costs and higher quality than systems that don't have strong primary care. You see that in international comparisons, you see that in studies within the United States that compare regions with one another, you see that within health systems. So there is lots of evidence of that sort, whether CBO considers that strong enough to score is --

REP. GREEN: Well --

MR. HACKBARTH: -- a CBO issue not --

(Cross talk.)

REP. GREEN: Maybe by your testimony we can encourage CBO to ***look*** at other countries that have a primary care emphasis and how that can reduce the cost. So maybe the bean counters can actually say this works. And so I appreciate your testimony and hopefully, we'll get that in our response when we're -- when we get that score. So thank you.

Mr. Chairman -- Madame Chairman, I yield back my time.

REP. CAPPS: Congressman Gingrey is now recognized.

REP. PHIL GINGREY (R-GA): Madame Chairman, thank you, and I'm going to direct my questions to Mr. Hackbarth.

Mr. Hackbarth, among the barriers to achieving value in Medicare cited in your testimony, you state that Medicare payment policies ought to, quote, "Ought to exert fiscal pressure on providers." You go on to state that on a fully competitive market, which I'm guessing, infers that Medicare does not compete in a fully competitive market, that this fiscal pressure happens automatically in a fully competitive market.

In the absence of such a competitive market you suggest that Congress must exert this pressure by limiting payment updates to Medicare physician updates. When creating Medicare Part D, Congress considered instituting a set payment rate in lieu of creating a competitive market, where competition among the pharmacy benefit plans might automatically keep the cost down.

In the end, this Congress elected to go with that competitive model and forgo payment rates set in statute, some of those that exist on the current Medicare fee-for-service.

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

So instead of exerting the fiscal pressure on providers that you suggest must be exerted due to the lack of competitive markets that do it automatically, I'm curious as to your thoughts, on how using a competitive bidding process like what we did in Medicare Part D might achieve the same sort of efficiencies you suggest are required in traditional Medicare, but without having to resort to restricting the payments.

MR. HACKBARTH: Well, let me approach it from two directions, Dr. Gingrey. If we ***look*** at private insurers in the private insurance market place, and we compare the cost of those programs with Medicare costs, what we see is that on average, and my evidence here is from the Medicare Advantage program is that the bids submitted by the private plans are higher than Medicare's costs. They are not lower.

Now, there are some plans that bid lower, but on an average, the private bids are higher. So that's an opportunity for private plans to come in and compete, and to show that they can reduce costs, and by their own bids they have not done that.

REP. GINGREY: You're talking Medicare Advantage.

MR. HACKBARTH: Medicare Advantage.

REP. GINGREY: But of course, they -- Mr. Hackbarth, they do provide something that these three committees that have come up with this draft legislation, if you will, really want -- and that is, of course, emphasis on things other than just episodic care, treatment of pain and suffering, but also a wellness, prevention, and that sort of thing.

MR. HACKBARTH: Yeah, some do, some don't. The private plans are quite variable in their structure, how they deal with the providers, what sort of care coordination programs they have, and most importantly, they are quite variable in their bottom line results. Some are outstanding, some are not.

REP. GINGREY: Yeah, let me go on to another question. I thank you for that response. One of the foundations of your testimony today is that the American health care system has serious quality problems. You quote, "At the same time that Americans are not receiving enough of the recommended care, the care they are receiving may not be appropriate," end of quote.

And then you go on to cite the Dartmouth Center for the Evaluative Clinical Services as proof of a wide variation in Medicare spending and rates of service use. Just to be clear, when you say "the American system," Mr. Hackbarth, are you referring to the American Medicare system and not the entire American health care system?

Am I correct in that assumption, given that the Dartmouth study used only Medicare data for its findings? We're talking about the American Medicare system and not the entire health care system.

MR. HACKBARTH: Well, in fact the Dartmouth study is done using Medicare data, because it's the most readily available comprehensive database. I don't think there is any reason to believe that physicians are practicing different for Medicare patients and private patients.

In fact my own personal experience in working closely with physicians is that it's a matter of principle that they don't vary their care based on the insurance coverage of the patient. They treat the patient based on what the patient needs. So I think it's a reasonable inference if you see this variation in Medicare you will likely have the same variation --

REP. GINGREY: Well, I know my time is up, Madame Chairman. But I -- and the reason I asked you this question, Mr. Hackbarth, because we're going to have another ***panel*** -- several more ***panels*** today. But I think there are going to be some physicians that are practicing in the private market that might want to --

MR. HACKBARTH: Okay.

REP. GINGREY: -- dispute what you just said. But thank you so much for your response.

And I yield back, Madame Chairman.

REP. CAPPS: Thank you. I now yield myself -- my time for questions. And thank you both for your testimony today.

Mr. Hackbarth, we're sort of picking on you I think, but you can tell from the questions that Medicare payment ***reform*** seems to be a very pressing issue for many of us. And one of the Medicare payment ***reforms*** we're suggesting in this legislation is the change to the GPCI formula in California so that it is now based on MSAs, metropolitan statistical area.

Two of the counties I represent in California are negatively impacted by the current payment formula. Physicians in both San Luis Obispo and Santa Barbara counties are paid less, much less they would say, than the actual cost of practicing medicine.

My question to you is in general, but also specifically toward California. Will the GPCI provisions improve the accuracy of payments in the new fee schedule areas that you -- across the country -- as you have envision them?

MR. HACKBARTH: Yeah, the provision related to California in the bill is based on one or two options that MedPAC developed for CMS back, and I think it was 2007. So the approach in the bill is consistent with the advice that we've given CMS.

REP. CAPPS: Excellent. And then maybe you could elaborate a little bit on the benefit, obviously, that you are seeing from having physician payment areas aligned with hospital payment areas, and is that again consistent around the nation once we get our alignment correct in California.

MR. HACKBARTH: Well, the issue that we focused on was specific to California. As you know the GPCIs work differently in different states. And so our recommendation wasn't that this approach be applied everywhere, but we saw it as a reasonable solution to the California issues that you and other members have raised.

REP. CAPPS: Now, we did -- we have seen that other areas within a country have this disparity as well, but do you think those are best resolved on a regional basis?

MR. HACKBARTH: Yeah, different states have elected to resolve it differently. And we think the problems are not national in scope but more isolated, and the more tailored approaches are the best way to go.

REP. CAPPS: And that would be a pattern that you might suggest in other areas as well that we ***look*** at regional issues, particularly, at least in the payment schedules --

(Cross talk.)

MR. HACKBARTH: Yeah. Well, you know, that's a big statement. And I --

(Cross talk.)

REP. CAPPS: -- to see how far you want to go.

MR. HACKBARTH: Yeah, I'd like to ***take*** a ***look*** at -- and consider the issues one by one as opposed to make that as a broad policy statement.

REP. CAPPS: Well, I know our -- my California colleagues -- that this has been a real, serious detriment to Medicare.

MR. HACKBARTH: Yes.

REP. CAPPS: In the practice of Medicare in our state, in many of the regions that the cost of living has been --

MR. HACKBARTH: Right.

REP. CAPPS: -- very different from what the allotment has been. So this becomes for us, a really vital component of Medicare ***reform*** under this bill.

MR. HACKBARTH: Yes, and as I said, we think the approach in the bill is a reasonable one and it's one of the options that we recommended to CMS.

REP. CAPPS: Okay. I'm going to yield back my time and recognize Mr. Buyer for his questions.

REP. STEVE BUYER (R-IN): See, a company in Tampa just shut their doors to 500 jobs due to the SCHIP bill. They are going to send the tobacco -- those cigars to be made offshore, just thought I'll let everybody know. Who really cares, I guess.

This has been a challenge to get my arms around this in a short period of time, just being very honest with you. So I'm trying to understand -- I just went through that tobacco bill where the majority froze the market. So there now -- they love this talk about competition, and they love to freeze the market in place. And I'm getting a sense that that's what you are doing in this bill also. You freeze the market.

So those of whom who had existing plans, you freeze it, grandfather it, and then you got to figure out how you move people into the exchange, and if you -- and when we freeze that market -- help me here with my logic, I'm trying to figure out what you are trying to do. We freeze that market and you want to move a population into an exchange. You can -- we'll grandfather so people can keep their existing coverage, but if at some point in time that employee chooses to move to a government plan, then the employer has to pay an 8 percent tax on it. Is that right?

(Cross talk.)

MR. HACKBARTH: Mr. Buyer -- Congressman Buyer -- Buyer, I'm sorry.

REP. BUYER: Okay.

MR. HACKBARTH: Our focus is on the Medicare provisions of the bill, and the bill is not our bill. We are advisory --

(Cross talk.)

REP. BUYER: Okay. So you can't answer that question.

MR. HACKBARTH: Absolutely not.

REP. BUYER: All right.

MR. HACKBARTH: It's beyond our jurisdiction.

REP. BUYER: No, no, no, that's okay. Let me ask a question that is within your jurisdiction. You had -- so you had suggested that encouraging the use of comparative-effectiveness information would facilitate informed decisions by

providers and patients about alternative services for diagnosing and treatment of most common clinical conditions, is that correct?

MR. HACKBARTH: Uh-huh.

REP. BUYER: "Uh-huh" means yes?

MR. HACKBARTH: Yes, sir.

REP. BUYER: Thank you. Following your line of reasoning, could the Medicare program also use this research to exert fiscal pressure on drug and device-makers or even restrict certain procedures based solely on price?

MR. HACKBARTH: What MedPAC has recommended is that the federal government invest in comparative effectiveness research, make it available to physicians, patients, insurers, for them to make their own decisions about how to use the information.

REP. BUYER: Then how best do we -- i.e., Congress, how best do we make sure that this research is used to inform the consumer and providers without being an excuse to exclude or ration certain types of care. How do we best do that?

MR. HACKBARTH: Well, decisions about how Medicare would use the information are issues on which Congress can legislate. What MedPAC has recommended is investment in information to be used in a decentralized way by all of the participants in the system.

REP. BUYER: All right. Mr. Levinson, the -- one of the great concerns I have is -- can you -- would you be able to address Medicare -- a comparison or an analogy on Medicaid, I know you're Medicare -- you guys are claiming lanes of jurisdiction here.

MR. LEVINSON: Mr. Buyer, we -- actually as an Office of Inspector General, we oversee all 300 programs --

REP. BUYER: Okay.

MR. LEVINSON: -- of the department.

REP. BUYER: All right.

MR. LEVINSON: So we also have --

REP. BUYER: Most of these --

(Cross talk.)

MR. LEVINSON: -- on the side of Medicaid.

REP. BUYER: All right, thank you. So most of the fraud cases, with regard to Medicaid, are they discovered by the states or are they discovered by the federal government?

MR. LEVINSON: Medicaid cases can be developed along a very wide spectrum of possible sources.

REP. BUYER: I understand, but are most cases discovered in the states or by the federal government?

MR. LEVINSON: I would have to find out those numbers for you. I suspect that it would be mostly states in terms of absolute number, but in terms of dollars because some of the biggest Medicaid --

REP. BUYER: All right, don't do it by dollars, you do it by cases.

MR. LEVINSON: By the number of cases --

REP. BUYER: I think commonsense tells us. Let me jump -- jump ahead --

(Cross talk)

REP. BUYER: I think commonsense is going to tell us that if states had a stake in the game that they have an incentive then to make sure they go after fraud cases. If the federal government picks that up at 100 percent, my concern is, are we dis-incentivizing states with this oversight responsibility, which put -- lays this more on you, and is that a concern to you?

MR. LEVINSON: It is a certainly a very important concern that we make sure that every Medicaid dollar, and we of course have responsibility for the federal share of that Medicaid, is accounted for as much as possible. And as the federal share, as the FMAP goes north, goes up, obviously our reach needs to be greater, our concern needs to be elevated on the Medicaid side, absolutely.

REP. PALLONE: Thank you.

The gentleman from Iowa, Mr. Braley.

REP. BRUCE BRALEY (D-IA): Thank you Mr. Chairman.

Mr. Levinson, to follow up on that point, all of us on this subcommittee are strongly opposed to fraud in any health care delivery system. So let's start with that premise. I think the real elephant in the room is that fraud is a small component of what the real obstacle is to meaningful ***reform*** health care ***reform*** and that's waste.

Because according to many reliable projections there are $700 billion annually of waste in Medicare delivery. Which is a much greater problem because if you ***take*** that number and multiply it over the 10 year period of this health care bill we're talking about, you're talking about $7 trillion of cost savings that would more than pay for the entire cost of the program we're talking about. So isn't it waste that's really the problem here?

MR. LEVINSON: Mr. Braley, we try to identify and correct issues of fraud, waste, and abuse. And we do not have solid figures in which to share with you exactly how that pie maybe divided specifically. But all of those kinds of issues are of great concern to the office. And we have work that supports recommendations in all of those areas.

REP. BRALEY: And they should be of concern to American taxpayers also.

MR. LEVINSON: Absolutely.

REP. BRALEY: Okay.

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

MR. HACKBARTH: It's our belief that -- yeah, we can do better with less. And there is lots of research to support that.

REP. BRALEY: Well, and one of the problems that my health care providers in Iowa have is that for years they consistently rank in the top five in every objective quality measurement and at the very bottom of Medicare reimbursement. Isn't that a summary of what's wrong with our health care model today?

MR. HACKBARTH: Yeah. Well, my home state of Oregon is also one --

REP. BRALEY: Exactly.

MR. HACKBARTH: -- with you in Iowa. And so that's a type of evidence that we can do better for less in Medicare. You know, I think it's good for Iowa and good for Oregon that we've got lower health care costs and high quality. Not only does it hold down Medicare expenditures, it's good for our beneficiaries. It holds down their out-of-pocket expenses, their Medigap premiums. So I don't want to increase Iowa and Oregon to be more like some of the high cost states.

REP. BRALEY: Exactly.

MR. HACKBARTH: I want to bring the high cost states down to Iowa and Oregon.

REP. BRALEY: And isn't that the problem because under Medicare's ***proposed*** pay-for-performance system, the modeling is based upon improvements in efficiency? So if you are a state, like Oregon and Iowa, who is already delivering efficient low-cost, high-quality health care, you get no incentive from a model of reimbursement that's based only on improvement, isn't that true?

MR. HACKBARTH: Well, as we move to new payment systems, move away from our siloed, fee-for-service system to bundled payment systems or ACOs, one of the critical decisions that's going to have to be addressed is how to set those initial rates for these new types of --

REP. BRALEY: Right.

MR. HACKBARTH: -- payment systems. And in that is an opportunity to address some of these regional inequity issues that have come up in the program.

REP. BRALEY: But if you're going to base a public health care insurance option on a Medicare model that already has built-in inefficiencies and inequities in reimbursement, what ***reform***, hope does that give to this country?

MR. HACKBARTH: Yeah. Well, we need to change the Medicare model independent of the public plan issue for Medicare's own sake, and for the taxpayer's sake; for the beneficiary sake, we have to change the Medicare model.

REP. BRALEY: Well, and I'm glad you mentioned that because Congressman Ron Kind and I have introduced the Medicare Payment Improvement Act of 2009, H.R. 2844 that attempts to do just that by identifying clear, objective, quality measurements that are highly recommended by a number of health care organizations that are ***looking*** to improve efficiencies and increase quality.

It examines things like health outcomes and health status of the Medicare population, patient safety, patient satisfaction, hospital readmission rates, hospital emergency department utilization, hospital admissions for conditions, mortality related to health care, and other items determined by HHS.

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

MR. HACKBARTH: Yes. We believe that we need to adjust payment to reflect the quality of care. That's one type of change. But we also believe that we need to move away from fragmented fee-for-service payment to paying for larger bundles, paying for populations of Medicare patients.

The big difference between Iowa and the high-cost states is on the utilization of services, how many hospital beds per thousand, how many referrals to specialists, and the like. Iowa tends to be low on those things, and the high-cost states tend to be high on those things. If we move towards a payment system that advantages places with lower utilization like Iowa, that will begin to address these regional inequity issues that you are focused on.

REP. BRALEY: Thank you.

REP. PALLONE: Thank you, Mr. Braley.

Mr. Shimkus.

REP. JOHN SHIMKUS (R-IL): Thank you, Mr. Chairman, and I appreciate the little comments we had before my questioning.

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

The formula does not accurately reflect the difference between a state's fiscal earnings, low-income citizens, or cost of delivery of service. This result in states like mine -- and I think other states if my colleagues would do some research -- which only having a match of around 50 percent.

We know in the testimony -- yesterday we had New Jersey here, we had California, they are also 50 percent match states, and I've got the list here where every state falls. But it falls short of its needs. Yet other state have matches as high as 75 percent. Overall, the FMAP formula has resulted in the federal government's financing remaining around 57 percent across the board.

Yet the discussion drafts seeks to have states enroll childless adults ages 19 to 64 up to 137 percent of poverty line, and have the federal government finance 100 percent of this new Medicaid population. That was part of the discussion we were having offline.

Do you think it's fair that we continue to have these inequities among states when it comes to FMAP, given we aren't meeting the needs of many states, especially those with low matches?

MR. LEVINSON: Mr. Shimkus, would you like me to respond to that question?

REP. SHIMKUS: Both -- it's a question to both.

MR. LEVINSON: Because I would have to say that our office not being a policy office, we don't actually establish the FMAP rates. We certainly audit those among our auditors, but we are not a program office. We oversee that. So I can't --

REP. SHIMKUS: So as an auditing office, you wouldn't disagree with that analysis that I've given?

MR. LEVINSON: Well, actually the rate is higher now in some of the states as a result of the American --

REP. SHIMKUS: Yeah, and that's a good point.

MR. LEVINSON: Yeah.

REP. SHIMKUS: That's true. But there is still percentage in equities. So you have a 75 percent state that's now up to 83 percent. You have a 50 percent state that's up to maybe 60 percent. But of course, there is no assumption -- I mean, depending upon what we do on a bill, there is no assumption that those amounts remain, because the stimulus bill was a short-term bill. And there is no certainty that that input of money will remain.

MR. LEVINSON: Mr. Shimkus, we work with the numbers that we are given as opposed to calculating the numbers ourselves.

REP. SHIMKUS: Okay, that's --

Mr. Hackbarth?

MR. HACKBARTH: Mr. Shimkus, we focus exclusively on Medicare issues, not Medicaid. That's our jurisdiction under the statute.

REP. SHIMKUS: Okay. Let me just -- then let me go with a few other questions just to put it -- yeah, of our frustration with this process of rushing through and having a draft, is we've got to ask these questions when we have to because -- and don't want to give these out. Would it be appropriate in the context of health ***reform*** to address the inequity of FMAP by recalculating the FMAP to accurately reflect needs, or at the very least, level of playing field for every state?

Levinson, do you want to --

MR. LEVINSON: Mr. Shimkus, that's really beyond my charter.

REP. SHIMKUS: Good, okay.

Mr. Hackbarth, same answer?

MR. HACKBARTH: Yeah.

REP. SHIMKUS: Okay. So what I'm trying to establish is this. Illinois is a 50-50 match state, which means that for every dollar spent on Medicaid, we will write a check to the state for $0.50, okay? There are states out there that for every dollar they spent on Medicaid, the federal government sends them $0.75.

If we're doing health care ***reform*** -- and the premise of this bill is when we add people to Medicaid, 100 percent of that will be spent, but it still does not affect the basic fundamental inequity of the FMAP. So what states have to do is they have to gain the system. They have to go to HHS. They have to find, pass additional tax incentives to get additional rebates.

We have the tax increase on beds in hospitals that we pass, so they pass a tax. They remit the tax back to the federal government. The federal government again is giving the tax back to them plus some additional revenue.

So I would encourage folk to ***look*** -- my colleagues to ***look*** at their FMAP percentage. And if we are going to move on streamlining health care reimbursement, that'd be -- even as we increase the amount for the new Medicaid people we bring on, we really bring some clarity and equality across the state lines and FMAP.

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

REP. PALLONE: Thank you.

The gentlewoman from Florida, Ms. Castor.

REP. KATHY ANNE CASTOR (D-FL): Thank you, Mr. Chairman.

Good morning.

MR. HACKBARTH: Good morning.

REP. CASTOR: Mr. Hackbarth, you state in your testimony that the payment system for Medicare Advantage plans needs ***reform***. The Medicare Advantage program continues to be more costly than traditional Medicare health services. The Medicare Advantage -- government payments per enrollee are projected to be 114 percent of comparable fee-for-service spending in 2009.

It's up from 2008. The high Medicare Advantage payments provide a signal to plans that the Medicare program is willing to pay more for the same services in Medicare Advantage than it does in traditional Medicare and fee-for-service. Our discussion draft tackles the overpayment issue, but what would happen if we did not do this?

MR. HACKBARTH: Well, let me begin by saying that MedPAC very much supports giving Medicare beneficiaries the option to enroll in private plans. So we are enthusiastic about that. Our objections are to the current payment system, which as you say, pay significantly more on average for private plans than it would cost traditional Medicare to pay for the same patients.

If we were to lower the rate, one of the effects of that would be to send a market signal to private plans about what we want to buy as a Medicare program. And it would reward plans to ***take*** steps to be more efficient, more effective in the care that they provide. So long as we continue to pay more, the signal that we're sending is mimicking Medicare -- traditional Medicare just at a higher cost is okay with us.

And so long as we send that signal, we'll get more of that. We've got to change the signal to get the market response that we desire.

REP. CASTOR: And ultimately help us control costs across the board.

MR. HACKBARTH: Absolutely. And control costs with beneficiaries as well, because all beneficiaries, even those who un-enroll in private plans, are paying part of the additional costs for Medicare Advantage.

REP. CASTOR: And I'm afraid these overpayments have created incentives for extensive unethical behavior by insurance companies. Three quarters of the states report marketing abuses in Medicare.

And I have some firsthand experience with this talking to seniors at retirement centers in my hometown where insurance salesmen have come in, targeted seniors with dementia who were on traditional Medicare, and signed them up for Medicare Advantage, sometimes under the guise of coming in and selling their Medicare Part D policies and then switching them out.

And what happens is that senior, who has a longtime relationship with their doctor, oftentimes they lose access to that doctor they had under traditional Medicare because their Medicare Advantage plan doesn't have the same doctor. There've been cases that where cash incentives had been provided to insurance salesmen, and this shouldn't be -- we shouldn't have these incentives for fraudulent behavior.

I think it's gotten out of hand, and unfortunately, CMS has all but abdicated its oversight role. The Congress, some years go, ***took*** the state's ability away, their ability to regulate and oversee these terrible marketing abuses. Now our discussion draft, it makes some very subtle change with enhanced penalties for Medicare Advantage and Part D marketing violations.

But don't you think we need to go back to having as robust a strike-force as we possibly can, and give the states the ability -- you know they are closer to the ground -- the ability they had before to tackle the marketing abuses? The National Association of Insurance Commissioners supports such a move. Without it -- unless we do this, we'll continue to have this huge regulatory gap. But what is your view?

MR. LEVINSON: Ms. Castor, we certainly work with the states to, as much as possible, protect the Medicare and the Medicaid programs. We have a very good collaborative relationship with our state auditors and state and local law enforcement. There are jurisdictional divides, and we try to respect those.

But to the extent that we can actually understand schemes that are broader than just one particular matter, that really allows us to do our work more effectively, because the fact of the matter is, although we are one of the larger inspector general offices in government, given the size of our programs, we are very stretched.

We only have a few hundred criminal investigators to handle, you know, billions and billions of dollars stretched across the country in a variety of health care contexts. But I certainly would underscore the importance of being able to work very much hand in glove with our state and local partners.

REP. CASTOR: Thank you.

REP. PALLONE: Thank you.

Gentleman from Pennsylvania, Mr. Murphy.

REP. TIM MURPHY (R-PA): Thank you, Mr. Chairman.

I thank the panelists for being here. Some questions about Medicare. It was founded in 1965. In the ensuing years, has there ever been a time when any president or any Congress has really gone back and overhauled the program -- and this program being established back in pre-CT scan and MRI days -- has there ever been a comprehensive overhaul of the system to modernize and ***reform*** it, make it work more effectively?

MR. HACKBARTH: Well, the payment systems have changed. Medicare began with -- payment systems --

REP. MURPHY: Right.

MR. HACKBARTH: -- were based on cost reimbursement.

REP. MURPHY: But in terms of how it functions -- because still you are talking about a number of interesting ***reforms***. And has that ever been attempted before?

MR. HACKBARTH: Well, the payment systems have been ***reformed***. They have changed substantially over the life of the program.

REP. MURPHY: But I mean the things like --

MR. HACKBARTH: We think more changes are warranted.

REP. MURPHY: You're talking about the other delivery like care coordination and preventing readmissions and things like that. That's never been attempted, right? I mean, in terms of overall ***reforms*** in the system.

MR. HACKBARTH: In terms -- there has not been payment ***reforms*** focused on readmissions, no.

REP. MURPHY: Okay. I'm assuming you are talking about more than just payment ***reforms*** today, because your report has a lot more than just how the money gets spent. Okay. And in that -- I mean I noted in the 110th Congress, there was 452 bills put in by members of Congress to make some ***reforms*** to Medicare and Medicaid. I think 12 passed.

And some 13,000 co-sponsors to these bills came through the members of Congress. So I ***look*** upon this that members of Congress themselves recognize there need to be some changes in Medicare and Medicaid. But it seems to come slow. I'm wondering -- and in this process were some of the changes you recommend here, and I applaud them because they're things I've been asking for, for a long time too -- care coordination.

I mean we'll pay to amputate the legs of a diabetic, won't pay to have some nurse call them with these cases. We recognize one in five chronic illnesses gets readmitted to the hospital, but we haven't been working at keeping them out. Those are major changes to make here.

My concern is the speed at which the federal government moves to make changes, number one; and two, does the federal government have to run its own insurance plan given its track record of not being very good at coming up with timely changes? Can we come up with some of these changes with the federal government pushing forward and mandating some of these changes in the private market, and in the meantime, Medicare pushing some within itself? Is that possible to do that?

MR. HACKBARTH: Well, I think we need to do some of each. The potential for Medicare Advantage is to invite private plans to enroll Medicare beneficiaries to do things differently to get better results for both beneficiaries in the program.

Because of the way Medicare Advantage works, the way the prices are set, it has not fulfilled that potential. It's allowed private plans to enroll Medicare beneficiaries essentially mimic traditional Medicare with all the same problems. So one of the reasons we believe Medicare Advantage ***reform*** is so important is to reward private plans to do it better.

REP. MURPHY: Okay. So that's a -- I -- so in other words, it can't just continue on with business as usual. But Medicare Advantage, they should really be using these things for what it was designed to be, and that is really work at prevention, really working at care coordination. Am I correct on that?

MR. HACKBARTH: Yeah.

REP. MURPHY: Okay. There is something else mentioned here. You -- a point was made earlier, encouraging use of comparative effectiveness information and public reporting and provider quality, et cetera. This also relates to the issue of evidence-based medicine and evidence-based treatments that many of you referred to.

Throughout medicine there is many branches that have their own standards and protocols, the College of Surgeons, the American Academy of Pediatrics. Would those be things that Congress or the FDA or HHS could ***look*** towards in terms of what these standards might be in terms of what is the best practices and what would be the standards and protocols to use?

MR. HACKBARTH: Well, specialties are quite variable, and how they develop those standards, those protocols, it's difficult to generalize about them. Let me focus on the area of imaging as one example. We had as a witness before the MedPAC, the president of the College of Cardiology to talk about imaging issues.

And one of the things that she called for was more information so they can move from just consensus-based guidelines to evidence-based guidelines. The potential in comparative effectiveness research is that we give physicians and societies the raw material to do a better job of what they want to do.

REP. MURPHY: So -- I mean, this is a critically important point and one that we should not rush here, because it's going to have long- term implications. So the College of Cardiologists or radiologists or whatever that is, we have to make sure it isn't just they've all sat down and voted, this just would be the best thing.

But there really needs to be a demand and this is where a valuable -- (inaudible) -- the HHS or FDA to have oversight and say we want to see evidence-based medicine here. Is that what you are suggesting?

MR. HACKBARTH: That's the goal, and we need information for physicians as well as patients.

REP. MURPHY: I mean, this is a critical thing, Mr. Chairman, and one I hope we continue dialogue on, because it's going to be a factor that I think makes or breaks some of the budget is how we go through there. And I think also deal with the issue of who is making the decisions, and I think a valuable place for this committee can have tremendous oversight in working with medicine. And with that I yield back.

Thank you, sir.

REP. PALLONE: Thank you, Mr. Murphy.

Gentlewoman from Wisconsin, Ms. Baldwin.

REP. TAMMY BALDWIN (D-WI): Thank you, Mr. Chairman.

Mr. Hackbarth, welcome back to the subcommittee. I recall when you were here in March, we had quite a dialogue about -- as we have today -- about the difference between pilot projects and demonstration projects. And you expressed then, as you have here today, some hesitation about the administrative and regulatory burdens

associated with demonstration projects and how that affects the ability to scale those up if they're proven successful.

This draft health care ***reform*** legislation offers new pilot projects in accountable care organizations and medical home models. And I'm wondering if it's your sense that these pilots will provide us, the Congress and MedPAC with sufficient evidence to make broader payment ***reforms***, and also if you've examined these provisions in the draft, if you have any recommendations for further improvement.

MR. HACKBARTH: Well, on the issue of pilots, we welcome the fact that the committee is ***looking*** at pilots. And what MedPAC has advocated -- and we've talked about this before -- is that Congress gave the secretary discretion to test a new payment method and to implement it if the pilot is successful, establish goals in advance, and then give the secretary discretion plus the resources necessary.

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

REP. BALDWIN: In MedPAC's most recent reports, there is an interesting sidebar concerning the physician group practice demonstration which serves really as a foundation for the accountable care organization pilot in the draft bill that we're ***looking*** at.

You noted that a surprising number of the sites for the Physician Group Practice Demonstration Project had high-cost growth, and it's linked to the risk profiles of the patients at those sites. And it strikes me that basically there is an inference that these demonstration sites may be picking up more of their patients' medical issues resulting in more treatments and increasing costs. What lessons do you suggest that we ***take*** from this demonstration?

MR. HACKBARTH: Well, in setting payment rates for new payment systems like ACO, the details are very important in how the targets are set, how the potential gains are shared between the providers in the Medicare program, and how you adjust for things like risk, the risk profile of the patients. And so there are important steps that have to be ***taken*** from endorsement of a broad concept like ACOs to making it an operational, effective idea.

And this is part of why we think the secretary needs some flexibility and discretion in design, and the resources to be able to do that quickly and effectively. On an idea like ACOs, we're unlikely to get it exactly right the ***first*** time, and so there needs to be ongoing cycles of refinement and improvement. That requires discretion and resources.

REP. BALDWIN: And we can certainly relate to the difficulty to create a national program to rein in Medicare spending. And on the ACOs, the idea is to start spending targets to hold the providers accountable to the targets.

If you tied spending targets to national averages, I guess I'd like to ask how are we going to attain or incent participation in higher cost areas. And do you have any ideas of how we would address that challenge?

MR. HACKBARTH: Yeah. Well, this goes back the dialog that I had with Mr. Braley. One of the very important details in these new payment systems like ACOs is how you set those targets.

If you ***take*** a group that has a very low historic level of utilization, they've been very efficient, very high quality, and say, okay, we're going to set your target at your historic level of cost, it's going to be more difficult for them to beat that and earn rewards than for a practice that's in a very high-cost state and performing very poorly.

That's not an equitable way to get to where we want to go. So setting that target rate so that you reward historic performance, as well as future performance, is for me a goal in the target setting.

Now, in order to do that, you've got to squeeze some place else. You've got to squeeze those high-cost places to offset the cost. So again, the details and they're sort of very, very important. And the secretary needs to be given the latitude to strike that balance.

REP. PALLONE: Thank you. Mr. Pitts is next.

REP. JOSEPH PITTS (R-PA): Thank you, Mr. Chairman.

Mr. Levinson, in your testimony, you mentioned Medicaid specific services that are services unique to Medicaid that could lead to significant savings, and one example you site is school-based health services. You say that OIG, quote, "Consistently found that schools had not adequately supported their Medicaid claims for school-based health services, and identified almost $1 billion in improper Medicaid payments," end quote. Can you go into this further?

MR. LEVINSON: Mr. Pitts, we do make audit recommendations to the Centers for Medicare and Medicaid services based on our audit findings as our auditors ***look*** at programs that are supported by the program. And that is an area that the OIG has identified over the last few years as one that CMS needs to focus on more clearly, to make sure that those dollars are really spent appropriately.

REP. PITTS: Well, what were some examples of these improper payments? What was Medicaid paying for?

MR. LEVINSON: Well, overall, they were paying for those kinds of services that are not included in the program, but I would need to provide more detail to you as a follow-up to our hearing.

REP. PITTS: Now, the Bush administration ***proposed*** regulations which would stop these fraudulent services and stop wasting taxpayer dollars. However, the present administration has put a moratorium on these regulations. Do you believe that this moratorium should be lifted?

MR. LEVINSON: We do not comment on what the executive branch decides to do with those kinds of regulations or not. We certainly, you know, advance what we believe would be appropriate ways of being able to account for the Medicare dollars better, and our recommendations are given in the ***first*** instance in these kinds of cases to the Centers for Medicare and Medicaid Services.

REP. PITTS: Do you have any idea how much money in total might have been wasted in this way?

MR. LEVINSON: Our audit findings will indicate the dollars that we believe are not appropriately spent under the Medicare program. And I don't have that dollar figure immediately on my fingertips.

We'll certainly provide as much detail as we can based on the audit findings we already have.

REP. PITTS: All right, in your testimony, you mentioned the creation of the health care fraud prevention and enforcement action team. Can you give me some examples of what cases this team is currently addressing?

MR. LEVINSON: One of the most -- the most recent example would be the case that was publicized yesterday in Detroit, a Medicare infusion drug fraud case that has resulted in 53 indictments. There have been 40 arrests so far.

Forty of our agents have been involved in what is claimed as $50 million in false claims. This is a strike team in which we're working with the FBI and local law enforcement to clean up a significant Medicare infusion drug problem that now infects the city of Detroit.

Some of these issues have actually migrated from South Florida. So the strike force effort is to try to provide both national and regional focus on those kinds of frauds that not only tend to plague particular cities in the country, but that also have regional impact. We already have strike forces in operation in a number of cities, but the effort now will be to extend that to more cities over the course of the next year.

REP. PITTS: Mr. Chairman, I don't know --

REP. PALLONE: You want the time? The time?

REP. PITTS: Yes.

REP. PALLONE: You have a minute left.

REP. PITTS: One minute left?

REP. PALLONE: I'm sorry --

REP. PITTS: How do you get the provider ID -- the criminals get the provider ID numbers?

MR. LEVINSON: Well, obviously through a variety of fraudulent means, but it's too easy at this point in our system to get provider numbers. And that has been a constant theme of our office over the years, that enrollment standards have not been sufficiently rigorous to ensure that we're not allowing in effect criminals to masquerade as health care providers.

And that has been a significant problem not just in Detroit and Miami, but really throughout the country. And one of the key principles we have in terms of our antifraud fighting effort is to make more rigorous who actually gets in the program, because historically there has been too much of a right to access as opposed to the privilege of actually being enrolled in the program.

REP. PALLONE: Mr. Buyer wants to follow up.

REP. BUYER: I guess we want to be responsive here. How are these -- are they relying on insiders within the system to get these ID numbers, or you don't want to tell us so that others will know how to -- I mean we can always, you can tell us offline.

REP. PALLONE: Mr. Buyer, let him answer the question, but the time has expired. I have to apologize, the electronics are going off again. So I'm going to just have to tell everybody when their five minutes is up. But go ahead and answer your question.

MR. LEVINSON: Thank you, I think it probably would be better to have an offline conversation because the schemes are varied and some of them are rather sophisticated and it's probably better not to discuss in any detail what actually occurs in a public hearing.

REP. BUYER: Thank you, Mr. Chairman.

REP. PITTS: Thank you.

Next is Ms. Eshoo, and I'll just tell you when the five minutes are up.

REP. ANNA ESHOO (D-CA): Thank you, Mr. Chairman.

Gentlemen, thank you for your testimony today and to the chairman for this series of hearings with many, many, ***panels*** this week. As we ***look*** to reshape America's health care system, we have very clear goals that we have set down.

We want it to be universal, it needs to be affordable. We think the choice is important. We believe that many of the rules that need to be rewritten that the insurers, the private insurers, employ amongst them knocking people out because they have preexisting conditions, and gender-based issues et cetera, et cetera. So that's on the -- kind of on the one side of the ledger.

The other side of the ledger in my view are two major issues. One, that we be able to achieve this without raising taxes, and number two, maybe, I should have said number one, number one, that we ***reform*** Medicare and strengthen it.

We've read the report of the trustees, we know that they shaved off two years and that we've got until 2017. 2017, believe it or not, is not that -- it sounds like it's another century away. It's a handful of years away. So my question to both of you is, what are the large-ticket items that you can name today for us that will strengthen Medicare.

Now, Mr. Levinson, I recall a hearing here many, many, years ago on waste, fraud, and abuse and what -- essentially the private sector ripping off the public sector and you've touched on that today. In fact, we had testimony from someone whose case had been adjudicated and he was on his way to prison, and he came here and explained how he had ripped Medicare off. And it was essentially the private sector ripping off the public sector.

So what are the price tags that you can tell us about, and these efforts that will save us money, save Medicare money, and overall strengthen Medicare as we come through this large effort, this overall effort to ***reform*** our nation's health care system? Because I believe if we don't ***reform*** and strengthen Medicare that we will not have accomplished what needs to be accomplished.

MR. HACKBARTH: Let me go ***first***. I would name four things. One is that we need to continue to apply pressure under the existing payment systems in Medicare. The update factors --

REP. ESHOO: Can you speak a little louder please? Can you speak just a little louder?

MR. HACKBARTH: We need to continue to apply pressure to the update factors in the existing payment systems.

REP. ESHOO: And what is that going to -- what do you think that's going to save us?

MR. HACKBARTH: Well, you know, it depends on exactly what the levels are, but it's, you know --

REP. ESHOO: Has MedPAC done that work?

MR. HACKBARTH: Well, CBO does the estimates of the budget impact of different recommendations.

REP. ESHOO: You have any idea what that might be?

MR. HACKBARTH: Yeah, again it depends on the specific level, but tens of billions or more over a 10-year horizon. A second area that I mentioned is Medicare advantage. There, as I think you know, the CBO estimate is higher than $150 billion over 10 years.

A third area that I mentioned is readmissions, excess readmissions. And off the top of my head, I don't know what the estimate is for that, but there was a ***proposal*** in President Obama's budget on that, and that's a fairly significant number.

Then the fourth area that I'd emphasize is assuring a primary care. Now, that doesn't lead to direct savings. But I mention it here because if we allow things to go as they are right now, our primary care base is going to continue to erode away and it will cost money.

REP. ESHOO: You spoke to that earlier, so I appreciate that. Mr. Levinson?

MR. LEVINSON: Yes, Ms. Eshoo --

REP. ESHOO: And thank you for your wonderful work as IG.

MR. LEVINSON: Thank you very much.

REP. ESHOO: We really can't function well and do oversight without the IGs, and I just think that you all should be canonized. So --

MR. LEVINSON: Well, on behalf of 1,600 --

REP. ESHOO: It'll be interesting to have a Levinson canonized, right?

(Laughter.)

I'm pretty ecumenical though, so --

MR. LEVINSON: Well, it so happens that of course Dante was talking about fraud 700 years ago.

REP. ESHOO: That's right.

MR. LEVINSON: So it's an issue that is both timely and --

REP. ESHOO: Right.

MR. LEVINSON: -- and has a long and very troublesome pedigree. But on behalf of 1,600 very dedicated auditors, and evaluators, investigators, employers, thank you so much.

REP. PALLONE: Somebody must tell her her time has expired.

MR. LEVINSON; In just one -- as I ***looked*** at some of the recommendations that are in our compendium of unimplemented recommendations, our auditors estimate that we could -- the program could save $3.2 billion over five years if we just limited the rental time for oxygen equipment. And I think that there are specific areas where there are significant savings that can be had.

As I ***look*** at just our most recent semiannual report, in terms of monies returned to the Treasury, we're expecting just in the ***first*** six months of the fiscal year, $275 million in audit receivables, and $2.2 billion in investigative receivables. A lot of that has to do with pharmaceutical cases. Pharmaceutical pricing of course is a very significant area that can also, if properly addressed, can save significant dollars.

It would be hard to come up with total figures on a list of top 10, but certainly pharmaceuticals, DME, getting the DSH payments right. We think that it is important to clarify exactly what Medicare should be paying -- the Medicare and the Medicaid DSH payments and how the states handle those dollars.

We need to avoid gaming the federal dollar, so that it's clear, it's transparent about who is actually paying for what, and how the states account for the dollars that come from Washington. I would hesitate to put a dollar savings on it, but I think that there is a great need for much more significant transparency and accountability in our programs. And that is a very helpful trend from the standpoint of our office.

REP. ESHOO: Do I have any time left, Mr. Chairman?

REP. PALLONE: No, I'm trying not to interrupt right now.

REP. ESHOO: Okay, thank you very much. Thank you.

REP. PALLONE: Sure. Next is the gentlewoman from Illinois, Ms. Schakowsky. I'm going to just tell everybody when the five minutes are up, just so you know. Thanks.

REP. JANICE SCHAKOWSKY (D-IL): Mr. Levinson, one of the biggest single expenditures out of Medicaid is for long-term nursing home care. And I've been working with Chairman Waxman and Chairman Stark on a nursing home quality and transparency legislation which has been included in the draft bill. And I'd like to know what you have found in terms of problems with nursing homes that would necessitate more transparency and oversight of them.

MR. LEVINSON: Yes, Congresswoman, it's been difficult actually to find out who makes the decisions when we investigate substandard care in nursing homes and try to locate exactly who financially is in charge. So I think the effort to create greater transparency in terms of ownership, in terms of management, and get a clear understanding of actually who is in charge would help our investigators and lawyers significantly in being able to both investigate and resolve some of the very serious quality of care cases that have emerged in the nursing home area.

REP. SCHAKOWSKY: We're going to hear some testimony a bit later that disparages the notion that there is any substantial fraud or wasteful spending on the part of some doctors that participate in the Medicare program. Would you agree with that assessment?

MR. LEVINSON: Well, I can only point to individual cases that we have actually worked on. We try not to generalize. Our investigators and auditors are very focused, very anchored on particular instances when it comes to either individual venues or a larger corporate structure. And we do have an existing and unfortunately a growing caseload, workload.

REP. SCHAKOWSKY: Let me ask this though. Would you say that some may be fraudulent, some may be wasteful, but that in general the decisions about utilization are provider-driven, as opposed to the kind of fraud of -- or wasteful spending that's generated by individuals in the program?

MR. LEVINSON: You know, I would hesitate again to make any kind of generalizations because these individual cases are very much focused on the facts as we find them. But there are certainly cases in which we have found that we are frustrated in our ability to actually understand who makes the decisions in the nursing home chain.

REP. SCHAKOWSKY: Let me ask Mr. Hackbarth about the Medicare Advantage Plans. It's great that in the Medicare program, consumers can actually go online and find out what Medicare pays for health care services. To your knowledge, is there a place where consumers can actually access rates that Medicare Advantage Plans pay providers or other private insurers?

MR. HACKBARTH: The actual payment rates for providers? Not to my knowledge. I think most private plans consider that information proprietary business information.

REP. SCHAKOWSKY: In your view, will Medicare advantage plans remain in the market if we eliminate over payments?

MR. HACKBARTH: I believe that they will, many will. Some will leave the market because they have a model that can't compete with traditional Medicare. But as I said earlier, we'd be sending an important market signal about the type of plan we want to participate.

We want plans that can help us improve the efficiency of the system, not plans that just add more cost to the system. And when you send that signal, I believe -- in the market, I believe that will get more plans that can compete effectively with traditional Medicare.

REP. SCHAKOWSKY: What mechanisms will we need to ensure that Medicare Advantage Plans and private insurers in the exchange meet a minimum loss requirement -- a minimum loss ratio requirement?

MR. HACKBARTH: The minimum loss ratio I think is -- it's a tricky issue. As you may know, I used to work for Harvard Community Health Plan, Harvard Pilgrim Health Care, two very well-regarded HMOs. And this was a big issue for us sometimes with employers, how you calculate loss ratios.

Our piece of the organization, the one I ran is an integrated prepaid group practice. And we have a lot of clinical programs that we believe improve patient care that sometimes employers wanted to characterize not as medical care, but administrative cost. So the -- and that works against you in terms of calculating the loss ratio.

So the details of this can be pretty tricky in my personal experience. So I'm always a little uneasy about just having simple rules on loss ratios. How you define those loss ratios is very, very important.

REP. SCHAKOWSKY: Thank you.

REP. PALLONE: The time has expired, I'm sorry. Thank you.

And next is the gentleman from Maryland, Mr. Sarbanes.

REP. JOHN SARBANES (D-MD): Thank you, Mr. Chairman.

Thank you all. I've got a couple of quick questions at the outset.

Mr. Levinson, you talked about the -- trying to step up efforts to curb some of the fraud. In particular you talked about in response to one question the application process for new provider numbers, and having that vet properly. Have resources been an issue in terms of the capacity of those people that do the processing, and the review as a resource in terms of the number of folks that can do that been an issue or not an issue?

MR. LEVINSON: Well, that's an important question, Mr. Sarbanes, that in the ***first*** instance I think needs to be addressed and responded to by CMS, which is the agency that runs the program. And as an office that ***looks*** to see where the vulnerabilities, where the weaknesses are in the administration of a program, we have identified for some years now that enrollment standards are too lax, especially in specific areas of vulnerability like DME.

And whether or not there are resource issues, we find, you know, too many of the wrong kinds of people are getting into the program. And therefore we have urged, we have recommended over the course of the last few years that enrollment standards be strengthened.

REP. SARBANES: Well, I'd imagine -- I mean, I used to do some of that work. And I would imagine that the best way to vet it on the front-end is with a little more intensity of resources applied, actually going out and finding out who's behind these applications that are being filed.

Let me shift gears. I was really intrigued by the discussion on the school-based health centers, and some of the findings of fraud. In that discussion, there was an allusion to the possibility that there was services being -- that reimbursement was being sought for services that were not actually provided, but possibly there were other services being provided that might -- that one might view as important services. They just aren't services that Medicare or Medicaid reimburses.

And I wanted to ask the question of whether this phenomenon, and this is in my view the problem is whether you're talking about fee- for-service, or you're talking about capitation, either one of those can work okay, if you're paying for quality as opposed to paying for quantity, and if you're paying for the right things as opposed to not paying for the right things. But maybe both of you could comment on whether the potential for fraud is greater when you have a system that pays for quantity versus quality or is paying for the wrong things. And while I don't want to excuse fraud, if somebody is trying to find some payment for what they view as a very important service that is not covered under Medicare or Medicaid, that's a different kind of impulse than seeking to get paid for a service that's not being provided at all.

And it seems to me, the way the system is structured right now, and it's so distorted that it leads to that kind of thing, because people say this service is valuable, but Medicare won't pay me for it. And if we can move in a direction where we're paying smarter for things that make a difference, we might actually make some progress on this fraud issue. So maybe you could each --

MR. LEVINSON: Well, I do think the facts that you've laid out, Mr. Sarbanes, are important ones to focus on, the notion that there can be money spent that are just not appropriately covered by the program. And in many instances, we're really not talking about fraud in terms of the legal definition of fraud.

We're talking though about dollars that Congress, that the program says should be directed in a particular way, and our audit people, not our criminal investigators, find have not been spent appropriately, and then we make the appropriate findings and recommendations to CMS. Not all of our recommendations are acted upon by CMS.

There unquestionably are judgments. Perhaps some of the kinds of judgments you're talking about here are the judgments that programmatically are made by CMS over the course of ***looking*** at our recommendations, because just by the fact that we make those recommendations doesn't necessarily mean that the dollars will actually be collected.

And I do think that it is important to distinguish, you know, between those who have an intent to ***take*** advantage of the program, and those who unfortunately are simply not paying appropriate attention to our rules. But of course, given the precious resources, we ***take*** the rules as set by Congress and the department seriously, and we report accordingly.

REP. PALLONE: Now, the time has expired, I'm sorry. Next is Ms. DeGette.

REP. DIANA DEGETTE (D-CO): Thank you very much, Mr. Chairman, and thanks to this committee.

I know you've discussed some of the issues in general that I want to talk about, but I'd like to hone in on them a little more.

My ***first*** question is, as you talked about -- actually, Mr. Hackbarth, the MedPAC has talked about changing the Medicare payment system incentives by basing a portion of provider payment on quality of care. And to do this Congress could establish a quality incentive payment policy for physicians, and other plan -- Medicare Advantage Plans, health care facilities. I'm wondering if you have some specific recommendations you can make as to what kind of quality measures people would have to include to be -- or to develop to be included in a quality incentive payment policy.

MR. HACKBARTH: Well, let me focus on a few different areas of the program. For example, in the Medicare Advantage program, we've long advocated that a piece of the payment be adjusted to reflect the quality. And there are --

REP. DeGETTE: But how do you do that?

MR. HACKBARTH: There are well established industry measures developed by NCQA that private employers use to assess health plans. We believe Medicare should be doing the same and adjusting payment accordingly.

In the case of dialysis services, again there's a pretty strong consensus about what the critical quality measures are. We've advocated that the dialysis payments be adjusted to reflect those outcomes for patients.

Likewise in hospitals, we think there are some strong consensus measures. In fact, Medicare requires, as you know, specific measures to be reported. We'd like to see payment made for that.

REP. DeGETTE: Do you think that the current -- and I do know that because my -- Harold and Patty Gabow from Denver Health is here on the next ***panel***. But do you think that we could -- do you think that these quality measures that we have in place now are sufficient as we move forward with comprehensive health care plan?

Do we need some kind of additional mechanism? Do we need additional quality measures? What do need to do this?

MR. HACKBARTH: Yeah, I think the measures need to evolve over time. I think we've got starter sets if you will, for a lot of providers, but we need to invest in developing in the long term.

REP. DeGETTE: And who should do that?

MR. HACKBARTH: Well, Congress has invested some money now in NQF, the National Quality Forum, which I think is a wise investment to build infrastructure for ongoing improvement in quality measures.

REP. DeGETTE: And do you think some of these quality measures that you talk about for Medicare Advantage can also be used for physicians and other types of health care facilities like hospitals and community health facilities?

MR. HACKBARTH: Well, each provider group presents its own challenges and will require unique measures. I mentioned three areas, Medicare Advantage, ESRD, and hospitals. But I think there's a pretty strong consensus on starter set of measures.

Other areas are more challenging. Physicians are more challenging just because of the nature of medical practice. You often have small groups or even solo physicians, so not a lot of numbers to measurement.

REP. DeGETTE: But you know what, though people like Geisinger, and Kaiser, and others have been able to develop quality measures for doctors, that it would seem to me you could develop, and if you don't develop those for physicians, then it's hard to see how you can get the improvement in medical care at the same time that you get the cost-containment in our system.

MR. HACKBARTH: And I agree with that, that we do have initial measures, they're not comprehensive measures, for physicians. They tend to be very focused process measures.

REP. DeGETTE: Right.

MR. HACKBARTH: I think we can do a better job in assessing physician performance as we move to bundled payment systems where we get groups of physicians working together. We can start to measure outcomes not just --

REP. DeGETTE: That was my next question. So to develop those measures again, what kind of mechanism do you think -- would it be the same one you talked about that Congress or -- there's a group of us, Senator Whitehouse, and myself, and others who are very concerned that if we don't develop quality measures throughout the system

MR. HACKBARTH: Yes.

REP. DeGETTE: -- that we're really not going to have improvements in patient outcomes.

MR. HACKBARTH: So we need a process for forging a consensus and establishing a set of measures.

REP. DeGETTE: Right.

MR. HACKBARTH: You don't want, you know, 12 different ones

REP. DeGETTE: Right.

MR. HACKBARTH: -- and everybody using different measures.

REP. DeGETTE: Right.

MR. HACKBARTH: That's a burden on providers.

REP. DeGETTE: Right.

MR. HACKBARTH: And NQF can be that process. It can grow into that process where we have consensus. Then we also have to invest in the research about what works.

REP. DeGETTE: What works --

MR. HACKBARTH: That's where comparative effectiveness comes in. That can provide raw material for specialty societies and the like to develop guidelines on what constitutes good care. And that can also feed ultimately into the assessment process.

REP. DeGETTE: Thank you.

Thank you, Mr. Chairman.

REP. PALLONE: Thank you. Gentleman from Texas, Mr. Gonzalez.

REP. CHARLES A. GONZALEZ (D-TX): Thank you very much, Mr. Chairman.

This will go to the chairman. There are two major components of what we're considering, in the experience gleaned from Medicare is going to be used either by the proponents or the opponents. Just again, it'll be the performance of Medicare in the eye of the beholder.

One is the public option; the other is the Health Insurance Exchange. So I'm going to pose a couple of questions, and then just let you respond. And that way, it'll be the chairman that'll be advising you that my five minutes are over.

But ***first***, I haven't met with a group of doctors in San Antonio yet that have agreed with the compensation adequacy. And what they're all saying is that you guys are basically working with stale data and information, that it's at least two years behind the times of what modern medicine in its practice entails. That's the ***first*** question.

And I know that we touched on it more or less, but that is going to be very, very important as we go out there with a broader plan that again has something that will mimic what we've been doing under Medicare. So that's the ***first*** complaint that we get.

My colleague, Ms. DeGette, also touched on something, and that was how do you establish proper protocols, what is acceptable, best practices, and standards? On the Small Business Committee we had Governor Pawlenty, who came up, and I asked him that, because my doctors ask the same thing, different patient populations may dictate different practices and such.

What Governor Pawlenty told me, he says we've got Mayo, they established the standards pretty much, and no one is going to argue with them. The question to you is how do we ever really achieve nationwide standards that may address diverse populations and such?

The last question is a somewhat interesting one because it presents a real dilemma for me back home. Texas has probably the greatest number of specialty hospitals. The question really is how is modern medicine being delivered in this country, and to keep up with that. There are portions of this bill that would discourage of course specialty hospitals.

Yet we are ***looking*** at what we refer to as bundling, and that is more centralization, more coordination, medical home, all that that entails. But in essence, isn't that what specialty hospitals in many of these specialty practices provide?

And that is when a patient goes into those settings, that there are many different services that are being provided within that environment that otherwise would be separated out to different locales, offices, and other doctors. And we even have different specialists that argue among themselves as to what extent they should be able to do that. And I would just like your views on those three points. And again, thank you for your service.

MR. HACKBARTH: Okay. That's a lot of ground to cover in just a minute or two. Starting with the stale data, I imagine what your physician constituents are referring to is Medicare claims data which in fact is a couple of years old by the time it's used in the policy process.

That is a problem. That's an area where I think some wise investments in Medicare infrastructure would pay dividends. I'm not sure however that the age of the data would alter any of the recommendations we're talking about for ***reforming*** the payment system.

With regard to a standard setting, I do believe it's very important to have a process that is coherent, incredible from the perspective of providers. I fear that sometimes we have an embarrassment of riches. We have a lot of different people saying this is what constitutes quality of care. Some of it's well-founded in research; other pieces of it are not.

If you want to send clear consistent signals to providers, not just from Medicare but from private insurers as well, we need to have a coherent standard setting process. As I said a minute ago, Congress I think wisely has invested some money in NQF to start building that infrastructure.

On the last issue of specialty hospitals, roughly two years ago now, MedPAC, at Congress's request, invested a lot of effort in analyzing specialty hospitals. Our basic findings where that when physician-owned specialty hospitals entered a market, costs tended to increase, not decrease.

More procedures were done. The evidence on the quality of care was not definitive evidence one way or the other that was better or worse. It seemed to be about the same.

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

REP. PALLONE: Thank you. Mr. Matheson is next.

REP. JAMES D. MATHESON (D-UT): Thank you, Mr. Chairman.

I'm sorry I was not able to be here for all of your testimony, but I do appreciate you're coming before the committee today. The question I want to raise is, you know, MedPAC has had the opportunity to make a lot of recommendations about how we can achieve greater efficiencies, or greater value, or good practices. And often, in terms -- when it comes to implementation, Congress has not necessarily followed through on that. Do you have suggestions for if there'd be a better structure to help assist in allowing these recommendations to be implemented in a more effective way?

MR. HACKBARTH: Well, one of my themes this morning has been that I think the secretary of Health and Human Services and CMS need both more discretion and more resources. So they need the flexibility to refine, change payment systems over time to achieve goals established by the Congress.

For every small change to have to come back through the legislative process is a very cumbersome process, and it makes progress very slow. And I'm not sure that's a luxury we can afford at this point. So more discretion and more resources for the department would be my ***first*** recommendation.

REP. MATHESON: Do you have -- in terms of making that recommendation, is there a specific ***proposal*** about what the resource needs might be, or is that something that we can ***look*** to maybe get some information from you all?

MR. HACKBARTH: Yes, I would urge you to go to the department for that information. They're the best judges of exactly what they need.

REP. MATHESON: Do you feel like the way MedPAC is structured right now that you are adequately insulated from having members of Congress come in and tell you, here's what we think you really ought to be doing?

MR. HACKBARTH: Well, we welcome our exchange with members of Congress, and the MedPAC staff works very closely with both the committee and personal staffs to understand Congressional perspective. I have never felt undue pressure from any member of Congress.

REP. MATHESON: You feel like you're adequately structured to be an independent entity? I guess that's what I'm asking.

MR. HACKBARTH: Absolutely, yes.

REP. MATHESON: Okay, thanks, Mr. Chairman, that'll be it for me.

REP. PALLONE: Thank you.

Mr. Barrow.

REP. JOHN BARROW (D-GA): Thank you, Mr. Chairman.

And thank you, gentlemen, for being here today. I too, along with Jim, had several other meetings and wish to apologize for being a little late, but I'm glad to have the chance to visit with you. And thank you for coming and offering your testimony.

You know, fixing what's broke with Medicare Part D is a large part of comprehensive health care ***reform***. A lot of attention is being given to Ways and Means to trying to plug the doughnut hole among other things.

I want to focus on a problem with the Medicare Part D program that has bedeviled the people I represent. I hear about it every one of my town hall meetings. And that's the excessive degree of discretion and variety in the formularies that all of these various for-profit insurers are paid by the public essentially to assume a public risk, and the incredible confusion, you know, that such a thing is too much of a good thing.

You know, there's too much variety and choice in the marketplace, you have a hard time finding what you need, and you have to do a lot of hunting in trying to find the drug that you want. And then with the potential of a baton switch that can exist, and formulary being changed on the -- after you've signed up, that just makes things so much worse.

My question to you is, and I guess, Chairman Hackbarth, you're probably in the best position to answer this; is any thought being given, since this is a public financed plan, to get the for-profit insurance industry to compete with each other to make money trying to offer a benefits package to assume a public risk in providing these benefits? Any thought given to trying to make more -- to have a centralized or more standardized formulary that is comprehensive in its scope, but provides all of the necessary flexibility and variety to allow doctors to opt out when there's a medical necessity that they know about, a generally good reason to do so.

But to make it clear that when folks go into this very confusing marketplace with so many people competing for the customer's business, that they know when they're comparing apples to apples, they know that the benefits package is substantially the same, just as the entity that's paying for this substantially the same, just as what you hope to get is substantially the same. Is any effort being made to do that?

MR. HACKBARTH: Well, you're absolutely right that the choices that Medicare beneficiaries face are complicated are complicated in choosing among plans because of, among other things, differences in formularies. I would also add that it doesn't stop with the beneficiaries, you know, differences in formularies also have a significant impact on practicing physicians and how they deal with patients, what they prescribe needs to vary according to the plan that the patient is covered by, and that can be a real problem for physicians.

There's a tradeoff here though. The flexibility around formularies and the exact benefit structure, those are tools that private plans can use to try to offer a better value for Medicare beneficiaries. Those are the tools that they can use to reduce the cost of the plan. And so, there's a tradeoff to be made, there's not a --

REP. BARROW: If you have a plan, this design to the health profile of the patient, in theory, you can get yourself into a much smaller risk pool and be shopping for something that's just tailored for you. But the point is it looses the quality of being insurance and it ***takes*** on the quality of being sort of a revolving loan program.

MR. HACKBARTH: Yeah. And some people have expressed concern in particular about specialty drugs, very high cost drugs for patients with serious illnesses --

REP. BARROW: Well, there's a medical necessity for that, the smaller the risk pool of folks buying into the program the more expensive that's going to be when it is absolutely necessary to get it. So that sort of drives up the cost for those folks who need it when they need it so --

I guess what I'm getting at is, if you really have too much choice you don't know what you're choosing. And the other party on the other side of this deal can change the deal on you if you've signed up. We make this thing much more complicated and much less user-friendly than it has to be. And I want to make sure we're not driving up the cost by having exotic stuff, driving up the cost for the ordinary everyday stuff. But there is a profile, there is a comprehensive scope of conditions that we can treat effectively, and cost effectively, with medication.

And it seems to me the more we can eliminate the confusion in this the more -- and make it genuinely available and comprehensive in its scope, the better service we'll be providing all of our customers. Because after all, we're paying these folks to assume this public risk and we ought to make sure the folks know what they're getting when they're going into the marketplace.

What is MedPAC doing about this? Are you all ***looking*** into this?

MR. HACKBARTH: Well, on the specific issue of the complexity, you know, we have ***looked*** at the choices that Medicare beneficiaries have to make in choosing among plans, and ***looked*** at the tools that beneficiaries have available to them. CMS does have some tools, as you know, to try to help beneficiaries compare plans and choices.

We think, here again, this is another area where some investment could pay dividends in helping beneficiaries understand their choices. There's no way around though the ultimate tradeoff that you're going to face between complexity on the one hand and flexibility for plans to manage the costs on the other. There's no right answer in how to strike that balance.

REP. BARROW: I think doctors --

REP. PALLONE: The time has expired, but if you want to say something?

REP. BARROW: I just think doctors ought to be able to those calls.

Thank you, Mr. Chairman.

REP. PALLONE: Thank you. Unless anyone else has questions, we're going to proceed to the next ***panel***. So thank you very much. Your input is obviously very important as we proceed on this. And appreciate your being here this morning. Thank you.

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

Okay, our second ***panel*** is on Doctor, Nurse, Hospital, and Other Provider Views. And as you can see it's a rather large ***panel***. So they want to get started. And let me -- I don't think I've seen such a large ***panel***.

We'll start on my left, with Dr. Ted Epperly, who is president of the American Academy of Family Physicians.

And then we have Dr. M. Todd Williamson, who is president of the Medical Association of Georgia. And then is Dr. Karl Ulrich, who is clinical president and CEO of the Marshfield Clinic; and Dr. Janet Wright, who is vice president of Science and Quality at the American College of Cardiology.

Dr. Kathleen White, who is chair of the Congress on Nursing Practice and Economics, at the American Nurses Association. Dr. Gabow, okay -- Dr. Patricia Gabow who is chief executive officer of the Denver Health and Hospital Authority for the National Association, which will be speaking for the National Association of Public Hospitals.

Dan Hawkins, who is senor vice president, Public Policy and Research for the National Association of Community Health Centers; and Bruce Roberts who is executive vice president and CEO of the National Community Pharmacists Association. Bruce Yarwood, president and CEO of the American Health Care Association. And Alissa Fox, who is senor vice president of the Office of Policy and Representation for the Blue Cross Blue Shield Association.

Now before we begin, I just wanted to make -- point something out that I believe has been shared with staff but I think needs to be repeated because of the ***panel***. It would touch upon some of the things particularly with regard to community health centers.

In several sections of the draft -- well, I should say in several sections of that part of the draft that deals with the public health and workforce development, in that division, a sentence that was supposed to be in addition to current authorizations, was instead drafted to ***take*** the place of them.

So instead of "in addition," it says "to ***take*** the place of" in that division; and this is an error. It was caught on Friday afternoon, shortly after the draft was announced, and we did notify both Democrat and Republican committee staff of the mistake. And corrections have been sent to the Office of Legislative Counsel. But I did want to point that out before I started here today, because I wasn't sure that all of you, who were testifying, were aware of that.

The mistake is particularly glaring in the provision related to community health centers. And I think Mr. Hawkins knows this, but just let me point it out to everyone that the draft is supposed to have included an additional ($)12 billion over five years in new money and that's over and above the current appropriation.

And again, that's why we have drafts, I guess. But let us start, as you know, we asked you to keep your comments, your oral comments, to five minutes. And of course, all of your written testimony will be included in the record.

And we'll start with Dr. Epperly.

DR. EPPERLY: Chairman Pallone, Ranking Member Deal and members of the Energy and Commerce Health Subcommittee. I am Ted Epperly, president of the American Academy of Family Physicians, which represents 94,600 members across the United States. I'm a practicing family physician from Boise, Idaho.

I'm delighted to say that your draft bill goes a long way towards providing quality, affordable, health care coverage for everyone in the United States. The AAFP has called for fundamental ***reform*** of our health care system for over two decades.

We commend you for your leadership and commitment to find solutions to this complex national priority. We appreciate efforts to improve primary care through this draft bill.

The academy believes that making primary care, the foundation of health care in this country is critical. Primary care is the only form of health delivery charged with the long-term care of the whole person and has the most effect on health care outcomes.

Primary care is performed and managed by a personal physician leading a team, collaborating with other health professionals, and using consultation or referral, as needed. Many studies demonstrate that primary care is high quality and cost-effective because it includes coordination and integration of health care services.

The academy believes the key to designing a new health care system is to emphasize the centrality of primary care by including the patient-centric medical home, where every patient has a personal physician, emphasizing cognitive clinical decision making rather than procedures. And ensuring the adequacy of our primary care workforce and aligning incentives to embrace value over volume.

Many of these key provisions are contained in your draft legislation. Specifically, we applaud the committee for including a medical home pilot program in Medicare as a step towards a primary care system. Your definition of the patient-centric medical home is consistent with the one established by the AAFP and other primary care organizations.

We also support the PCMH demonstration project in Medicaid. Use of the medical home will achieve savings and improve quality. We appreciate the inclusion of a bonus of five percent for primary care services and up to 10 percent for services provided in a health profession shortage area. We urge you to make this bonus permanent.

Medicare is a critical component of the U.S. health system and must be preserved and protected. With this draft, you ***take*** the ***first*** bold steps needed to remedy the Medicare physician payment system.

The AAFP appreciates your recognition of the longstanding problems with the dysfunctional formula known as the Sustainable Growth Rate or SGR. We thank you for ***proposing*** that it'd be rebased. This is an important, necessary, and welcome step.

We also appreciate the bill's attention to workforce issues. Numerous studies indicate that more Americans depend on family physicians than on any other medical specialty. We are deeply concerned about the decline in the number of medical students pursuing a career in primary care at a time when the demand for primary care services will only be increasing.

The majority of health care is provided in physician's offices now and will be in the future. We must revitalize the programs to train the primary care physician workforce that will meet our needs in those locations.

We thank you for reauthorizing and providing a substantial investment in the section 747 of the health profession's primary care medicine training program. The National Health Care Workforce Commission in the discussion draft is needed to recommend the appropriate numbers and distribution of physicians.

The AAFP is also pleased that the Medicaid title provides for substantial expansion of coverage to the uninsured. In particular, we support increases to the Medicaid primary care payment, so that it is equal to Medicare by 2012.

The AAFP supports a public plan option consistent with the principles included in our written testimony. Patients should have a choice of health plans and a public plan should be one of them. However, the public plan should not be Medicare. We acknowledge that for transition purposes, there may be some similarities to the federal program, but we urge Congress to delink the public plan for Medicare by a date certain.

The AAFP strongly supports the inclusion of comparative effectiveness research in the draft bill. We appreciate the establishment of a center within the agency for health care research and quality.

If we wish to improve the patient care and control costs in this country, this type of research is crucial. It is only with CER that we can provide evidence-based information to patients and physicians for use in making health care

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

In conclusion, the academy believes that health care should be a shared responsibility and applauds the section of the bill that requires all individuals have coverage. Now is the time to provide affordable high quality health care coverage, the status quo is not working. We urge Congress to invest in the health care system we want, not the one we have.

Thank you very much, Mr. Chairman.

REP. PALLONE: Thank you, Dr. Epperly.

Dr. Williamson.

DR. WILLIAMSON: Good morning, Chairman Pallone and Mr. Deal. My name is Todd Williamson, and I want to thank you for the opportunity to speak to you today. I'm a neurologist from Atlanta and I serve as the president of the Medical Association of Georgia, and I'm speaking on behalf of that association.

I recently had the privilege of speaking on behalf of a coalition of twenty state and specialty medical societies representing more than 100,000 physicians which is nearly, half of the practicing physicians in the United States. This coalition believe that ensuring the patient's right to privately contract with their physician is the single most important step we could ***take*** to ***reform*** our medical care system.

I would like to begin by addressing three assumptions that underpin the discussion draft. The ***first*** relates to geographic disparities in spending. Peter Orszag recently said that "Nearly 30 percent of Medicare's costs could be saved without negatively affecting health outcomes if spending in high and medium cost areas could be reduced to the level in low-cost areas."

We do not agree. This flawed claim was ***first*** made by the Dartmouth group, which used only Medicare data to analyze spending and quality. Please consider the work of Dr. Richard Cooper, which shows that an examination of total medical spending per capita reveals that quality and cost are indeed connected.

He also demonstrates that Medicare payments are disproportionately higher in states with high poverty levels and low overall medical care spending. The suggestion that our medical care expenditures are greater than other countries is also misleading. Countries account for expenditures such as out of pocket payments and the cost of long-term care in different ways, some countries drive down costs by rationing care. The cost of research and development distorts our expenditures as well.

A third faulty assumption is that medical care outcomes in the United States are worse than in other countries. America's often cited infant mortality statistics cannot be directly compared to statistics from other countries that do not record the deaths of low birth weight newborns that we try to save.

Comparisons of a host of specific diseases such as diabetes, clearly, show our outcomes are superior. We cannot support and would actively oppose the discussion draft. As I noted, we believe that allowing patients and physicians to privately contract is the single most important step we can ***take*** towards ***reforming*** the nation's medical care system.

This will empower patients to choose their physician, spend their own money on medical care, and make their own medical decisions. Medical expenditures can only be appropriately controlled and allocated where there is complete transparency and acknowledgement of necessity and value, at the time of the patient physician interaction.

Private contracting will enhance access to medical care. Many physicians opt out of government plans because payments do not cover costs. If private contracting was allowed, every patient would have access to every doctor. This option is currently not available under government plans and is prohibited in the discussion draft.

Critics cite that private contracting will disadvantage impoverished patients. I would argue that they will benefit from increased access and competition in the medical community and their physicians will be at liberty to waive co-pays which is currently forbidden in government plans.

We applaud the draft sponsors for planning to rebase the SGR payment system, but we remain concerned that they continue to rely on a target-based approach. We support the emphasis on prevention, wellness, and claims transparency. We agree that primary care should receive greater support and administrative burden should be reduced.

We do not believe that the federal government should replace current research and development mechanisms or the training and judgment of physicians with federally controlled comparative effectiveness research. While we recognize the need for ***reform***, we believe that the private marketplace should remain the primary means of obtaining insurance. A government-sponsored health insurance program for working-age adults will invariably eliminate private options.

Recall that Medicare was originally introduced as an option for seniors, but today it has essentially become their only choice. We can reduce obstacles to individual ownership and control of medical insurance by adopting new tax policies.

This would eliminate the phenomenon of preexisting conditions because individuals could carry their insurance with them for life independent of their occupation or employer. To those who assert that the private sector has failed our patients, I say that our patients have been disadvantaged in the marketplace by a tax system that penalizes individual ownership of health insurance.

When all Americans own their policies, insurance companies will be forced to compete for the business of millions of individuals, and they will focus on satisfying the patient, not the patient's employer. Finally, we can significantly reduce health care expenditures and improve access by enacting proven, effective medical liability ***reform*** measures.

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

REP. PALLONE: Thank you, Dr. Williamson.

Dr. Ulrich. Or is it, Ulrich or Ulrich?

DR. ULRICH: Ulrich is right.

REP. PALLONE: Ulrich.

DR. ULRICH: Thank you. Mr. Chairman, Ranking Member Deal, and members of the subcommittee, my name is Karl Ulrich, and I'm president and CEO of Marshfield Clinic in Marshfield, Wisconsin. On behalf of myself, our staff, and the tens of thousands of patients that we care for, we commend you for advancing the national health ***reform*** debate.

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

As background, Marshfield Clinic is one of the largest medical group practices in Wisconsin, and indeed the United States, with almost 800 physicians, 6,500 additional staff, and 3.6 million annual patient encounters per year. As a 501(c)(3) not-for-profit organization, our clinic is a public trust serving all who seek care, regardless of their ability to pay. As part of our commitment, the clinic has invested in sophisticated tools that complement and support our mission such as an internally-developed certified electronic medical record, a data warehouse, and an immunization registry.

With this infrastructure, the clinic is presently publicly reporting clinical outcomes, and providing quality improvement tools to analyze processes, eliminate waste, and improve consistency while still reducing unnecessary costs. These initiatives are consistent with the stated goals of the national health ***reform*** debate.

Our clinic has long used information to facilitate care redesign, and we expanded these efforts after becoming a participant in the federal physician group practice demonstration. As a result, we have improved care, reduced costs, and achieved significant savings for the Medicare program.

In the ***first*** two years of the demonstration, we have saved taxpayers more than $25 million with our redesigns, while meeting or exceeding all 27 of possible quality metrics. We believe that equivalent or even greater results are possible with the creation of the ***proposed*** accountable care organizations, especially if the subcommittee aligns the incentives of the Medicare program reimbursement with value and efficiency.

However, of concern is the current tri-committee mark, the authors have ***proposed*** the establishment of a public health insurance option. Providers who voluntarily participate in Medicare would be required to participate in the public option, and would be paid at Medicare rates plus some incremental percentage for the ***first*** three years of operation.

This raises substantial financial and operational questions around how the federal government could compel physicians to see those patients. For instance, would this mean that patients must be seen when they present, or would providers be compelled to see the patient within a certain timeframe?

Further, if the public plan pays at Medicare rates, the reduction in commercial service revenue would compel radical restructuring of our institution perhaps resulting in our demise. As such and in this current form, Marshfield Clinic strongly opposes the public plan alternative based on the belief that a true level playing field could never exist between public and private providers.

In Wisconsin, where commercial rates vary between 180 percent to 280 percent of Medicare rates, this public plan would have such a profound competitive advantage that one needs to be concerned that providers would uniformly abandon the Medicare program to survive in the practice of medicine. Further, there is a significant problem with Medicare payment rates in Wisconsin as well as the rest of rural America.

For example, Medicare currently reimburses us at only 51.6 percent of our allowable costs. We believe that this is a result of Medicare's failed formulas for reimbursing physician work and practice expense, and Medicare's geographic adjustment.

To address these systemic problems, we believe that Congress and CMS must refine Medicare payment systems to address the problems of access and encourage appropriate care by providing incentives that focus on quality and efficiency. Similarly, we are also concerned about the practice expense components of the Medicare physician formula.

It is widely agreed that the data used to estimate non-physician wages does not reflect current patterns and practice of medicine. As a result, the formula distorts payments paying some too much and others too little.

To resolve this disparity, we would like to heighten the legislative work of Congressman Braley and Kind, who have each authored legislation to correct this inequity. And we urge the subcommittee to include these members' thoughtful provisions in any health care ***reform*** legislation that advances.

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

REP. PALLONE: Thank you, Dr. Ulrich.

Dr. Wright.

DR. WRIGHT: Chairman Pallone, and Ranking Member Deal, and members of the subcommittee, thank you for the opportunity to appear before the subcommittee today. My name is Janet Wright. I am a board-certified cardiologist having trained in San Francisco and practiced in Northern California for 25 years.

For the last year, I've been serving as the American College of Cardiology's senior vice president for science and quality here in Washington. And in that role, I oversee our registries, our scientific documents like guidelines and performance measures and appropriate use criteria, and also our quality improvement projects and programs.

On behalf of the 37,000 members of the ACC, I commend you for setting out the health care ***reforms*** in the current draft bill. We see so many improvements, and we commend you and applaud your efforts to both attend to and correct the flawed physician payment model.

We also registered concerns about ***proposed*** cuts in imaging and the effect they may have on patient's access to care. But in broad overview, the ACC is completely committed to comprehensive ***reform***, and we are very grateful for your attention to the matter.

Ranking Member Barton invited me to speak today about his draft ***proposal***, the Health Care Transparency Commission Act of 2009. And I'm delighted to offer these comments.

The American College of Cardiology values performance measurements, its analysis, and improvement, and it demonstrates this commitment through a 25-year history of producing guidelines for clinical practice. The more recent generation of a particular kind of guidance called the Appropriate Use Criteria to help clinicians choose the appropriate type of treatment, or technology, or procedure that best fits that patient's clinical scenario.

And then our efforts in what's now called the implementation science, ***taking*** what we know works and trying to get that into the practice of medicine in a systematic way. Examples of that in recent years are the Door-to-Balloon Project, the Alliance for Quality, over a 1,100 hospitals here in the U.S. and beyond are trying to shorten up that time from diagnosis of a myocardial infarction until the balloon opens that artery.

And more recently, we are about to launch a program called Hospital to Home, excellence in transition along with key partnerships, particularly with the Institute for Healthcare Improvement. And finally, we are beginning to implement our Appropriate Use Criteria both in imaging and soon in revascularization to help clinicians, their patients, and their surgeons make good decisions about revascularization.

Our -- in fact, our vision is not just separate projects, but a network of practices and hospitals. We are currently in about -- our registries are in about 2,300 hospitals around the country, and our ambulatory registry, quality improvement program is just beginning, but we are out into about 600 practices in the country.

Our fully realized vision is to connect these practices in the hospitals in a quality network. Those individuals practicing in the hospitals and outpatient settings are committed to the systematic delivery of scientifically-sound patient-centered care, and to fully realize that vision will include primary care network as well.

Because we understand most of cardiac disease is actually managed by primary care docs and nurses. In order to affect this vision to make this come true, obviously, payment needs to be readjusted from the volume that we've known to the value that we treasure.

I enlist and again appreciate your efforts to make that happen. And we believe that good data are the foundation for quality improvement and sort of to stimulate innovation, a very healthy competition amongst providers, and a rapid and continuous learning network. As the science of performance measurement improves and the skill of all of us at communicating complicated statistics to lay people, as that skill is honed, consumers will likewise find great value in quality information.

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

But number one -- these five principles -- number one, the driving force for performance measurement and public reporting should be quality improvement. We acknowledge and support Mr. Barton's critical inclusion in his draft bill of quality ratings along with pricing information.

Number two, public reporting programs should be based on performance measures with scientific validity. Number three, public reporting programs should be developed in partnership with health care professionals those being measured.

Number four, every effort should be made to use standardized data elements to assess and report performance and to make the submission process uniform across all public reporting programs. This helps reduce the measurement fatigue and the disengagement that we often see in health care professionals who are exhausted with the effort of measuring.

Number five, performance reporting should occur at the appropriate level of accountability. I think this is true in all areas of medicine, but certainly in cardiology. The most effective care is delivered by teams, focusing on an individual within that team may skew the measurement and the result of that measurement in a way that has adverse consequences.

REP. PALLONE: Dr. Wright, just you're almost a minute over so -- if you could just summarize.

DR. WRIGHT: Okay. Number six, is avoiding those unintended consequences.

Thank you very much.

REP. PALLONE: Thank you. Sorry.

Dr. White. Your mike is not on. You have to turn that green light on and then bring the mike a little closer. Yes.

MS. WHITE: Chairman Pallone, Ranking Member Deal, distinguished committee members, and congressional staff. I'm Kathleen White, a registered nurse speaking today on behalf of the American Nurses Association. And we thank you for this opportunity to testify.

The ANA is the only full service national association representing the interests of the nation's 2.9 million registered nurses in all educational and practice settings. ANA advances the nursing profession by fostering high standards of nursing practice.

ANA commends the committee for its work in the tri-committee's draft legislation which represents a movement toward much-needed, comprehensive, and meaningful ***reform*** for our healthcare system. We appreciate the committees' recognition that, in order to meet our nation's health care needs that we must have an integrated and well resourced national workforce policy, that fully recognizes the vital role of nurses and other health care providers and allows each to practice to the fullest extent of their scope.

ANA remains committed to the principle that health care is a basic human right and all persons are entitled to ready access to affordable, quality health care services that are patient-centered, comprehensive, and accessible. We also support a restructured health care system that ensures universal access to a standard package of essential health care services for all. That is why ANA strongly supports the inclusion of a public health insurance plan option as an essential component of comprehensive health care ***reform***.

We believe that inclusion of a public plan option would assure that patient choice is a reality and not an empty promise, and that a high-quality public plan option will, above all, provide the peace of mind that is missing from our current health care environment. It will guarantee the availability of quality, affordable coverage for individuals and families no matter what happens and generate needed competition in the insurance market. ANA ***looks*** forward to partnering with you to make this plan a reality.

There are a wide variety of ideas currently circulating on health care ***reform***, but all include discussion of prevention and screening, health education, chronic disease management, coordination of care, and the provision of community-based primary care. As the committee has clearly recognized in its drafts, these are precisely the professional skills and services that registered nurses bring to patient care. As the largest group of health care professionals, registered nurses are educated and practice within a holistic framework that views the individual, family, and community as an interconnected system.

Nurses are the backbone of the health care system and are fundamental to the critical shift needed in health services delivery with the goal of transforming the current sick care system into a true health care system. ANA deeply appreciates the committee's recognition of the need to expand the nursing workforce and thanks you for your commitment to amend the Title VIII Nursing Workforce Development Programs under the Public Health Service Act. And commend the inclusion of the definition of Nurse Managed Health Centers under the Title VIII definitions.

We applaud the removal of the 10 percent cap on doctoral traineeships under the Advanced Education Nursing Grant program and the inclusion of special consideration to eligible entities that increase diversity among advanced educated nurses. Additionally, the expansion of the Loan Repayment Program eligibility to include graduates who commit to serving as nurse faculty for two years will help address this critical shortage of both bedside nurses and nursing faculty. We are also grateful for the funding stream created through the public health investment fund and the commitment of dollars through 2014 that would offer vital resources and much needed funding stability for these Title VIII programs.

ANA applauds the use of community-based multidisciplinary teams to support primary care through the Medical Home Model. ANA is especially pleased that under this ***proposal***, nurse practitioners have been recognized as primary care providers and authorized to lead medical homes.

Nurse practitioner skills and education, which emphasize patient and family-centered, whole-person care, make them particularly well- suited providers to lead in the Medical Home Model focused on coordinated chronic care management and wellness and prevention. Many recent studies have demonstrated what most health care consumers already know, nursing care and quality patient care are inextricably linked, in all care settings, but particularly, in acute and long-term care.

Because nursing care is fundamental to patient outcomes, we are pleased that the legislation places strong emphasis on reporting nurse staffing in long-term care settings both publicly and to the secretary. The availability of nurse staffing information on the Nursing Home Compare website would be vital to help consumers make informed decisions, and the full data reported to the secretary will ensure staffing accountability and enhance resident safety. ANA hopes that, in the same vein, the committee will ***look*** toward incorporating public reporting of similar nurse staffing measures and nursing sensitive indicators in acute care through the Hospital Compare Website, as recommended by the National Quality Forum.

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

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

REP. PALLONE: Thank you, Dr. White.

Dr. Gabow.

DR. GABOW: Chairman Pallone, Ranking Member Deal, and members of the committee, thank you for the opportunity to testify. I'm Dr. Patricia Gabow and I'm speaking for Denver Health, and the National Association of Public Health and the Hospital System.

Please excuse my voice. Denver Health is an integrated safety net institution that includes the state's busiest hospitals, all Denver's federally qualified health centers, the public health department, all the school-based clinics, and more.

Since 1991, we have provided $3.4 billion in uninsured care and have been in the black every year. We have state-of-the-art facilities and sophisticated HIT. These characteristics have enabled amazing quality, 92 percent of our children are immunized, our hospital mortality is one of the lowest in the country, 61 percent of our patients have their blood pressure controlled compared to 34 percent in the country. This is despite the fact that 46 percent of our patients are uninsured, 17 percent are minorities, and 85 percent are below 185 percent of federal poverty level.

So you may ask if we're doing so well at meeting patients' needs, why am I here supporting health ***reform***. The answer is straightforward. As a safety net physician leader, I see everyday that America is failing to meet people's health care needs in a coordinated, high-quality, low-cost way. The number of uninsured in our door and the cost of their care increases every year.

In 2007, our uninsured care was $275 million. Last year, it was $318 million, and it's projected to be ($)360 million this year. This is not sustainable. Moreover, not every American city has a Denver Health. As a doctor, I ask myself why should where you live in America determine if you live, why should a uninsured cancer patient get care if they live in Denver, but not if they live in another Colorado county.

You have included important ***reform*** components in your draft bill. We support your goal to ensure affordable quality care for all. I agree that costs must be reduced, if we are to cover everyone. And costs can be reduced by developing integrated systems that get patients to the right place at the right time with the right level of care with the right provider, and the right financial incentives.

We support your continued investment in DISH hospitals, community health centers, and public health. I would encourage incentives to move these separate entities to integrated systems. These entities will be important during the transition to full-coverage and afterwards to vulnerable patients, including Medicaid, which will be a building block for much of the coverage expansion.

Integrated systems are cost efficient. Our charges per Medicaid admission are 30 percent below our peer hospitals. Your investment in primary care and nurse training in the National Health Serve Corps is critical. Without this we will not be able to get patients to the right provider for the right level of care.

As a public entity, we believe in the power of the public sector to meet the needs, not only of those patients on public programs, but also private patients. We are the major Medicaid provider for our state. But our HMO also

serves private patients including Denver's mayors. We are -- we and other safety net systems would welcome the opportunity to continue to be a plan of choice.

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

REP. PALLONE: Thank you, Doctor.

Mr. Hawkins.

MR. HAWKINS: Well said, Dr. Gabow.

Good morning, Mr. Chairman, Ranking Member Deal and distinguished members of the subcommittee. Distinguished meaning, present and accounted for.

On behalf of the National Association of Community Health Centers, the nation's more than 1,200 community health center organizations and the more than 18 million people they serve today, thank you for the opportunity to contribute to today's discussion. In community health centers all across the country, we witness the urgent need for fundamental health ***reform*** every single day, in the faces and the struggles of our patients, who for too long have been left behind by our dysfunctional health care system. Our 43 years experience in caring for America's medically disenfranchised and underserved has taught us three things.

First and foremost, that health ***reform*** must achieve universal coverage that is available and affordable for everyone, and especially for low-income individuals and families. Second, that that coverage must be comprehensive and must emphasize prevention and primary care. And third, that it must guarantee that everyone has access to a medical or a health care home, where they can receive high quality, cost effective care for their needs.

Mr. Chairman, we believe that the plan we have before us today meets those principles and also moves our nation much closer to achieving the equity and social justice in health care that has proven so elusive over the past century. Community Health Centers strongly support the draft legislation's call to expand Medicaid to cover everyone with incomes up to 133 percent of poverty without restriction.

This Medicaid expansion may well be the most important and the most essential feature of this plan, especially, for the patients we serve. At the same time, we urge you to ensure that as these Medicaid beneficiaries are potentially moved into the Health Insurance Exchange, they can continue receiving as supplemental Medicaid benefits, those key services like outreach, transportation, nutrition and health education screening and case management that will remain so vital to their health and wellbeing, but will most likely not be covered by their exchange plans.

It is also clear that the expansion of insurance coverage, while a vital ***first*** step, can only ***take*** the country so far. Most importantly, the increased demand for care that comes from expanding coverage must be met with an augmented primary health care system, as the people of Massachusetts learned in the wake of their state's ***reform***.

Here again, the draft legislation delivers a solid response to this challenge. And we applaud its call to expand the health center system of care through increased funding as part of the new public health investment fund. The members of this committee have consistently provided broad bipartisan support for health centers over the years, and we deeply appreciate that. And I can assure you that health centers are repaying your trust and your investment in them every day.

For example, a recent national study done in collaboration with the Robert Graham Center found that people who use health centers as their usual source of care have 41 percent lower total health care costs and expenditures than people who get their care elsewhere.

As a result, health centers saved the healthcare system $18 billion last year alone; more than nine times the federal appropriation for the program, and better than $2 for every dollar they spent in care. With the new funding in the draft bill, these savings will grow even larger.

The National Health Service Corps is a vital tool for health centers and underserved communities seeking to recruit new clinicians. And the draft legislation would bring a historic investment to the program leading to thousands more primary care providers to practice in underserved communities.

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

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

Mr. Chairman and members of the committee, we again thank you for your leadership and your commitment to make health care ***reform*** work for all Americas and we pledge ourselves to work with you to make that a reality this year. Thank you.

REP. PALLONE: Thank you, Mr. Hawkins.

Mr. Roberts.

MR. ROBERTS: Chairman Pallone, Congressman Deal, and Members of the Health Subcommittee, I'm Bruce Roberts, the executive vice president and CEO of the National Community Pharmacists Association, NCPA. I'm a licensed pharmacist in the state of Virginia. And I've owned four community pharmacies over the last 33 years in Loudoun County, Virginia.

NCPA represents the owners and operators of 23,000 independent community pharmacies in the United States. We appreciate the opportunity to testify before you today on the role of pharmacy in health care ***reform***.

In many communities throughout the United States, especially in urban and rural areas, independent community pharmacies are often the primary source of a broad range of health care products and services; services such as medication, therapy management and immunization programs for seniors under Medicare Part B and D.

We believe that a ***reformed*** health care system should expand the availability of these programs, because they can help improve the quality of care and reduce health care costs. The reality is that for every dollar the health care system spends paying for prescription medications, we spend at least another additional dollar on health care services to treat the adverse effects of medications that are ***taken*** incorrectly or not at all.

For example, a primary cause for costly hospital readmissions is the lack of patient adherence to medications used to treat chronic medical conditions, such as hypertension and high cholesterol. Pharmacists can play an important role in the post acute care in helping patients manage their medications through education, training, and monitoring.

We applaud the fact that the draft ***House*** language would allow the involvement of non-physician practitioners such as pharmacists in the medical home pilot project. Pharmacists can help improve the use of prescription medications, especially in those individuals that have multiple chronic diseases.

NCPA is very -- much -- very much appreciates the fact that the draft ***House*** legislation includes ***reform*** of the Average Manufacturer Price, AMP, based reimbursement system for Medicaid generic drugs. We would like to get this fixed this year. We are concerned that the Medicaid generic reimbursement at 130 percent of the weighted average AMP as ***proposed*** in the draft ***House*** bill, combined with low dispensing fees paid by states will, in total, still significantly underpay pharmacies for the dispensing of low-cost generics in the Medicaid program. This could create a disincentive for the use of generic drugs causing a rise in Medicaid cost over the long term.

NCPA asks that the committee to consider a higher FUL reimbursement rate for generic medications, especially for critical access community pharmacies that serve a higher percentage of the Medicaid recipients, or rural pharmacies. With respect to our ability to continue to provide durable medical equipment, DME, to Medicare beneficiaries, we believe that the requiring state-licensed, state- supervised community retail pharmacies to obtain both accreditation and surety bonds to simply sell DMEPOS items such as diabetes testing supplies to Medicare beneficiaries is basically overkill.

Thousands of pharmacies across the country, mostly small pharmacies, will not be accredited at all, or not be -- finish the accreditation process by October 1st, which will mean that they will be -- not be able to provide diabetes testing supplies for Medicare beneficiaries. We applaud the 90 bipartisan members of the ***House*** and 13 members of the Energy and Commerce Committee who supported H.R. 16 -- 616, the bill that introduced -- was introduced by Congressman Berry and Congressman Moran that would exempt pharmacies from redundant and unnecessary accreditation requirements. We also appreciate the work of Congressman Space in introducing H.R. 1970, which would exempt pharmacies from the unnecessary surety bonds.

We ask that the provisions from these bills be included in the Chairman's remark. If there is willingness to exempt pharmacies from these requirements, we ask that Congress consider acting by October 1st, which is the deadline for providers to attain accreditation and surety bonds.

Finally, I would make a few comments regarding the public plan option. Under the ***House proposal***, payment rates for prescription drugs under the public plan ***proposal*** would be negotiated by the secretary. We would be very concerned giving the secretary authority to set payment rates for prescription drugs without some basic guidance to how those rates should be established and updated.

We also ask that the language be clarified such as the administration of any benefit under the public plan would be accomplished by a pharmacy benefit administrator as opposed to a pharmacy benefit manager. We would prefer a model used in the Medicaid program or in the Department of Defense TRICARE program, where the administrator is used. Under this model, most if not all, the negotiated drug manufacturer rebates would be passed through to the public program.

In conclusion, we ***look*** forward to working with Congress and the administration to ***reform*** health care -- the health care system.

And we ***look*** forward to the opportunity to work with you to meet that end.

REP. PALLONE: Thank you, Mr. Roberts.

Mr. Yarwood.

MR. YARWOOD: Yes, sir. Am I on? There we go. That do it?

REP. PALLONE: Is the mike on? You have to -- or maybe bring it closer. Is the green light on?

MR. YARWOOD: That -- we got it.

REP. PALLONE: That's good.

MR. YARWOOD: Okay -- I'm afraid you'll hear me.

(Laughter.)

I should, ***first*** of all, say thank you for including me in the distinguished ***panel***. I mean, with doctor, doctor, doctor, doctor, pharmacist, and here's old Yarwood sitting right in between of them all. But thank you very much, I appreciate this, being here.

As you know, I'm Bruce Yarwood. I'm president and CEO of American Health Care Association and National Center for Assisted Living, which -- we represent about 11,000 facilities across the country with a great cross-section, you know, of the profession. We have big, we have small, we have rural, we have urban, proprietary and non-proprietary.

And I would -- I'd be remiss if I didn't say we ***look*** ourselves as a pretty significant force in the economy right now. We're about 1.1 percent of the gross domestic product when you kind of sort it all out. Now, having said that, we've ***taken*** a ***look*** at the 800 pages, and it's a significant bill.

And I must admit one that does not include a long term care ***reform*** as a ***reform*** at the same time it includes a whole bunch of stuff that has impact on us. And let me try to synthesize a little bit of the comments.

First, as we move forward and try to do a better job in terms of quality, it's really important for us to have economic stability. And one of the things we find in the bill is we have three pretty big problems with it.

First of all, the bill has a provision that would institutionalize what the CMS is doing to cut 3.3 percent out of our Medicare rate based on a formulary mistake that was made by them four years ago. Secondly, we're concerned about the discussion draft that will eliminate a part of the market basket.

And so what we're ***looking*** at then is not only a 3.3 percent cut in our rate coming from CMS, but then an additional cut coming from the committee that would significantly ***take*** resources out in terms of our ability to pay. And as you know, we are two-third to three- quarters percent or 25 or -- 75 percent labor based. And so a significant reduction in reimbursement causes us an -- a big problem in terms of our ability to pay and keep staff.

Third, which is not your doing, but Medicare cuts are being considered the same time we're ***looking*** at what we call the unfortunate reality of Medicaid under-funding. What we have seen -- the stimulus package was a help. However, the -- in response to recession, we see 46 percent of the states are freezing or cutting nursing home rates and that the 75 percent are not keeping up with inflation.

So in the shortfall, or in a short statement, what's occurring is that we're ***looking*** at -- we're ***looking*** down the barrel of a Medicare cut, and at the same time we're ***looking*** across the country of Medicaid rates either staying stable or falling in a period of inflation. And so we're feeling caught in a -- an economic vice, if you will.

Now, let me talk a little bit about some other stuff that is, I would say, very positive. Regarding Part B, we applaud you for the -- ***proposing*** to extend the therapy cap extension process -- exception process.

Second, I think the -- I think in testimony earlier we talked about Medicare rehospitalization. We have a rehospitalization problem and we need to join -- address that issue. We think there are ways to do that.

In a short statement, we find that our rehospitalization comes on day two, three, and four of admission. And typically, they go back to the hospital, because we probably shouldn't have ***taken*** -- or they come in the weekend, or things of that nature. So we think we should continue work on that together.

Third, we think that we should be ***looking*** at the whole post-acute setting and trying to integrate that much better than it is now. And we have numbers that would show that if we, either on a pilot or demonstration basis, I don't care -- from what you were talking about before, but we find that if we would integrate and pay based on diagnosis,

not on sight, we can save multibillion dollars ranging above $50 billion for the next 10 years. And that's -- simply stated, is that we can ***take*** a knee or a hip, that is not an IRF, but in a nursing home and do it for about half the cost.

I would be remiss if I didn't respond a little bit to a 100 pages of your bill that was addressed somewhat earlier by the prior ***panel*** that talks about transparency in long term care. Very basically put, the question is, is that what we need to do is ***take*** a lot better ***look*** at who owns places, how they're owned, who makes the decisions.

We've been in discussions with the staff for about last 18 months. And frankly, we support the concept and the direction of the committee. And we believe firmly that by continuing to work together the final legislation, that we can parse together, we can absolutely support.

I would say there are a few specifics though that, as I would be remiss if I didn't say that, that we have problem with. ***First***, we've a difficult time with what's to disclose to both party. And in the bill itself, for example, it mentions that we should be disclosing our bankers, boards of directors. That's something we don't have or can't get to.

Secondly, we would suggest the provisions that you're ***looking*** at be tailored to talk about exactly who we want to disclose. We'd ***take*** a ***look*** at the bill and we're in the position of disclosing people like who our landscapers are, painters are, and things of that nature that don't have a significant amount. So we think we can work that out.

Third, now we hear a lot about compliance programs from the inspector general. We have no problem with compliance programs, but what we need is tailor those based on the size of the facility. A compliance program for Kindred Healthcare, which is the large in the country versus a compliance program for the 35-bed facility in Oakland are two different things. So we just need to be sympathetic as to what those are.

REP. PALLONE: I had a -- you're a minute over, yeah, five minutes.

MR. YARWOOD: Well, then let me say this. Thank you very much for letting us be here. We certainly want to work together, and there's some great things in the workforce area, that and the transparency stuff, we are here to make it work for you.

REP. PALLONE: Thank you. Thanks a lot.

Ms. Fox?

MS. FOX: Thank you very much, Chairman Pallone, Ranking Member Deal, and other members of the committee. I really appreciate the opportunity to be here today. Blue Cross Blue Shield plans strongly support enactment of health ***reform***. We must rein in costs, improve quality, and importantly, we must cover everyone.

Today, the Blue System provides coverage to more than 100 million people in every community and every ZIP code in this country. For the past two years, we have been supporting five key steps to ***reform*** our system. ***First***, we believe the Congress should encourage research on what treatments work best by establishing a comparative effectiveness research institute.

We are very pleased the ***House*** draft bill recognizes the importance of this key step.

Second, in order to attack rising cost, we must change the incentives in the payment systems, both, private and in Medicare to promote better care instead of just more services. The draft bill includes some of the Medicare delivery system recommendations we support. We also agree with provisions in the bill to help build an adequate medical workforce to care for everyone in the country.

Third, consumers and providers should be empowered with information and tools to make more informed decisions. Fourth, we need to promote health and wellness and prevention and managed care for those with chronic illnesses. Finally, we believe a combination of public and private coverage solutions are needed to make sure everyone is covered.

We support a new individual responsibility program for all Americans to obtain coverage along with subsidies to ensure coverage as affordable. We also support expanding Medicaid to cover everyone in poverty. We are also supporting major ***reforms*** in our own industry including new federal rules to require insurers to open the doors except everyone regardless of preexisting conditions and eliminate the practice of varying premium spaced upon health status.

And we also support a national system of state exchanges to make it easier for individuals and small employers to purchase coverage. I know there is a perception that this is a new position for the insurance industry. It's not for the Blue System. We had the same position in 1993.

We appreciate this opportunity comment on the Tri-Committee bill. We support the broad framework of the bill, which includes many of the critical steps we believe are needed. However, we've very strong concerns that specific provisions would have serious unintended consequences that will undermine the committee's goals.

Our chief concern is creation of a new government-run health program. We believe a government-run health program is unnecessary for ***reform*** and will be very problematic for three reasons.

First, many people are likely to lose the private coverage they like and be shifted into the government plan. This is because the government plan will have many price advantages that private plans won't, including paying much lower Medicare rates than the private sector. This is enormous advantage on its own as Medicare rates are already 20 to 30 percent lower than what we pay in the private side, and that's a national average.

I think here you heard Marshfield Clinic talk about much huger variations in Wisconsin. But there are other advantages in the bill as well. I'd give you two examples. Individuals in the government plan, they can only sue in federal court for their denied services.

However, individuals in private plans can sue in state court for punitive, compensatory, and other damages. In addition, private plans would have to meet 1,800 separate state benefit and provider requirements, while the government plan would not.

Second, the draft bill would underpay providers in the government plan. This is likely to lead to major access issues in the health care system such as long waits for services.

And third, the government plan would undermine much needed delivery system ***reforms*** that are critical to controlling costs. We agree Medicare needs to be ***reformed*** to reward high quality care. We commend the committees for including ***reforms*** to modernize Medicare. However, history has shown the government can be slow to innovate and implement changes due to the complex legislative and regulatory processes.

The private sector, on the other hand, is free to innovate. And let me just give you one example from our program that is improving outcomes and lowering costs through our Blue Distinction Centers of excellence. Recent data shows that readmission rates at our cardiac care centers around the country are -- have 26 to 37 percent lower readmission rates than other hospitals.

In closing, I would like to emphasize the Blue System's strong support for health care ***reform*** including major changes in how insurers do business today. We believe the federal government has a vital and expanded role to play in ***reform*** by expanding Medicaid to cover everyone in poverty and enrolling all the people that are now eligible for Medicaid coverage by ***reforming*** Medicare to pay for quality and assuring Medicare's long term solvency and setting strict new rules for insurers to assure access to everyone regardless of their health.

We're committed to working with all of you to enact meaningful, health care ***reform*** this year. Thank you very much.

REP. PALLONE: Thank you, Ms. Fox. And now we'll have questions starting with me obviously. I can't reach everyone, so I am going to direct my question -- I would try to get the three questions about primary care, Medicaid, and DSH, if I could. And I am going to start with Dr. Epperly on the primary care promotion issue.

We've obviously heard a lot of testimony about the primary care shortages. We've heard that action on a single front is not enough, but the concerted action across the health system is going to be required. And the discussion draft reflects these calls for action and ***proposes*** major investments in our list, ***first*** in increasing the rate paid by Medicaid for primary care services.

Second, the primary care workforce including increases for the National Health Service Corp and scholarship and loan programs. Third, payment increases in Medicare and the public option for primary care practitioners including an immediate 5 percent increase in payments and high growth allowances under a ***reformed*** physician fee schedule.

Fourth, an additional payment incentive for primary care physicians and health profession shortage areas. And finally, an expansion of medical home payments and added flexibility for that model of care. The draft also ***proposes*** a ***reform*** to graduate medical education programs funded by Medicare and Medicaid. Two questions is, ***first***, will these ***proposals*** help to reverse the decline in interest in primary care among medical students?

Dr. Epperly?

DR. EPPERLY: Absolutely.

REP. PALLONE: Okay.

DR. EPPERLY: Did you want me to expand on that or --

REP. PALLONE: Yeah, but let me give you the second one, and then you can talk. The second one is will the rate increases ***proposed*** for primary care services in Medicaid and Medicare help to address problems of access we've seen in those programs over the past several years. So, generally, will you reverse the decline among medical students, and secondly, what will it do for access to Medicaid and Medicare?

DR. EPPERLY: Thank you, Mr. Pallone. I'd say to you that the return to a primary care based system in this country is essential. It's at the -- if you will, it's foundational to building the health care system of our future to get primary care physicians back into a position where they can integrate and coordinate care, lower costs, and increase quality, we must do that. Right now primary care is in crisis. A lot of that has to do with the dysfunctional payment system. Primary care practices are barely making in regards to the margins. So what we have to do in terms of the ***reform*** measures is, number one, make this viable financially for physicians to choose primary care.

REP. PALLONE: But tell me whether you think these ***proposals*** that are in our draft discussion will accomplish that? Will we get more medical students to go into primary care, and what will that mean to access to Medicaid and -- specifically with this ***proposal*** before us?

DR. EPPERLY: Right. So medical students now are opting not to choose primary care because they can see that incomes can be three to five times higher if they choose some specialties. So the payment ***reform*** will help narrow that gap and disparity, so that they choose more to do primary care. The derivative effect of that is that workforce will then be enhanced access than increases. What we must do in the system is not only cover people, but we've got to have the right types of physicians in the right communities to see them.

So it's kind of multi-faceted, multi-layered.

We have got to fix payment, which will increase workforce, workforce will enhance access, that's how it's all linked. What it saves America is cost in the long run, increases affordability and access as a derivative.

REP. PALLONE: Do you believe that this discussion draft will accomplish that?

DR. EPPERLY: Yes.

REP. PALLONE: Okay. Now, let me just ask my Medicaid and DSH question to Dr. Gabow if I can. Can you talk to us on Medicaid? What will it mean to have Medicaid covering up to 133 percent of the federal poverty level, having subsidies that help people access health care up to 400 percent, and to have individual response to encourage -- (inaudible) -- to make sure that their dependants have health insurance. So basically, you know, the increase to the poverty level to eligibility for Medicaid, the subsidy in the health and marketplace and the individual mandate. That's a lot -- (laughs) -- in one minute.

DR. GABOW: Yes. Well, clearly -- and even if that expands coverage, particularly for low-income multiple people, will reduce our $360 million of uninsured care. And as it relates to Medicaid disproportionate share payment, I think the timing is important.

We would like to makes sure that we see that the patients actually who are eligible get enrolled, and that they are covered and that are uninsured costs go down before there is any change in disproportionate share payments. So we applaud your version of the draft bill regarding this.

We know that many patients who we hope to get enrolled are the most difficult to enroll. For example, the homeless for whom we did over a $100 million of care last year, the chronically mentally ill, illiteracy, these patients have been difficult to enroll in Medicaid. So I think expanding Medicaid is terrific, but I don't know that immediately it will reduce our need for other coverage.

Ultimately, it should and I think we've seen in Massachusetts that a reduction of DSH at the front end has had negative effect on the two principal safety-net institutions. So I think the expansion of coverage that you are planning will reduce the amount of uninsured care over time. And we need to deal with that then sequentially as we go on the stage.

REP. PALLONE: Thank you.

Mr. Deal?

REP. DEAL: Thank you. I'm going to ask for yes or no answer from a couple of you on this ***first*** question. We just heard the preceding ***panel*** member, who was Chairman of MedPAC, say that he felt that Medicare reimbursements were adequate. And I would ask you if you concur with that.

Dr. Williamson?

DR. WILLIAMSON: No.

REP. DEAL: Dr. Ulrich?

DR. ULRICH: No.

REP. DEAL: Dr. Wright?

DR. WRIGHT: No.

REP. DEAL: Dr. Epperly, I'm going to ask you that question in the context of the current reimbursements on the Medicare, not counting the bonuses that are ***proposed*** in this legislation. Do you consider the current Medicare reimbursements to be adequate?

DR. EPPERLY: No, sir, I don't.

REP. DEAL: Have you, Dr. Epperly, as a result of that inadequacy, seen many of the members of your organization not ***take*** Medicare patients?

DR. EPPERLY: Yes, sir, I have.

REP. DEAL: All right.

Dr. Williamson, ***first*** of all let me make acknowledge that he is the president of my -- Georgian Medical Association and I'm pleased to have him here. I made those statements yesterday in your absence as we began these hearings yesterday.

Dr. Williamson, let me ask you what do you think the impact would be for the public option plan to adopt the Medicare reimbursement plan as its model? How would that impact the delivery of health care under the public option plan, and also as it been migrates, in my opinion, to the private insurance market?

DR. WILLIAMSON: I think it would have a very adverse impact on access for patients and on the delivery of quality medical care. Right now, access for Medicare patients I think is really a ***house*** of cards. A lot of doctors are there simply by inertia.

And surveys that have been done in Georgia amongst practicing physicians show that a large percentage of doctors plan on dropping Medicare in the near future. And I think that is just basically a train coming down the track. And I think any system that is modeled on that premises is really going to fail in the short-run, not the long-run.

REP. DEAL: The doctor-patient relationship has been really the corner stone of the importance of our health care delivery system that makes it work. I would ask you, Dr. Williamson, in light of this draft legislation, in particular the comparative effectiveness portion of it, how do you see that potentially impacting that doctor-patient relationship?

DR. WILLIAMSON: I think it's going to push us farther and farther away from it, which is really I think the opposite direction that we need to be going. I have serious concerns that bundling payments is going to drive the wedge between patients and their physicians.

I know that in some clinics that we've ***looked*** at as examples, that type of environment works, but those are rare, and I think they are different than the general practice of medicine across the country, and they have a different patient population in some cases. I have grave concerns about comparative effectiveness as well.

I think this would essentially give the federal government the ability to practice medicine. And I know that's a strong statement, but let me say this, scientific research is not new; it's always been done, and it's always been the basis of medical learning and medical treatment. But the art of medicine is ***taking*** this science, these large studies, and applying to an individual patient.

When you try to treat the individual from the 30,000 foot level, it's very difficult. And I'm afraid that this would drastically diminish our choice of options for our patients. I can tell you that I'm well aware as a neurologist of the importance of the last 20 years in pharmaceutical research. I have a lot of options for our patients now that weren't available before.

And some of these things are found quite by accident. And we ***take*** them, and we apply them, and that may be off-labeled drugs and that sort of thing. And they may even be therapies that have not been shown to work in large randomized control trials that ***take*** many years and millions of dollars to accomplish. And if we are limited by that, we are going to have a lot of therapies ***taken*** off the table for our patients.

And I would also tell you that I think that's a bit of a conflict of interest to have the government deciding what is valuable to patients because there are serving as the largest payer. I think that the physician and the patient ought to be able to decide in the context of private contracting what is of value and what is appropriate care.

REP. DEAL: Thank you. Mr. Roberts, you have alluded to the issue with AMP. As you know, earlier this year, I introduced an amendment that I think was more appropriately dealing with this federal upper limit for reimbursement of going to 300 percent of the volume-weighted average, and also included a minimum prescribing fee for pharmacists, or dispensing fee I should say, for pharmacists.

Which of those options do you prefer, what I offered earlier this year versus what's in this bill?

MR. ROBERTS: Well, I think, Congressman Deal, that your -- the challenge that we have is that we really don't know what this benchmark is. We have made -- been some changes made in the current version that redefines the benchmark in a way that it will make it much better than what it was, but the reality of what you are ***proposing*** in having a minimum dispensing fee I think is absolutely critical.

The challenge that we have is that you know the benchmark is just meant to get us to even, to break even on the cost of the product. But the reality is the state set the dispensing fees. And the dispensing fees are all over the place from one state to another. And so unless the federal government ***takes*** some action to say, you know, our costs of dispensing and a small, small profit are available to the pharmacy, it's going to be very difficult to have pharmacies remain viable and still stand the medication --

REP. DEAL: Mr. Chairman, I will ***take*** that as an endorsement of my approach and I will yield back.

(Laughter.)

REP. PALLONE: Thank you. All right, Vice Chair Ms. Capps.

REP. CAPPS: Thank you, Mr. Chairman. And I want to thank again all of the panelists for appearing today. It was a very interesting presentation that each of you made. A lot of linking which, I think, is really important for us to have as part of this discussion.

Of course, Dr. White, I want to single you out. And thank you for being here today to represent the voice of America's nurses who are so important everyday in delivery of health care, but also in understanding what this crisis is all about. I was very pleased to hear that the American Nurses Association has endorsed the public plan option. I also support this option and the one that we are developing in this legislation, and want to hear your perspective a bit more, as a nurse, on why this is so essential because it is one of the crucial parts of the choice that people are going to make whether or not they support this ***reform*** legislation.

Nurses, I would ask you, within this framework, I often speak about the role that nurses have, not only as providers of health care in delivering service, but we are also patient advocates. And would you talk about maybe the reason you endorse as ANA the public plan option and why you feel it is best for patients and perhaps are encouraging patients to advocate for this as well as the choice, to have this choice be made available?

MS. WHITE: Thank you, Ms. Capps. I'm happy to answer that question because I do think it is extremely important the American Nurses Association endorsing the public option plan because, as you said, our role in direct care, we are there 24/7, 24 hours a day, 7 days a week, 365 of -- you know, depending on how long a patient is in there.

We don't like to think it's that long. But we see patients and families, and how they are dealing with the catastrophic impact of illness, whether it's an episodic, a single acute, that affects the patient and their family, or whether it's long-term kind of chronic condition that includes, you know, many admissions or many returns.

And not being able to have a choice of insurance I think is key. And unfortunately, we've seen employer plans rising, the cost of those to patients rising greater than wages over the last several years. And so patients are ***looking*** for other ways of paying for their health care insurance.

And sometimes those plans may not be exactly what they think they are. They may have surprises. So certainly, a public plan that includes some type of defined or essential benefit package that the patient, the family, could be sure will be there when they need it, I think, is extremely important.

REP. CAPPS: Let me follow this by another aspect of our ***reform*** legislation. One of the ways -- Dr. Epperly mentioned this, but he wasn't the only one on the ***panel***, which was interesting, who is stressing now primary care, as one of the ways we can lower health costs, and the ways that he discussed on how we can improve our primary care workforce.

But there are many -- and there are many advanced practice nurses, nurse practitioners, and others who can and do serve as primary care providers. And this bill ensures that nurse practitioners can be the lead providers in medical home models and increases reimbursements, for example, for certified nurse midwifes.

Can you discuss this little bit? You mentioned one bill that I've coauthored on nurse managed things, but that is not the only avenue. And you might mention a few others for the record?

MS. WHITE: Oh sure. Absolutely. Obviously, the nurse managed clinics is an extremely important way for many vulnerable populations inner city rural areas that get primary care and other -- even other follow up care in those areas. And as far as nurse practitioners, as are advanced practice nurses functioning within the primary care medical home and being able to lead those teams, we've seen in the demonstration projects throughout the country that nurse practitioners have been ***paneled***.

They do function to their scope of practice in the different states in the different demonstration projects and have been able to lead the ***panel*** of patients and provide that primary care. I think it's extremely important, when we are talking about this, the shortage of primary care, that all providers be able to be used to the fullest extent of their scope that they can provide the care.

REP. CAPPS: Thank you very much. I'll yield back.

REP. PALLONE: The gentleman from Indiana, Mr. Buyer.

REP. BUYER: The challenge we have with the ***panel*** this large is try to get our questions in. So if you can ***take*** out a pen and pad, I might rip through some questions. Not all -- it won't apply to all of you. ***First*** I'm going to Mr. Yarwood.

When you say the provisions in the draft bill would cut Medicare reimbursement rates to skilled nursing facilities by $1.05 billion in FY 2010 alone, and ultimately $18 billion from skilled nursing care over 10 years, I'd like to know whether you've calculated the number of jobs that would be lost due to these cuts?

Next question I have would go to Dr. Ulrich

MR. ULRICH: Right.

REP. BUYER: The draft bill provides the physicians to treat both Medicare and the public plan. Patients would receive Medicare plus five percent for treating their public plan, really the government plan, patients for the ***first*** three years. What is the quote "magic number," end quote, regarding the percent of Medicare that it would ***take*** to you keep you whole? Is it Medicare plus 10, plus 12, plus 13, plus 14?

The other question I have for Blue Cross Blue Shield, what are the advantages that the government plan would have over the private insurers? What about state premium taxes, state solvency regulation, state benefit mandate requirements?

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

DR. EPPERLY: Yes, we believe that.

REP. BUYER: Dr. Williamson?

DR. WILLIAMSON: Absolutely.

REP. BUYER: Dr. Ulrich?

DR. ULRICH: Yes.

REP. BUYER: Dr. Wright?

DR. WRIGHT: Yes.

REP. BUYER: Dr. White?

MS. WHITE: Yes.

Dr. GABOW: Yes.

MR. HAWKINS: We have FTCA coverage. So I can't really comment.

REP. BUYER: All right. One equivocator.

MR. ROBERTS: Yes.

MR. YARWOOD: Yes.

MS. FOX: Yes.

REP. BUYER: All but one, except Mr. Hawkins testified in the affirmative that it should be included.

The other is, would everyone on this ***panel*** agree that individual liberty is a cornerstone of our society as an unalienable right? Would everyone on this ***panel*** agree?

MR. : True.

REP. BUYER: Okay. Mr. Hawkins, you in?

MR. HAWKINS: (Off mike.)

REP. BUYER: He is in.

(Laughter.)

All right. Awesome. Now, an individual right, an individual right, if in this scheme, we are moving people into the government plan, what about an individual's right to contract with the physician of their choice? Should an individual in America have the right to contract with an individual doctor of their choice? Yes or no? Dr. Epperly?

DR. EPPERLY: Yes.

REP. BUYER: Oh, let me go down -- without penalty from their government? Dr. Epperly?

DR. EPPERLY: Yes.

REP. BUYER: Dr. Williamson?

DR. WILLIAMSON: Yes.

DR. WRIGHT: Yes.

MS. WHITE: Individual provider, yes.

REP. BUYER: That a girl.

DR. GABOW: Yes.

MR. HAWKINS: With their own money, yes.

REP. BUYER: That a boy.

MR. ROBERTS: Yes.

MR. YARWOOD: Yes.

MS. FOX: Yes.

REP. BUYER: Aha, we are on a roll. Now, does everyone agree that in the capital economic system that we have, even though we may have a public option plan, that the market place should be able to create some type of an instrument that would be a supplement, a potential medical insurance supplement plan? Should that be some type of an option that the marketplace could create?

Dr. Epperly?

DR. EPPERLY: Yes.

DR. WILLIAMSON: Yes.

DR. ULRICH: Yes.

DR. WRIGHT: Yes.

DR. GABOW: No.

MS. WHITE: No, I'm not sure.

REP. BUYER: Okay. Dr. White is an unsure.

DR. GABOW: No.

REP. BUYER: A no.

MR. HAWKINS: I'm not sure I understand --

REP. BUYER: I'm not sure.

MR. ROBERTS: I'm not sure I do either.

REP. BUYER: Two I'm not --

MR. YARWOOD: I'm a number three, not sure.

MS. FOX: Well, we are hoping that there is no public plan.

REP. BUYER: Pardon?

MS. FOX: We're hopeful there will be no public plans in the program.

REP. BUYER: All right. But if there is a public plan, should individuals in the marketplace have an option -- be able to create supplemental coverage?

MS. FOX: Yes.

REP. BUYER: Yes?

MS. FOX: Just like Medicare, yes.

REP. BUYER: All right, thank you. Now I'll rest and allow those individuals to answer the questions that I'd asked.

DR. ULRICH: The answer is Medicare plus 100, and I can expound as to why if you'd prefer. I think in my testimony I cited the fact that we currently in Wisconsin from the private sector get anywhere from 180 to 280 percent of Medicare in payment. Medicine is changing, and this is what's really interesting is that we've gone from kind of being a cottage industry to now much more high-tech.

Our costs are very different than what Medicare allocates to us now. We now employ, for example, systems engineers. Why? Trying to understand the efficiency of workflow. We also, in our clinic and others as well, employ many people in information technology. We develop our own electronic medical record. We have close to 350 employees now, software engineers, et cetera.

Our cost structure has shifted dramatically from what the traditional concept of what medical practice is, a non-nurse practitioner, physician, a nurse, a technician, et cetera. And so cost keep changing.

The other thing I would ask this committee to keep in mind is that medicine, as an entity, is an ever-evolving one in the sense that we've come from --

REP. DONNA M. CHRISTENSEN (D-VI): Dr. Ulrich, could you --

DR. ULRICH: Yes?

REP. CHRISTENSEN: We're way over time.

DR. ULRICH: Okay.

REP. CHRISTENSEN: Could you wrap up your response, please?

DR. ULRICH: Okay. I will just stop there if my initial answer satisfied you.

REP. : (Off mike.)

MR. : (Off mike.)

REP. CHRISTENSEN: Thank you. The gentleman's time has expired. The chair now recognizes Ms. Castor for five minutes.

REP. CASTOR: Thank you, Madame Chair, very much.

And I'd like to return to the workforce issues. This bill rightfully targets workforce incentives, because we must bolster the primary care workforce especially. Fifty years ago, half of the doctors in America practiced family medicine and pediatrics. Today, 63 percent are specialists, and only 37 percent are family doctors.

And it's those family doctors and the nurses on the frontlines and the pediatricians that really help us contain cost over time. I do not know what I would do if I did not have the ability to call the nurse in my daughter's pediatrician's office and ask a question. And they've had a consistent medical home over time, and yet millions of American families do not have that type of medical home and relationship with their primary care providers.

So I think our bill does ***take*** important steps to bolster primary care workforce. But one place that I think it falls short, and I'd be very interested in your opinions, is that we are not increasing the residency slots for our medical school graduates -- these doctors in training.

The discussion draft provides a redistribution of unused residency slots to emphasize primary care which is a good ***first*** step, because we're going to hopefully sent them to community health centers and other hospitals in need, and other communities in need. But we've got to enact the second step, the complementary step to even out the residency slots, because for example, in my home state of Florida, the fourth largest state in the country, we rank 44th in the number of residency slots.

And most folks do not understand that this is -- those slots are governed by an old outdated arbitrary formula that assigned a distribution many years ago, and has not changed even though the population of the country has shifted. So I'd like to know do you agree.

Dr. Epperly, you might be the one most in tune, but I think many of you would have an opinion on that. Do you agree we need to alter the residency in total? And then are there sections in the bill -- the sections in the bill relate to scholarships and loan repayments. Are they adequate? Are we doing enough?

DR. EPPERLY: Yes, ma'am. Can I expand for just a second?

REP. CASTOR: Yes.

DR. EPPERLY: In my day job I'm a residency program director of a family medicine program in Boise, Idaho. And you're right on. In fact, the workforce numbers are about 70, 30 sub-specialists to generalists. We must increase residency training, especially for primary care. And what are we trying to build? What system are we after? We think there should be some regulation of what kind of physicians medical schools are producing. It needs to meet community needs.

And so we are in agreement with some sort of workforce policy center to kind of ***take*** a ***look*** at this and what it is we're trying to accomplish -- totally agree with you. In terms of scholarships and loan repayment, scholarships on the front end will be more effective than loan repayment on the backend, because it helps shape the types of physicians we're trying to train.

REP. CASTOR: Anyone else want to comment quickly?

(No audible response.)

REP. CASTOR: Okay. Then I'll move on.

Ms. Fox, thank you so much. It's great to hear that Blue Cross is supportive of health care ***reform***. I want to share with you, I had a great meeting last week with the Florida CEO -- president and CEO of Blue Cross, and you all are very important provider in the state of Florida.

You have about 32 percent of the market share in the state of Florida -- let's see I wrote down -- 4 million Floridians are enrolled in Blue Cross and depend on you all every day. It was interesting that the CEO from Florida had a slightly different ***take*** and spoke much more favorably of the public option.

Because at the -- well, Blue Cross in Florida has 30 percent of the market share, and over 4 million folks enrolled. You know, in Florida we have 5.8 million people who do not have access to health insurance because it is so expensive. And I think that in the discussion we had, he just saw it as an opportunity that you all are so effective that you wouldn't have any trouble competing against a startup public option.

And I thought that was -- we had a great discussion and exchange, and I was heartened to hear that maybe it's not -- maybe while big Blue Cross has a certain position, the folks on the ground in my state are not daunted by the challenge they had.

MS. FOX: Well, I would respond that I think people are ***looking*** at can you create a level playing field. And I think it's very difficult to imagine how you can. And when I ***look*** at the ***House*** draft bill, I just see huge advantages for the government plan ranging from, you know, big advantages in the payment levels to lawsuits, to covering different -- the government plan would cover a lot fewer benefits than private plans would be required to do.

There's just a long list. For example, the government plan didn't estimate their premiums correctly. Would the government step in and subsidize them --

REP. CASTOR: But where do these 5 -- almost 6 million residents of my state go now? How do they -- we can't afford -- America can't pay for all of them to go into subsidized Medicaid. We've got to provide a level playing field and a real opportunity for them to be taxed as affordable care.

MS. FOX: Well, we agree we need to cover everyone. And we're recommending covering everyone in poverty under Medicaid, and then above that having subsidies as you do in your bill, for private insurance to help people afford coverage.

We think that is actually critical, and you know, I've been doing health care issues for over 25 years -- and it used to be that everybody believed that if you have individual mandate, employer mandate, alliances, insurance ***reforms***, that really would cover everyone. It's only been the past year since we've talked about a public plan.

REP. CHRISTENSEN: Ms. Fox --

MS. FOX: We think it's totally unnecessary and very problematic.

REP. CHRISTENSEN: Thank you, gentle ladies, time has expired.

I now recognize Mr. Burgess for five minutes.

REP. BURGESS: Thank you, Madame Chairman.

And Ms. Fox, let's continue on that. And maybe if I could, I think Mr. Buyer was asking a question -- or you were answering a question when time ran out, and maybe we could just get the answer to the question that Mr. Buyer posed about the advantages that a public plan rather would have over private insurance in premium taxes, state solvency regulations, and state benefit mandates.

MS. FOX: Yes, I mean private plans have to pay a wide range of premium taxes, assessments, federal taxes; the government would be exempt from that. We've actually prepared a little chart that we'd love to submit, that actually walks through what are the rules private plans have to abide by --

REP. BURGESS: If you'll suspend for a moment, I'd ask unanimous consent that that chart be made available to the members and made part of the record?

MS. FOX: -- and raises questions would the public plan abide by that. And when we ***look*** at the draft bill, we see it as a huge un- level playing field where the government would have so many advantages that you could see why people will estimate that millions of people will leave private coverage that they like today, and go into the public plan.

REP. BURGESS: Okay. Great. I appreciate that answer very much.

Dr. Ulrich, let me just address you for a second, and I really appreciate -- well, I appreciate all of you being here. I know that many of you are ***taking*** time off of your private individual practices and it's with great expense and inconvenience to your families. And we've had a long day and appreciate your willingness to be part of the ***panel*** here.

The Physician Group Practice demonstration project that you referenced at your clinic, I'm so much familiar with that. I think that those hold a lot of promise. In fact, you may have heard me question Mr. Hackbarth from the MedPAC about the feasibility of using the Federal Tort Claims Act for Medicare providers under a physician group practice model under the accountable care model.

If you comport with all of the requirements -- disease management, care coordination, the IT, the e-prescribing, if you do all of those things, getting some relief from liability under the Federal Tort Claims Act, do you think that's -- is that a reasonable thing to ***look*** at?

DR. ULRICH: Absolutely.

REP. BURGESS: Thank you. And -- (laughs) -- appreciate your brevity. Let me ask you this, since we're in agreement. And one of the things about the Physician Group Practice demonstration project was you were going to actually benefit financially by doing things better, faster, cheaper, smarter.

And in fact there are some great lessons for us that have come out of that, those management techniques. But there's a barrier to entry. And do you think the bar to that has been set too high? You've got to make a lot of initial investment when you get into that, and then your return for your doctor, for the people in your practice is a little slow in coming. Is that not correct?

DR. ULRICH: Dr. Burgess, you show keen insight here into this. And if I can just ***take*** a second to explain this?

REP. BURGESS: Sure.

DR. ULRICH: As part of the group demonstration project, what we're finding is that it's not just trying to strive for quality outcomes. There are operational changes that you need to make in how you deliver care. For example, we have consolidated all of our anticoagulation patients into one entity. Rather than being in each physician's practice, we now share that coordinated care under one entity.

And what we found is that our capacity to have bleeding times, for example, are much better be within the therapeutic range. We also are consolidating care of congestive heart failure -- rather than being in a particular individual physician's office, whether it be a cardiologist or a primary care physician, into a congestive heart failure clinic where physicians craft the criteria, we want -- our nurses watch those, we are proactive in working with the patients.

The problem with doing all that is that no one pays us, you know, to undertake those operational changes at ***first***. What we're hoping and while we partner with the federal government through the CMS PGP project is that we're trying to prove that yes, by undertaking these, ultimately there are cost savings.

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

REP. BURGESS: Yeah, one of the things that concerns me about our approach to things and what little I'd know of the great successes you've shown, for example, like bringing a hospitalized CHF patient back to the doctor's office within five days, not just you make an appointment in two weeks, you get that patient back to the office in five days, you can really reduce the re-hospitalization rate significantly.

And yet you've got CMS now ready to rule. It says, well, if that's the case and you could do that, we're just going to pay for one hospitalization every 30 days, and that will cut our cost down. It's an absolutely backward way of ***looking*** at what the data that you all are generating. And instead of building on your successes, in fact, we're going to make things punitive then for Dr. Williamson in Georgia who may have an entirely different type of practice.

DR. ULRICH: Correct.

REP. BURGESS: And again that's one of the things that concerns me about this. Do you have a concept -- you mentioned about the rate of reimbursement on the Medicare side. What would that multiplier have to be in your accountable care organization or Physician Group Practice? What would that Medicare multiplier have to be in a public plan?

DR. ULRICH: We would say Medicare plus 100.

REP. BURGESS: Medicare plus 100 --

DR. ULRICH: Hundred.

REP. BURGESS: -- percent?

DR. ULRICH: Yes.

REP. BURGESS: So double what the Medicare rates are.

DR. ULRICH: Yeah, exactly. Yeah.

REP. BURGESS: That's a fairly significant --

DR. ULRICH: That is significant, but it's also a realistic significantly --

REP. BURGESS: And you have data to back that up that you could share with the committee?

DR. ULRICH: I would be happy to provide information to you in written form relative to that, yes.

REP. BURGESS: That would be tremendous.

And Dr. Williamson, in words or one syllable -- we heard Glenn Hackbarth say that no doctors are not seeing Medicare patients now because of the reimbursement rate. Is that your sense? Do you think doctors are restricting their practice because of the reimbursement rates in Medicare?

DR. WILLIAMSON: Yes.

REP. BURGESS: Thank you.

REP. CHRISTENSEN: Thank you. The gentleman's time has expired.

I now recognize myself for five minutes. And let me just welcome everyone.

It's great to have such a diverse ***panel*** of witnesses here, and we thank you for all of the good work that all of you have been doing in a dysfunctional system that really doesn't always give you the kind of support that you need.

And I want to particularly welcome Dr. Epperly, president of the American Academy of Family Physicians. And I want to direct my ***first*** question to you, Dr. Epperly. In meetings -- for example, with the tri-caucus we're on record as supporting a public plan, and I do support a public plan, but also a public plan that is linked to Medicare.

I have raised concerns about that in our meetings, and I'd like you to elaborate on your concerns about linking the public plans in Medicare.

DR. EPPERLY: Yes, ma'am. Thank you. ***First*** we are definitely in support of a public plan option, but we do have a couple caveats. One of them is linked Medicare just as you're saying. We recognize there's going to be a huge infrastructure cost in getting this thing up and running.

So our position is that it can be the Medicare rate for the ***first*** two years, but with a date certain, then to elevate that. More of just Medicare rates won't cut it for the physicians across America. It's already a problem.

REP. CHRISTENSEN: Right.

DR. EPPERLY: So -- but we recognize that there's going to be a transition period. We recognize that flexibility. So what we would say is yes, we're in favor of a public plan. Medicare rates could be what it would be aimed at for the ***first*** two years but by a date certain that has to elevate.

REP. CHRISTENSEN: Thank you.

And I guess I can't ask everyone this question. So Dr. Epperly, Dr. Gabow, and Mr. Hawkins, you've heard reference to bundling of payments by Mr. Hackbarth of MedPAC. And I wanted to know if you are in support of the ***proposal*** to bundle payments to providers.

Dr. Epperly?

DR. EPPERLY: Yes, ma'am. We're in favor of bundling in terms of team approach. We do have concerns that we'd want to make sure that primary care and the Patient Centered Medical Home as a very important part of that bundling was not denigrated nor belittled into its importance.

For instance, with the heart failure example we're talking about heart failure patients and readmissions -- let's prevent it in the ***first*** place. So with a bundling model which ***looks*** at already this has occurred, it's in the hospital, how do we pay for this, why don't we ***take*** a better approach and ***look*** at what it ***takes*** to prevent that in the ***first*** place?

So therefore, the Patient Centered Medical Home, primary care is critical in that. Bundling could be a very interesting option if the primary care physician is reincorporated into that in a big way.

REP. CHRISTENSEN: Dr. Gabow?

DR. GABOW: As an integrated system that employs physicians, we favor moving away from fee-for-service to a more global payment. And we would favor the ultimate bundled capitation and think that capitation or more global bundling would have less administrative cost and if you bundle small things. So I would encourage it to be global, but we favor it given an integrated -- big integrated system.

MR. HAWKINS: Congresswoman -- miss -- Madame Chair --

REP. CHRISTENSEN: Would it affect community health --

MR. HAWKINS: Really I -- there are some important points to make here. On today's ***panel*** we're very fortunate to be joined by Dr. Epperly who runs a family medicine residency program, Dr. Ulrich who runs the Marshfield Clinic, and Dr. Gabow who runs Denver Health -- unique and especially with the last two, fully integrated health care systems.

What may not be known generally but should be, is that all three are community health centers or have community health centers embedded in them. As such, two examples -- Denver Health and Marshfield Clinic are good examples of integrated health systems that include community health centers.

But I'm sure, as Dr. Gabow and Dr. Ulrich would agree, the primary care component, the very issue that Dr. Epperly expressed concern, appropriate concern over, is identified and -- I'm not going to say separate, but it is able to function on a sort of coequal basis with the special being an inpatient care components of their institutions.

To the extent that that's done, I think that's what Dr. Epperly was relating to when he said primary care needs to be recognized and appropriately integrated. We would agree -- the notion of integrated care systems, accountable care organizations, and the like. And rewarding results is something that we all absolutely support, what should not be washed, however. And the integration of care, the vertical integration of care across primary secondary tertiary care is the small ambulatory care practice, be it independent practice, private practice physicians, health centers, or other forms of ambulatory care, within the context of a large multi-level institution like Denver Health, and I'm sure Dr. Gabow would agree with that.

REP. CHRISTENSEN: Thank you. To be a good example, my time is up, but I want to also, without objection, accept the chart from Blue Cross/Blue Shield into the record that was brought to us by Dr. Burgess.

Chair now recognizes Dr. Gingrey for five minutes.

REP. GINGREY: Madame Chair, thank you so much. I want to direct my ***first*** questioning to my colleague from Georgia, Gainesville, Georgia, and the president of the Medical Association of Georgia.

Glad to see you, Dr. Williamson. And I have series of questions that I would like to ask you. Let -- ***first*** off, do you support a government-run plan?

DR. WILLIAMSON: No, the Medical Association of Georgia does not support a public option or a government-run plan in addition to the public plans that already exist, Medicare and Medicaid.

REP. GINGREY: Right, we're talking about the government option plan.

DR. WILLIAMSON: Right, right.

REP. GINGREY: It would be competing with the private insurance so --

(Cross talk.)

DR. WILLIAMSON: Right, we do not support the public option.

REP. GINGREY: What would a government-run health plan that I just described do to your ability and those of your colleagues to treat your patients? What do you fear the most about that type of a government-run option?

DR. WILLIAMSON: My biggest concern is that it like Medicare will become the only option. And I think over time, I think the plan as is set up in the discussion draft already has the framework for that for basically all private plans to have to conform to certain rules over time. And my fear, and I think it's a very real concern, is that over time other plans will disappear, and the public option will become the only option.

And we'll be left with the single-payer system, which I think if you ***look*** at what's happened across the planet, single-payer systems basically save money by rationing care. And I see that as an inevitable consequence of the creation of a public option, no matter how benign it ***looks*** at ***first*** glance.

REP. GINGREY: Well, that was going to be my next question. You pretty much answered.

My question would be, Dr. Williamson, do you support a government- run health care system with the ability to ration care based on cost?

DR. WILLIAMSON: I absolutely do not support that. I think that care decisions should be made on an individual basis when the patient sits down in the physician's office, and I don't think that the government can substitute for the training that a physician has, and opportunity that a physician has to ***look*** the patient in the eye and decide what that patient needs.

REP. GINGREY: Let's see, I'm going to skip over number four. My fifth question -- fourth actually, we have heard testimony in this committee recently regarding the Massachusetts health care system, and the fact that those with public insurance in the state are twice as likely as those who choose private health insurance to be turned away from a desired physician.

As a physician, practicing physician, what are your thoughts on the reasons behind that kind of disparity in access between a public and a private insurance plan?

DR. WILLIAMSON: Well, public plans in general, and I'm speaking in general now, are associated with quite a lot of paperwork. They are associated with the hand of government, and you know, right now in Georgia, we're ***looking*** at these recovery auditor contractors that are moving across the nation and coming back and recouping money saying that you quoted something wrong 20 years ago, or 10 years ago, and coming after those dollars.

These sorts of things that the federal government has the power to do makes dealing with them as a payer a very daunting prospect. And traditionally government payers have been at the bottom of the barrel in terms of covering costs.

And so physicians feel like they can't deliver to patients what they've been trained to do, and the downsides associated with the government as a payer are daunting. And you know, I recently had the opportunity to go to the AMA, and one of my colleagues from Massachusetts stood and spoke loudly in support of a national public option. But I believe that the folks from Massachusetts probably want a public option nationally so they don't have to pay for their own anymore.

REP. GINGREY: Well, doctor, I appreciate that response, and I absolutely -- the reason I ask you the question because what we're talking about here is something very, very similar to this Massachusetts model.

And they had -- we have even heard suggestions from the majority that it may be that physicians who are treating people within this exchange would absolutely have to accept the public option plan, or they would be ruled ineligible to participate in Medicare or Medicaid.

So they would have their arm twisted behind their back and have no choice, which is pretty frightening. I've got just a little bit of time left, and I wanted to go to Dr. Ulrich and also Dr. Gabow if we have a chance.

So time permits, Madame Chair, I hope you'll let me get this in. If health ***reform*** were to include a requirement that all Americans purchase health insurance, do you think that hospitals would need continued federal funding to offset cases of uncompensated or charity care, and why?

And basically I'm talking about DSH hospitals and the suggestion that we're going to save money by eliminating all of DSH payments when we pass this bill.

DR. ULRICH: Well, my sense is that the answer to that is yes, you would still need to have some supplemental dollars rolling in simply because the reality is that there still are things as bad debt, you know, people who need care, get it, and then can't pay for it because of competing priorities of their own pocketbook.

And plus the fact that, you know, we really haven't gotten to the point of having fair practice expense accountability within the remunerative system yet. And that is absolutely critical to any kind of a public plan.

If we're going to go that way, then we have to have fair practice expenses covered before we can go forward.

REP. GINGREY: That would be a pretty painful pay-for for your --

DR. ULRICH: That is correct.

REP. GINGREY: Dr. Gabow?

DR. GABOW: My understanding, Congressman, is that this bill does not cut disproportionate share payments, and I think that that will be necessary to be sustained at least in the foreseeable future, because we know that many of the patients that we serve are homeless, the chronically, mentally ill, are traditionally difficult to enroll.

And so I think if we got to full coverage, certainly we may be able to decrease it, but I doubt it will ever go away. So we support the preservation of DSHs outlined in the draft bill.

REP. GINGREY: You support the elimination of DSH payments, is that what you said?

REP. CHRISTENSEN: Thank you. Time --

DR. GABOW: We support the maintenance of DSH payments --

REP. GINGREY: Oh, absolutely. Yes, yes.

DR. GABOW: As --

REP. GINGREY: As I expected you would, Dr. Gabow, and as Dr. Ulrich, and hospitals all across the 11th congressional district of Georgia support the continuation of those DSH payments.

REP. CHRISTENSEN: Thank you.

REP. GINGREY: Thank you for your patience, Madame Chair.

REP. CHRISTENSEN: Thank you.

REP. GINGREY: And I yield back. Thank you.

REP. CHRISTENSEN: The chair now recognizes Congresswoman Baldwin for five minutes.

REP. BALDWIN: Thank you, Madame Chairwoman. I want to welcome a fellow Wisconsinite, Dr. Ulrich. Pleased to have you on the ***panel***.

I wanted to probe into an area -- I stepped out for a little while, so I don't know if anyone else has raised this. But in your testimony on page 7, you talk a little bit about care issues at the end of life, and make some recommendations. And it's one of those very challenging topics, because we certainly hear from much research that much of our health care dollar goes to treat people at that stage of their lives.

But that's one thing. I mean, much more disturbingly that that doesn't often align with the wishes of the person being treated. Could you elaborate a little bit more about both your recommendations to this committee in that arena, but also the practices at the Marshfield Clinic, what you have implemented in this regard?

DR. ULRICH: Yes, thank you, congresswoman. I appreciate the question. At Marshfield Clinic, we do have in conjunction with St. Joseph's Hospital who is our hospital partner, developed a palliative care.

We have a palliative care fellowship center where we train young physicians who are interested in that. We work with families, the patient obviously, et cetera.

We try to do two things. One, there's a humanistic process that occurs under palliative care, and that's ***taking*** care of people in a comfortable surrounding in the last few weeks or days of life. And that really is a throwback, if you will, to the way medicine used to be practiced before we were very fancy with technology et cetera.

And it's not something that we should ever forget. It's something that we need to continue.

So we are committed to doing that and will, and I think most medical organizations of the country would be in synchrony with that kind of concept.

The question you raised about the cost of care at the end of life is obviously an important one, and if you think about the cost of medical care in our country, there are really two main things we need to understand. One, as you point out, the cost escalate rather dramatically as life is ebbing away from us, because it's an emotional decision for families and patients to keep mom, or dad, or grandma, or grandpa for a little while longer et cetera.

It's very difficult for families to say it's time to say goodbye to someone. So we continue then to provide medical care under those very difficult circumstances. There is a cost providing that care.

The other thing that I would like this subcommittee to understand is that not all costs within the system are the same, so that we know from the Commonwealth Fund for example, that really it's only about 20 percent of patients that are costing about 75 to 80 percent of care in this country.

So that -- if we can manage these chronic illnesses, and in particular patients who have more than one or two chronic illnesses concomitantly, that's where the cost savings will come as we get better in managing folks with complicated chronic illnesses who concurrently are suffering from several of them at the same time.

REP. BALDWIN: Your testimony specifically points to things that we could do earlier in life to talk about having people think about advance directives or other documents. I would offer you to elaborate on that, but also I see some other nodding heads; if -- I would open this up to any of the panelists who would like to make a contribution on this point.

DR. EPPERLY: Thank you. What Dr. Ulrich just described is the value of primary care. It's having that relationship of trust with people over time in which you can have that type of dialogue.

And I would say that those sorts of decisions are so important, so critical to the family as a whole, and many of those decisions can ***take*** place outside of a hospital in terms of where those final days and weeks are.

In fact, I would submit that most people would like to have a very dignified death in the place where they can be surrounded by most of their loved ones. And so again we return right squarely back to what primary care brings to the system.

It's what Dr. Ulrich said is -- used to be part of medicine that's kind of gone now. We need to recreate that kind of system. It's in that system that savings are made, quality goes up, cost goes down.

REP. BALDWIN: Please, Dr. Wright.

DR. WRIGHT: Yes, I just would like to agree that what needs to ***take*** place and is often missing is the conversation, which begins with the relationship. So I completely agree and would support recognition of the value of the cognitive services, not to say that folks who do procedures for a living are thinking them, they certainly are.

But the importance -- I've seen it over and over in my practice that while someone does indeed benefit from a procedure, what's wrapped around that procedure, the informed consent process, the education about the disease process, and right now the after-care to try to prevent that from ever happening again is incredibly valuable to that individual, and that family, and our economy at this point.

REP. BALDWIN: Dr. White, did you have a comment?

MS. WHITE: Yes, I'd just like to add that I think as Congresswoman Capps mentioned earlier that the patient-advocate role that nurses provide is absolutely important in this, I think the emphasis on primary care medical home nurse practitioners being involved in that you have the skills for those conversations, discussions, and the relationships, I think would be an important consideration for it all.

DR. WILLIAMSON: Thank you. I would like to add to briefly add I think that resources spent on time with the doctor saves money in the long-run. If you ***look*** at the percentage of medical expenditures, physicians' services constitute a small fraction of that.

By concentrating on that, whether it be for primary care or for specialists, you're going to save money in other areas, where it's the end of life, very sick patients. So funds, resources that are concentrated on giving the patient or the patient's family face time with their doctor is going to save you lots of money across the system.

REP. CHRISTENSEN: Thank you. The gentle lady's time has expired, and I now recognize Congresswoman Blackburn for five minutes.

REP. MARSHA BLACKBURN (R-TN): Thank you, Madame Chairman, and thank you to all of you. I want to do a yes and no and show of hands to get where you all are on some issues.

And by the way, thank you for your patience with us today. As you know, we have another hearing that's been going on upstairs.

Okay, show of hands; how many of you favor a single-payer system? Okay, nobody on the ***panel*** favors a single-payer system.

Okay, how many of you favor a strategy -- putting in place a strategy that would eventually move us to a single-payer system? So nobody favors doing that.

That's really interesting, because there are some of us that fully believe that this bill that is before us, whether it is the ***House*** version, the Senate version, or the Kennedy Plan would move us to a single-payer system. And we make that determination based on experience that we've had from pilot projects, and from programs that have ***taken*** place in the states, my state of Tennessee being one of those.

Okay, how many of you favor having government-controlled comparative research? Nobody favors government-controlled comparative research.

Okay, how many of you -- okay, we've got some takers on that one. All right, just show of hands. The comparative research board that they are talking about having, that this bill would put in place, how many of you want to see that?

Okay, so we've got Epperly, Ulrich, Wright, White, and Gabow. (Inaudible) -- all righty. And then how many of you favor having that comparative research board make medical decisions for patients? Nobody. Okay, all righty.

Dr. Epperly, if I could -- you know, makes it kind of a head- scratcher to me, and I appreciate having your views on this, because we know that the comparative research results board would end up making a lot of the medical decisions for patients and it would move that away from the doctor-patient relationship.

I wanted to ask you, you had mentioned in your testimony that you felt that a public plan would be actuarially sound. What I'd like for you to do is cite for me the research upon which you base that assessment and that decision. How did you arrive at that?

DR. EPPERLY: Yeah, I would say that I don't -- I'm not aware of anything I said that said that would be actuarially sound. But what I will say --

REP. BLACKBURN: Well, I think that that's the statement in your testimony.

DR. EPPERLY: What I will say as you ***look*** that up though is that we believe that expanding coverage to people and giving them choice is a sound decision for America in regards to helping people get health care coverage.

We are in agreement with that. As it presently stands, this would have to be at an enhanced rate above Medicare.

That's why we say that, you know, if the model is Medicare, that's not going to work.

But at anything that starts to promote primary care as being the solution to that, that will work. And that --

REP. BLACKBURN: Okay, let me interrupt you at that then. You say that it would be at an enhanced model above the rate of Medicare. So in other words it's going to cost more?

DR. EPPERLY: Yes, but the --

REP. BLACKBURN: Okay, now, yesterday, if I may interrupt you again --

DR. EPPERLY: Okay.

REP. BLACKBURN: Secretary Sebelius said yesterday that this would be deficit-neutral. So I'm trying to figure out, and I asked her yesterday how she could say it was deficit-neutral.

We've not had one witness out of all the hearings we've done that has said they felt like this would be deficit-neutral or would be a money-saver. Everybody has said it's going to cost more.

DR. EPPERLY: I would say that it would be beyond deficit-neutral in a positive way because where the savings will come from the system is in regards to reduced hospitalizations, reduced readmissions, more efficient --

REP. BLACKBURN: Okay, if I may interrupt you again, do you have any kind of model that shows that actually happens? Because you can ***look*** at TennCare in Tennessee, you can ***look*** at Massachusetts, and you can see that that does not happen.

DR. EPPERLY: Yes, Community Care of North Carolina proved that. Other international studies have proven that as well. That's why when we talk about the value of primary care, we're saying that there's systems savings from across the existing system that will save the entire system money.

REP. BLACKBURN: Okay. All right, but I can tell you that in Tennessee we found out that did not happen. And so I appreciate your input.

Dr. Williamson, I've got 15 seconds left. Medicare patients, senior citizens, are just up-in-arms. They see that their care is going to be diminished somewhat, that savings for Medicare are going to go to pay for care for younger enrollees in this public plan.

My seniors that are coming to me and saying we are scared to death, what do I say to them? What is Medicare going to ***look*** like after this public plan goes in place?

DR. WILLIAMSON: I don't see anything in the draft -- in the discussion draft that gives me hope for -- that we're moving in the right direction in terms of payment. I think the private contracting and the empowering patients to buy their own health care, I don't think we should ever ***take*** away a patient's right to pay for their own health care. And if we do that, we're committing a colossal mistake.

REP. BLACKBURN: Okay, thank you. I yield back.

REP. CHRISTENSEN: Thank you.

The chair now recognizes Congresswoman Harman for five minutes.

REP. JANE HARMAN (D-CA): I thank you, Dr. Christensen, and point out that our committee benefits a lot from the fact that many members are medical doctors and nurses and have extensive backgrounds.

I hope the ***panel*** is impressed that --

MS. : Very much.

REP. HARMAN: -- we actually -- some of us, others here know a great deal about this. In my case I don't have either of those, but I am the daughter of a general practitioner who actually made ***house*** calls to three generations of patients before he retired in Los Angeles and I am the sister of an oncologist, hematologist who was the head of that practice at Kaiser in Centerville, California, before he semi-retired. He is younger than I am. So go figure.

(Laughter.)

But he did win the Healer of the Year Award in Marin County for his compassionate treatment of patients. So I love listening to a bunch of docs and experts who put that on the front burner. I come from Los Angeles County as you just heard. We are extremely concerned, if not panicked, about the president's ***proposed*** cuts in DSH payments.

Listening to this ***panel*** and listening to you, is it Dr. Gabow or -- yes, and reading your excellent testimony, I think your bottom line is you don't want cuts on the front end. You want to see how all this works and phase in cuts later once the efficiency ***take*** hold. Is that what you are saying?

DR. GABOW: That's correct.

REP. HARMAN: Thank you.

And on this point, Madame Chair, I would like permission to put a letter in the record from the Board of supervisors of the County of Los Angeles talking about the dish cuts.

REP. CHRISTENSEN: Without objection it will be admitted into the record.

REP. HARMAN: Thank you. Well, I would just like to invite the ***panel*** on this subject to address -- and starting with you, Dr. Gabow. And it seems like you may have a bit of laryngitis, am I right?

DR. GABOW: Congresswoman, I have chronic voice problem called as spastic dysphonia and the treatment for it is Botox, but it doesn't do anything for my wrinkles.

(Laughter.)

As my kids would say, I think that's more information than we need.

(Laughter.)

But I appreciate this. I hope I'm not stressing you, but I would really like the record to be more complete on this subject because I think it is an urgent subject for at least our large metropolitan areas and one this committee has to ***take*** very seriously. And based on the comments I heard from the minority site, I think everyone here generally aggress about this. Yes.

DR. GABOW: Congresswoman, I think all of the safety net institutions would be very concerned if a disproportionate share funding were cut at the front end of this process. We rely heavily on disproportionate share funding to cover not only our uninsured patients, but also the gap between what Medicaid pays us and our costs.

So I think that timing of this issue is really critical. And as I said earlier, I think what we've learned from expansions in the past of Medicaid and SCHIP is that it ***takes*** a long time to enroll certain highly vulnerable populations.

They -- (inaudible) -- in many ways that enrollment is not an easy process. So it's going to ***take*** a period of time to really get to full coverage even with this bill. So I don't think we can condition the fund.

REP. HARMAN: Thank you. I realize I only have 48 seconds left. So let me just expand the question in case anyone else wants to answer it as well. One of my personal issues, since I focus on homeland security issues generally, is surge capacity in our hospitals in the event of a terror attack or a large natural disaster.

And so my question is what is the relationship between the ability of our Level I trauma centers, which are located in many of our DSH hospitals, what is the relationship between the ability of our Level I trauma centers to be available in the event of a terror attack or a natural disaster and the ***proposed*** cuts in DSH?

DR. GABOW: Congresswoman, I think you're right that these are related in that many of the trauma centers are at the disproportionate share hospitals and also many of the hospital care services and birth (ph) units so that much that you would need in disaster are located in these safety net institutions. So they need to be preserved and you can't destabilize them financially at the beginning of the process and still those critical resources.

REP. HARMAN: Thank you very much.

Thank you.

REP. CHRISTENSEN: Thank you.

The chair now recognizes Mr. Pitts for five minutes.

REP. PITTS: Thank you, Madame Chairman.

Dr. Ulrich, if a large number of private-payer patients were to shift into the public plan and the public plan is paid based on Medicare rates, what would be the effect on your ability to continue to offer the same level of services that you provided today?

DR. ULRICH: Well, it would be impacted extremely negatively and probably fairly rapidly. It would be beyond my capacity to give you an exact timeframe, but it would be disastrous I think is a fair word to use.

REP. PITTS: Now, are you treating a large number of Medicare or Medicaid eligible patients in your part of Wisconsin?

DR. ULRICH: Absolutely. If I can enlarge on that just a second, there already is a problem as you're describing. In certain parts of the service area that we provide, we comprise about 33 percent of the physicians. We are caring however for 70 percent of, what we call, fixed payer, which is Medicare and Medicaid patients. Why? Because other providers are not choosing to ***take*** care of those patients. So this is already happening. This is --

REP. PITTS: So how are you surviving now if you --?

DR. ULRICH: You know, we try to watch our costs as closely as we can. I found it necessary to try to branch into ancillary revenue streams, try to sell electronic medical record, we do food safety with Cargill, with Hormel, et cetera because I'm not confident that just providing health care is going to be a way to sustaining our organization.

REP. PITTS: Dr. Williamson, each year fewer and fewer physicians are willing to accept Medicare and Medicaid patients. From your perspective as a practicing physician could you tell us why you think this is?

DR. WILLIAMSON: I think as has been said, it's becoming more and more impractical to do that. I think inertia plays a large role here. Doctors have done it for a long time. It's becoming less and less practical because the Medicare and the Medicaid payment systems have not kept pace with the cost of providing care.

And physicians want to keep ***taking*** care of these patients. We want to keep doing that. And so what you're seeing across the nation are doctors basically doing the very best they can to control cost and keep functioning in this environment. But as I said, it's a ***house*** of cards.

Doctors -- some doctors are retiring early, they are getting out of medicine, they are going into ancillary revenue streams because these payment systems simply are not adequate to cover the cost of providing care. And moving more patients on to those types of payment schedules is going to adversely impact everybody's health care in this country, not just those patients that are ***taking*** -- that are enrolled in the public option.

REP. PITTS: Now, if we allowed more people to purchase health care services with untaxed dollars instead of relying heavily on third-party payers for routine health care services, do you think that we can solve many of our problems faced today by consumers or providers of health care services?

DR. WILLIAMSON: Congressman, I think you just hit the nail on the head. Right now, what we're trying to do is solve a problem for uninsured patients. That's what all this is about. We wouldn't be sitting here if we weren't dealing with this issue.

I think that by making it feasible for every patient to own and control their own insurance policy is the way to solve this problem. And I know that we can do that with the tax systems, with tax credits, tax subsidies we can put the control back into the hands of the patients so that the government doesn't have to orchestrate this massive machine that we're ***looking*** at right now that's going to not attend adequately to the needs of the individual patients.

I believe by restructuring the tax system, we can ***take*** care of the uninsured patients and we can solve this problem without putting private insurance companies out of business and ***taking*** away the ability of individuals to purchase their own health care.

MR. PITTS: Dr. Wright, if you could respond, polling has suggested that over 95 percent of the American people support the right to know the price of health care services before they go into for treatment. What do you view as the major barriers to the American people getting the price and quality information that they want and they need?

DR. WRIGHT: I think there has just not been enough transparency in the pricing structures. It's Byzantine at the very least. It's difficult to figure out even within a practice. Often, most of us have no idea what an individual patient is paying for a service. So I think this system would clearly benefit from additional transparency.

MR. PITTS: And how would they, the patients, the providers, the taxpayers benefit by public disclosure of price and risk-adjusted quality?

DR. WRIGHT: I think it lends to the -- it's one component of their decision-making process. I would not uncouple pricing information from quality information because cheap care may not necessarily be the best care. On the other hand, the best care can be less expensive than we're delivering it now.

MR. PITTS: What about the agency that reports price and risk- adjusted quality information to be completely separate from the Department of Health and Human Services? Do you see any conflicts of interest with HHS reporting on their own programs?

DR. WRIGHT: No, I don't.

MR. PITTS: Okay, my time is up. Thank you very much, Madame Chair.

REP. CHRISTENSEN: Thank you, Mr. Pitts.

The chair now recognizes Mr. Gordon for five minutes.

REP. BART GORDON (D-TN): Thank you, Madame Chair. Last week, the president put forth a challenge to find ways to reduce the number of medical liability suits without capping malpractice awards. I agree with the president. I think if you're going to be able to try to reduce the cost of health care, you've got to get all inefficiencies out and this is certainly one area.

PricewaterhouseCoopers estimate there's $280 billion spent in defensive medicine. We can't wrench all that out, but surely there's some savings that can be made there. That's why I am drafting a medical malpractice ***reform*** alternative legislation responding to the president's challenge.

The bill encourages states to step outside the box and test so- called alternative like health courts and I'm sorry methods.

And also I think that this will help lower the cost of defensive medicine and I think it will compensate patients faster and be more fair.

In my home state of Tennessee, we enacted a certificate of merit requirement last October. And it's already proven that there's been a four percent reduction in malpractice premiums. Earlier you were all asked about whether you would think that a malpractice ***reform*** should be a part of the overall ***reform***, and you agreed. So I want to quickly ask you to say why and what savings you think we might be able to achieve.

And Dr. Epperly, why don't we start with you?

DR. EPPERLY: ***First*** I applaud you for doing this. I think it is the right step in the right direction.

REP. GORDON: Don't applaud me. Let's just move on and tell me why it's good.

DR. EPPERLY: Oh, okay.

REP. GORDON: No, no, no, you tell me why, please tell me why it's good.

DR. EPPERLY: oh, okay. I think it's a step in the right direction. If there's not a relationship with patients, the default is to do more to patients, not less, so that you cover yourself. That's why the relationship is critical. If we don't get ***reform*** in place, then people that don't have that relationship will continue to order every test known to man to try to diagnose the problem.

DR. WILLIAMSON: I agree completely. I think the costs are hidden, but they are very, very real and I think they are gigantic. Physicians order expensive test to rule out conditions that they don't suspect, but might occur randomly in one in several thousands. And if someone gets $10 million from a lawsuits and it occurs in an incidence of 1 in 10,000, if you don't screen for that, you're statistically going to lose money.

And so you're exactly on target here. We must have real medical liability ***reform***. I will tell you, in George, in 2005, we enacted a very effective tort package. The number of suits in Georgia are down by 40 percent now. We only had three professional liability cares in Georgia. We now have something like in the teens. And we have a cap on non-economic damages. Not total damages, but only non-economic damages so that economic --

REP. GORDON: We're not talking about caps here. We're thinking about things less than that.

Dr. Ulrich?

DR. ULRICH: I would agree that -- what the gentleman before me said. The reality is that, you know, having to pay some dollars out, you know, in those unfortunate circumstances is an actual cost. And without some relief from that, we will continue to bear those costs.

REP. GORDON: Dr. Wright?

DR. WRIGHT: I also agree. I think the burden of this is quite large. And I particularly like the idea that you would test various options, various approaches to controlling the tort problem.

REP. GORDON: Yeah, what we want to do is give incentives for states to experiment and let's find out what might work.

Dr. White?

MS. WHITE: The American Nurses Association does have some concerns about caps. They have a position statement --

REP. GORDON: Again, we're not talking about caps. I said practices short of caps.

MS. WHITE: Caps. Well, they have a position statement that they can make available to the committee.

REP. GORDON: But they would support malpractice ***reform*** short of caps?

MS. WHITE: I --

REP. GORDON: You raised your hand earlier --

MS. WHITE: Yes, I mean, it's --

REP. GORDON: Dr. Gabow?

DR. GABOW: As a governmental entity, we have governmental unity, but in the broader discussion I think that it's very important to malpractice ***reform***. And I think your idea of experimenting with health courts is a very good one.

REP. GORDON: Dr. Hawkins, earlier you said you weren't personally affected. But that's not the question. It's for the system as an overall.

MR. HAWKINS: Yeah, and as a matter of fact, if I can, one important thing that a couple of members of the committee here had sponsored a legislation to extend to the Federal Tort Claims Act, FTCA, coverage that health center clinicians get today to clinicians who volunteers at health centers.

REP. GORDON: Well, that would be part of the bill in terms of emergency rooms. I think they should be considered as ***first*** response.

MR. HAWKINS: I would, yeah. I would just say we know for a fact.

REP. GORDON: And Mr. Yarwood.

Oh, I'm sorry. Okay, I'm sorry. You were saying you know for a fact that it helps.

MR. HAWKINS: That many local physicians and clinicians would volunteer time at a health center if this issue were addressed.

REP. GORDON: Mr. Roberts.

MR. ROBERTS: I think from a pharmacy's perspective it's not -- it's large an issue but still we would be supportive.

REP. GORDON: Mr. Yarwood.

MR. YARWOOD: It's a huge issue. We've talked about this before and include us.

REP. GORDON: Ms. Fox.

MS. FOX: We absolutely agree.

REP. GORDON: And let me -- if I could go back since we have a little more time concerning those individuals that have the hospitals. Are you finding it a problem now to get a specialist to come in to the emergency room because of the medical malpractice problem?

DR. GABOW: Because of --

REP. GORDON: Yes, Madame, go ahead.

DR. GABOW: Because of medical malpractice we aren't because we have governmental --

(Cross talk.)

REP. GORDON: You are covered.

DR. GABOW: -- and our physicians are employed so we have no problem getting coverage and we don't pay extra for that coverage.

REP. GORDON: But it's because they are already covered? Yes.

Okay. My time is up and I thank you for your advice.

REP. CAPPS: The chair now recognizes Mr. Shadegg for questions.

REP. JOHN B. SHADEGG (R-AZ): Thank you, Madame Chair.

Dr. Wright, I want to begin with you. I also want to follow with Dr. Ulrich because he mentioned a word that I think is very important. He talked about the incentives in the current policy or health care system.

Under the tax code in America today businesses can buy health insurance tax-free, individuals have to buy it with after-tax dollars making it at least 30 percent more expensive. You were just asking, I want to follow up by a question by Mr. Pitts about transparency.

I guess, my concern about transparency is that until we enable consumers, individual people to buy health insurance on the same tax- free basis that businesses can do it I don't see how a consumer has the motivation to ***look*** at transparency. That is to say if my employer provides with me health care and he or she pays for it I don't see what the motivation is for me to go research the cost of a particular procedure at one hospital versus another or one doctor for another or the quality outcomes because I agree with you.

I think that both cost and quality are things consumers want to know but only if they are a part of the marketplace where those factors can make a difference to them. Would you agree?

DR. WRIGHT: I'm not a pricing expert. I'm barely a quality-of- care expert. So I understand your point. I am greatly concerned about the number of people who are not covered at this point and I'm --

REP. SHADEGG: Me too.

DR. WRIGHT: I know you are. And so, I guess, most of my priority in terms of getting this fixed has been directed at them.

REP. SHADEGG: Dr. Ulrich, is that one of the incentives that concerns you?

DR. ULRICH: Yes, certainly, and if I can expand on that just briefly?

REP. SHADEGG: Please.

DR. ULRICH: If we ***look*** at the quality equation that's the outcomes of patient care and the patient-physician interaction being the numerator, costs being the denominator, quality being the end product of that the concern I have is this is that currently we don't pay for that. We absolutely need to move to that model.

But what hinders us now is the fact that patients don't understand necessarily what quality is. We did some market research and what patients tell us is that ***look***, you guys are all the same. You all went to medical school. You all did residency so there's really very little to pick between you. When in fact, for those of us that work in the industry there are differences. So the question before us is how do we now educate our patients so that they can make fully informed decisions relative to that quality equation?

REP. SHADEGG: Dr. Williamson, I think, if I gather your testimony correctly you think that's exactly the point. If we empowered or allowed, just permitted people to buy their own health insurance policy and therefore to shop for it, and to be involved in the selection of the plan, and the selection of the doctor they would be motivated to use transparency, cost data, quality data and make the market much more competitive bringing down cost and causing quality to go up?

DR. WILLIAMSON: Absolutely. And I think it would raise quality on two levels. It would raise quality on the national level in terms of saving money in the entire system and it would raise the quality that the individual patient perceives. Even though patients may not be able to judge scientific quality they do vote with their feet.

And I think if we had transparency, I think, doctors are going to have to compete with each other. And when you -- when -- if we can do what you have suggested which is to empower patients to buy with the same tax advantage that employers have now, their own health insurance policies and control that, then they control their medical decision- making. That's the best way to keep cost down and ensure good patient care.

REP. SHADEGG: The health care policy I have advocated, it says that we should tell every American that has employer provided health care that they can keep it and they can keep the exclusion. But every American that doesn't have employer provided health care would get a tax credit.

Those Americans who can't buy -- can't afford to buy their own health care would get a refundable and advancable tax credit to go out in the market and buy what they want. We would then bring consumer choice to the entire health care industry.

I'd like every member of the ***panel*** to tell me what other thing in our society somebody else buys for us? I mean, I struggle with this question. I don't understand it. Our employers buy our health care insurance. They don't buy our auto insurance. They don't buy our homeowners insurance. They don't buy their -- our suits. I don't buy my employees lunch.

But why in health care do we decide that only employers can buy? Is there something else that somebody on the ***panel*** can remember or can think of that is of that dimension where your employer buys it for you and you're just, kind of, a pawn in the whole system?

Dr. Williamson?

DR. WILLIAMSON: I can't answer the question but I can tell you where it came from. And it came from the notion of pooling risk. Patients realized that if I get really sick I'm going to need a lot of money. And so they went together and they pooled their money. And then what happened is over time they lost control of that pool of money. And

that's where all this is coming from. The patients have turned over to others the ability to make their health care decisions for them by allowing them to pay for it.

REP. SHADEGG: So if we empower them to be able to buy their own health care if they choose it from their employer or out of the market and we empower poor people to do that who can't afford it by giving them a refundable tax credit we would also need to create new pooling mechanisms. Would we not?

DR. WILLIAMSON: I completely agree with you.

REP. SHADEGG: Thank you very much.

REP. CAPPS: Thank you very much.

And I would turn to Mr. Green for his questions. And I'll just say probably this is our last series of questions because the vote has been called. And then your ***panel*** can be excused. You've really set a record for endurance. I have to thank you, each of you.

(Laughter.)

REP. GREEN: Madame Chairman, some of us were here last night at 7:00 o'clock. Well, you were too I think. And we realized it started at 9:30 yesterday morning and finished some time after 7:00.

REP. CAPPS: Be thankful you weren't on that last ***panel***.

REP. GREEN: Yeah, thank you. You can at least get out before dark.

Mr. Hawkins, as you know, I've been working with Representative Tim Murphy since we reauthorized community health centers program last year on a bill we introduced the Family Health Care Accessibility Act of 2009. The bill would extend Federal Tort Claim Act coverage to volunteers by deeming these volunteer practitioners at health centers as employees of the federal government.

These volunteers would have to be a licensed physician or licensed clinical psychiatrists -- psychologists and unpaid in order to qualify. This seems like an easy way, easy solution to the lack of primary care physician in some areas especially in medically underserved areas where community health centers are located.

Yesterday the GAO released a report stating that the lack of Federal Tort Claims Act coverage of volunteer practitioners can be a barrier for volunteers who wish to dedicate their time at a Federally Qualified Health Center.

Could you elaborate on how the extension of the FTCA coverage to licensed physicians or other licensed practitioners would help increase the number of volunteers at Federally Qualified Health Centers?

MR. HAWKINS: Sure, Mr. Green. And thank you for raising that issue. In fact, just a couple of minutes ago we were discussing the issue of malpractice and I specifically alluded to --

REP. GREEN: I hope my colleague Congressman Murphy is bringing it up.

MR. HAWKINS: That's okay. I specifically alluded to this legislation which you and Mr. Murphy have collaborated on in the past and continue to collaborate on. I can tell you not only for primary care, Mr. Green, but even for urologist, dermatologist, you know, the biggest frustration that health center clinicians, who are virtually all primary care today express is the barriers and difficulty they face getting specialty care, diagnostics, even hospital admits for the 7.5 million uninsured people we serve, in particular, not exclusively, but in particular, allowing FTCA coverage to extend to individuals, who as you note, come in to the health center and donate their time, do not charge the patient, don't charge the health center would be a phenomenal benefit and boon and --

REP. GREEN: Okay. But --

MR. HAWKINS: -- would provide for much more fully integrated care and better health --

REP. GREEN: And we discovered this problem in Texas in -- with the Hurricane Katrina with all the evacuees in our Federally Qualified Health Centers. We had medical professionals who couldn't volunteer in Texas because they weren't covered. So -- and it's -- we realize now that that's a way we can provide for our Federally Qualified Health Centers.

The discussion draft also addresses the issue of residency training in off-site locations like FQHCs and -- but it still allocates the funds to the hospitals and not to the off-site locations. Do you believe language in the draft should make it easier for Federally Qualified Health Centers and other off-site residency training programs to start up and operate residency programs?

And again, we have an example, in my district, of a Federally Qualified Health Center. It has a partnership with Baylor College of Medicine in Houston. And they do it. And what I'd like to do is see if we can get a number of medical schools because I want primary care physicians know they can make a living at a Federally Qualified Health Center in a community-based setting. So --

MR. HAWKINS: Not only that Mr. Green, but I'm honored to be part of the ***panel*** today that includes Denver Health, a community health center as well as a public hospital and --

REP. GREEN: Congresswoman DeGette has preached to me for years about Denver.

MR. HAWKINS: (Laughs) -- all the joys and a great work that Dr. Gabow has done, also residency training program. Marshfield Clinic, which has a community health center embedded in it doing residency training, and Ted Epperly, Dr. Epperly, whose family medicine residency training program in Boise, Idaho, is also a Federally Qualified Health Center, perfect examples.

Now, all are working locally with their medical schools and with teaching hospitals to ensure because those residents, even family medicine have to have med-surg residency in-patient based. So it can't be done independently. At the same time the vast bulk of family medicine residency training, pediatric residency training, even general internal medicine residency training can be done in an ambulatory care site.

More than 300 health centers today across the country are engaged in residency training programs that have rotations of residents through them and everyone's willing to step up and do more. Now all that's needed is the resources to be able to do so.

REP. GREEN: Well, and if we know we need a chronic need for primary care doctors then this is a way we can do that and hopefully expand it. One last question in my last 6 seconds, the discussion draft includes additional funding through the public health investment fund. And as many on the committee know we've been asking for additional funds for health -- federally qualified health clinics for years.

How do you intend to use any funds so that we can provide more services like dental and mental health and would allow us to help build more FQHCs because we know we need that in our country?

MR. HAWKINS: I think there are two or three quick points to make on that. Just last month the Government Accountability Office, GAO issued a report that pointed out that almost half of federally designated medically underserved areas in this country have no health centers, not a one.

There are 60 million people out there today across this country some of whom have insurance and yet do not have a regular source of preventive and primary care no family doctor, no medical or health care home. So the need is great. It runs in tandem with the extension of coverage that this bill would provide but ***takes*** it that one step further turning the promise of coverage into the reality of care through providing a health care home.

The expansion of coverage to serve more people, as you noted, very importantly, the expansion of medical care to include oral health and mental health services, so crucially important, all of that will be afforded through the new resources in this bill.

REP. CAPPS: And now thank you again to the panelists and we are in recess for the next ***panel*** to begin after the series of votes. It's eight votes but after the ***first*** one apparently it's two minutes per vote so it should go fairly quickly hopefully, thank you very much.

(Recess.)

REP. PALLONE: (Sounds gavel.) The Subcommittee on Health will reconvene. And our next ***panel*** is on employer and employee views. I think you're all -- hopefully the ***panel*** is -- I'll wait till you get seated here a minute.

Let me introduce the ***panel***. On my left is Kelly Conklin, Mr. Conklin who is the owner of Foley-Waite Custom Woodworking, Main Street Alliance. And then we have John Arensmeyer who's founder and CEO of Small Business Majority.

We have Gerald M. Shea who is the assistant to the president of the AFL-CIO; Dennis Rivera, who is the health care chair for the SEIU; John Castellani, who is president of the Business Roundtable Institute for Corporate Ethics; John Sheils, who is senior vice president for the Lewin Group; and Martin Reiser, who is manager of Government Policy for Xerox Corporation, I guess, representing the National Coalition on Benefits.

And you know, we ask you to speak for about five minutes. Your written testimony becomes part of the record. And then we'll have questions from the ***panel***.

So I'll start with Mr. Conklin. Thank you for being here.

MR. CONKLIN: Thank you, Chairman Pallone, Ranking Member Deal, and other members of the committee for inviting --

REP. PALLONE: Mr. Conklin --

MR. CONKLIN: Yeah?

REP. PALLONE: I see the green light is on, but you got to push that mike closer to your --

MR. CONKLIN: Okay.

REP. PALLONE: Closer to you -- almost like on top of you.

MR. CONKLIN: Okay, how's that?

REP. PALLONE: That's good.

MR. CONKLIN: Okay. Thank you, Chairman Pallone, Ranking Member Deal, and other members of the committee for inviting me to appear today.

My name is Kelly Conklin, and I co-own with my wife Kit, an architectural woodworking business in Bloomfield, New Jersey. My purpose today is to explain how the ***House*** tri-committee's health ***reform proposals*** might affect small companies like ours. To start, I think the draft legislation is right on target. I believe it will receive broad support in the small business community.

Before I go any further, let me provide some background. My wife and I opened Foley-Waite in 1978 in a 700-square-foot shop in Montclair, New Jersey. In 1985 we expanded, hired four employees, and started offering health insurance. The premiums were about 5 percent of payroll, and we paid it all.

Today we employ 13 people, occupy 12,000 square feet of space, and serve some of the most influential people in the world, and we fork over ($)5,000 a month in health insurance premiums close to 10 percent of payroll, and one of the largest single expenses in our budget. Practically speaking, we offer coverage to attract and retain skilled employees.

But like the majority of small companies, we do so because it's the right thing to do for our workers. And if we don't offer coverage, we're just passing our obligation and our share of the cost on to someone else. Cost is by far the single most important driver in making basic decisions regarding health care.

That applies whether it's a small firm like mine or the United States Congress, and no system that tends to dance around the cost issue can succeed. April is the month I dread -- not for taxes, but for health insurance renewal nightmares. Every year is worse -- unpredictable rate hikes, unaffordable premiums, an administrative tangle that is our system.

In three years we've had three different insurance companies. Most recently, Horizon Blue Cross/Blue Shield raised our rates 25 percent. Now we have Health Net. That means new primary care physicians, and for my wife who has a chronic illness, a new doctor who knows nothing of her medical history. It's very frustrating. There are no quality affordable health care options available for small businesses.

In reading the discussion draft, it is apparent the committee is determined to control cost. Responsible employers understand we will all be better off in a system where employers and individuals contribute a reasonable amount toward ensuring our common health and wellbeing. That's why I support the draft provisions requiring employees and individuals to pay their fair share.

For too long the small business community has paid too much for too little. We sacrificed growth, financial security, and the peace of mind of our employees and their families in the name of protecting private insurers from meaningful competition. The private health insurance market has failed to contain costs, enhance efficiency, or improve outcomes. It fails to provide coverage to millions.

Half-measures, warmed over, more of the same, second chances for the health insurance industry won't fill the yawning gaps in our patchwork coverage. We need a guarantee that individuals and small companies will have real choices and affordable coverage options. I commend the committee for including a strong public health insurance option in this legislation.

With the public option, small businesses will have leverage, real bargaining power, and guaranteed backup and greater transparency. Most importantly, by creating genuine competition and restoring volatility to market dynamic, this ***proposal*** will bring about the kind of broad-based changes in the private insurance industry Main Street is clamoring for.

For a small business like mine, bringing down health insurance premiums can be the difference between growth and sitting tight. Two years ago, we were interested in buying a building that represented growth potential, financial security, and long-term equity. We were ***looking*** at around ($)5,000 a month in mortgage payments as opposed to our rent of around ($)3,500.

If our health insurance premiums had been closer to our rent and not the future mortgage, we might be in that building today. We work in a competitive marketplace. All the time there are new competitors ***looking*** to ***take*** business away. We find savings, improve efficiency, invest in equipment and personnel -- that's how it is for us, and that's how it will be for the health insurers if a public option is available.

Transparency is critical. It's time for the insurance companies to come clean and in plain English explain where our premium money goes, to say upfront what's covered and what's not. It's time to put a halt to cost-containment by denial, copays, and hidden charges.

The draft discussion addresses this need by creating a health insurance exchange to offer real coverage choices that allow us to actually know where our premium dollars are being spent. We can provide access to both preventative and therapeutic care for everyone. We are encouraged by the provisions ***reforming*** common practices in the current insurance market.

Ending lifetime and annual benefit limits, discriminatory coverage and rating policies, and creation of a basic benefit are all important and necessary parts of a complete ***reform*** package. These are full measures designed to provide real relief. If enacted, they will represent a watershed for American health care, and a godsend to the small business community.

This committee, working with its counterparts to develop the tri- committee ***proposal***, has done yeoman's work ***taking*** on and meeting extremely complex set of issues. I will not be alone in supporting this extraordinary effort. I am a member of the New Jersey Main Street Alliance, a coalition of over 450 small businesses working for health ***reform*** that will finally give us access to quality health care we can afford.

I have canvassed small businesses. And when I say and we support a public option, they ***take*** the pen out of my hand, and the New Jersey MSA has a new member. Small businesses have sought your leadership, and with this document you have delivered. Now the real fight begins. We need you to enact this ***proposed*** legislation and bring about health ***reform*** that works for us and our employees this year so we can do our part for economic recovery.

Thank you, Mr. Chairman.

REP. PALLONE: Thank you, Mr. Conklin.

Mr. Arensmeyer.

MR. ARENSMEYER: Thank you, Chairman Pallone, Ranking Member Deal, and members of the committee.

Small Business Majority appreciates this opportunity to present the small business perspective on the ***House*** tri-committee draft health care ***reform*** plan. We support the effort to move this legislation through Congress expeditiously, and thank you for bringing a ***proposal*** forward in such a timely manner.

Small Business Majority is a nonprofit, nonpartisan organization founded and run by small business owners, and focused on solving the biggest single problem facing small businesses today -- the skyrocketing cost of health care. We represent the 27 million Americans who are self-employed or own businesses of up to 100 employees. Our organization uses scientific research to understand and represent the interests of all small businesses.

I've been an entrepreneur for more than 20 years, including 12 years owning and managing an Internet communications company. Together with the other senior managers in our organization, we have a total of 70 years running successful small businesses ranging from high-tech to food production, to retail.

We hear stories every day from small business owners who can't get affordable coverage and for whom health care is a scary, unpredictable expense. Louise Hardaway, a would-be entrepreneur in Nashville, Tennessee, had to abandon her business dream after just a few months because she couldn't get decent coverage. One company quoted her a $13,000 monthly premium for her and one other employee.

Others such as Larry Pierson, owner of a mail-order bakery in Santa Cruz, California, struggle to do the right thing and provide health care coverage.

Larry notes that, quote, "The tremendous downside to being uninsured can be instant poverty and bankruptcy, and that's not something my employees deserve."

Our polling confirms that controlling health care costs is small business owners' number one concern. Indeed on average, we pay 18 percent more than big businesses do for health care coverage. An economic study that we

released earlier this month based on research by noted MIT economist, Jonathan Gruber, found that without ***reform***, health care will cost small businesses $24 trillion over the next 10 years.

As such, we are pleased to see that the ***House*** bill addresses key cost-containment measures such as expanded use of health IT, transparency, prevention, primary care, and chronic disease management. Our polling shows that 80 percent of small business owners believe that the key to controlling cost is a marketplace where there is healthy competition. To this end, there must be an insurance exchange that is well-designed and robust.

We are very pleased that the committee's bill ***proposes*** a national insurance marketplace with the option for state or regional exchanges that adhere to national rules. Moreover, we are encouraged by the committee's ***proposal*** that there be standardized benefit packages along with guaranteed coverage without regard to preexisting conditions or health status, a cap on premiums and out-of-pocket costs, and marketplace transparency.

We understand that a balanced set of ***reforms*** will require everyone to participate. Sixty-six percent of small business owners in our recent polls in 16 states -- for which we released preliminary data this week -- support the idea that the responsibility for financing a health care system should be shared among individuals, employers, providers, and government.

It should be noted that respondents to our surveys included an average of 17 percent more Republicans -- at 40 percent -- than Democrats -- at 23 percent, while 28 percent identified as independent. According to the results of the economic modeling done for us by Professor Gruber, comprehensive ***reform*** that includes even modest cost-containment measures and a well-designed structure for employer responsibility will offer vast improvement over the status quo.

A system with appropriate levels of tax credits, sliding scales, and exclusions, will give small businesses the relief they need, potentially saving us as much as $855 billion over the next 10 years, reducing lost wages by up to $339 billion, and restoring job losses by up to 72 percent.

We are very pleased that the committees have addressed some of the affordability concerns of the smallest businesses. Professor Gruber has modeled specific scenarios described in detail in our report, and we ***look*** forward to working with you to ensure the best balance between the need to finance the system and our ability to pay.

Finally, another issue of great concern to us is the unfair tax treatment of the 21 million self-employed Americans. Under the current tax code, self-employed individuals are unable to deduct premiums as a business expense, and are required to pay an additional 15.3 percent self-employment tax on their health care costs. We encourage that this inequity be rectified in the final bill passed by the ***House***.

In closing, health care premiums have spiraled out of control placing our economy and the fortunes of small business in peril. Health care ***reform*** is not an ideological issue; it's an economic and practical one. We are encouraged by the overall approach of this bill, and ***look*** forward to working with you to make it a reality this year. Thank you.

REP. PALLONE: Thank you, Mr. Arensmeyer.

Mr. Shea.

MR. SHEA: (Off mike) -- and Congresswoman Capps, I really appreciate the opportunity to share the views of the AFL-CIO on this critically important issue.

And I want to start by saying hearty congratulations on producing a very good draft bill. I think you really responded to what the American people have asked for, and we ***look*** forward to working with you over the coming weeks to get that bill enacted. You've decided to build the health ***reform*** based on the current system, therefore based largely on the employment-based system, since that's the backbone of our health coverage and health financing.

And I want to direct my remarks to that today. And I hope that the experience I bring, which is the experience of unions that bargain benefits for 50 million workers each year, will be of some benefit to you. And the main thing I have to say is if you're going to proceed down this path -- and we certainly support it -- then job number one is stabilizing employment-based coverage.

It has proved remarkably resilient in the face of high cost pressures, but it is in fragile shape today. From 2000 to 2007 we lost 5 full percentage points on the number of 18- to 64-year-old working Americans who were covered. And the under-insured rate -- people who have insurance, but really can't afford to get care under it -- shot up from 16 percent to 25 percent in the last four years.

So despite the fact that it's still hanging on, employment-based coverage is really eroding very rapidly. And to stabilize that coverage, we would suggest that you focus ***first*** of all on cost, secondly on having everyone involved in coverage and in the system, and thirdly -- and I don't mean these in rank order they're really just all important -- thirdly, ***reform*** of the delivery system.

Let me start with participation, because in some ways that's the simplest. If you're going to base this on employment-based coverage, we think it makes simple sense -- as you've done in your bill -- to require that everyone, every individual participate and ***take*** responsibility to some extent -- certainly responsibility for their own health status -- and every employer to participate. And that is included in your bill.

And the benefits of this are simple -- it helps bring people into the system, it does stabilize the employment-based coverage, it helps reduce the amount of federal tax dollars that you have to spend, because everybody who is covered by an employer plan will not be dependent on monies that you have to raise and put into this bill for subsidies, it levels the playing field between employers who do provide and those who don't.

And there are really just three categories of workers in terms of their insurance coverage. The vast majority, as you know, get insurance coverage at work; some 92 percent of the employers that -- 50 or above workers -- provide health insurance. There are some employers who don't provide insurance, but certainly are well enough off to do that. The example of the lobby shop in Washington comes to mind.

And then there are a group of low-wage small employers who really need a lot of help to do this. Our suggestion is that everyone be included and there's no exemptions, because once you start exempting people, we think you're going to run into distortions in the marketplace as now exist.

But we do think it's appropriate, as you have done, to provide tax subsidies for employers with low wage and small numbers of employers. And I would emphasize that we don't think there's just small numbers of employees, it actually is some measure of the financial stability or success of the firm that should be ***taken*** into account.

Secondly, in terms of controlling costs, the most important thing we can do is to change the delivery system. If the Institute of Medicine estimate of 30 percent waste in the system is anywhere near correct, we could easily pay for health ***reform*** and cover all of the uninsured if we can get a substantial amount -- not all of that, but a substantial amount of that waste out of the system.

So that's the most important thing, and your bill includes a number of good provisions on that. We're working with your staff, because we think they could be strengthened in a number of areas, but we think you've made a very good start. However, in the short term, that's really not going to do the job. You're going to need to do something else.

And there are only two options, in our view, as to how to do this in the short term. One is to do it by regulation -- you could do global budgets or set rates -- and the other is to introduce competition into the marketplace that now doesn't exist.

And you have chosen the idea of competition through a public health insurance plan, and we strongly support that.

I would just point out that there is an additional advantage of a public health insurance program in that it can be a leader in ***reform*** of the system, as Medicare is now. I deal with a lot of employers and a lot of unions who wanted to change the delivery system for the better over the past few years, but it wasn't until Medicare started to change their payment rates that this really started to happen.

And then lastly, ***looking*** at the delivery system, I think as I said, that there's plenty of money in it to pay for ***reform***. But we're not going to get that money back very quickly. And some people are talking about having to pay for ***reform*** totally out of the current money of the system, which we think is just very unrealistic. We think you have to ***look*** outside for additional monies.

And if you ***take*** the view that you've got to ***look*** inside, you may well get to the very dangerous territory of the Senate Finance Committee talking about taxation of benefits, which we think would be a disastrous approach. It's unfair to the people involved, since they already pay an arm and a leg, many of them for health coverage. And it's unfair in terms of the inequities built into this.

Workers who are older, groups that have families, groups that have more retirees, will have much higher cost. And so there's -- and then there is the simple political dynamic of this. If you wanted to throw a monkey wrench into public support to health ***reform***, this would be the perfect way to do it, because in the process you'd really, really turn the applecart upside down in employment-based coverage.

Thank you, Mr. Chairman.

REP. PALLONE: Thank you, Mr. Shea.

Mr. Rivera.

MR. RIVERA: Thank you.

I'm chair of SEIU health care. There are 1.2 million health care workers who are committed to ***reforming*** our nation's broken health care system. We represent members like Pat DeJong of Libby, Montana, who works as a home-care aide. Pat and her husband, Dan, were ranchers, but had a hard time finding affordable coverage and were uninsured when he was diagnosed with Hodgkin's lymphoma in the year 2000.

The medical bills piled up for Pat and Dan, eventually forcing them to sell their land they loved, and that has been in Dan's family for generations. Dan succumbed to cancer, and Pat remains uninsured. This is America. We can and we must do better for hardworking families like the DeJongs.

Americans are ready to fix health care and they know that this is the year it must happen. Now it's up to you to deliver Pat and the millions who face the consequences of our broken health care system with a real choice of affordable quality, private and public health care coverage.

SEIU -- 1.2 million health care workers in hospital, clinics, nursing homes, and in homes and communities are at their bedside, everyday witnessing high price. Families pay for the delay and skip medical treatments. The uninsured are not just statistics. They are hardworking people, people such as Pat, who despite caring for those who cannot care for themselves cannot afford health care coverage for herself.

Your discussion draft includes many essential elements that will promote coverage and access, cost containment, and improved quality and value for American families. A strong public health insurance option is vital to ensuring consumer choice and access. The public plan will drive down the cost of insurance by competing with private insurance and lowering overall cost.

Medicaid expansion; we support increase in Medicaid eligibility for families up to a 133 percent of federal poverty. The discussion draft will also improve Medicaid payments to primary care practitioners to address concerns about access to needed services by Medicaid beneficiaries.

We caution the committee to -- that safety net providers and systems must be protected to provide access and support to low-income communities, and to maintain a mission that includes trauma care and disaster preparedness. Special payment to these facilities, such as the disproportionate share payments, must be maintained as coverage expand. In addition, essential community providers must be included in insurance plan that serve Medicaid beneficiaries and individuals eligible for health care credits.

Health care ***reform*** needs to work for everyone including the 4 million American citizens who reside in Puerto Rico. And we urge Congress to include Puerto Rico and the -- and all the territories in all parts of health care ***reform***. SEIU is pleased to see that the committee has recognized the need to improve the treatment of Puerto Rico and the territories under Medicaid by increasing their caps and federal matching rates. While this is important step in the right direction it falls short of resolving the longstanding inequities in federal health care program that have been hurting the people of Puerto Rico for decades.

Shared responsibility; employers, individuals and government must all do their part to make sure we have a sustainable and affordable system that covers everybody. For employers that do not provide meaningful coverage to their employees, they must pay into a fund. This "pay or play" requirement is necessary to ensure individuals can meet their responsibility to obtain affordable coverage. We especially support provisions to provide the small businesses with tax credits and access to an insurance exchange to help them purchase coverage for their employees.

Affordability; individuals responsibility must be augmented by measures to ensure affordability. We commend the committee for offering federal financial assistance to individuals and families with low and moderate income, and those with high health care costs relative to their income, to guarantee affordability.

Eliminating disparities; we congratulate the committee for recognizing disparities in access to quality health care. No one should be discriminated for pre-existing conditions. No one should be discriminated for being low-income, minority, disabled or aged.

Workforce; as coverage grows so must the health care workforce. Today there are chronic shortages in almost every area of health care from primary care physicians, to nurses, to long-term care workers. Health care ***reform***, to be effective, must include a diverse, well- trained workforce that is working in the appropriate setting across the delivery system, and is well-distributed in both urban and rural areas.

This is your moment, your moment to ensure that Pat DeJong and millions of other hardworking Americans do not have to wait any longer in America for quality, affordable health care coverage. The time is now. We cannot wait.

REP. PALLONE: Thank you, Mr. Rivera.

I wanted to apologize to Mr. Castellani because I said that you represented the Business Roundtable Institute for Corporate Ethics. And apparently it's just the Business Roundtable.

MR. CASTELLANI: I am president of the Business Roundtable.

REP. PALLONE: Yeah.

MR. CASTELLANI: I am a member of the board of directors of the Business Roundtable Institute for Corporate Ethics. That's probably --

REP. PALLONE: Oh, I see. Okay, well, thanks for clarifying that. Go ahead.

MR. CASTELLANI: Thank you, Mr. Chairman. I'm here on behalf of the members of Business Roundtable who are the chief executive officers of America's leading corporations. Collectively, they account for more than $5 trillion in annual revenues and 10 million employees but most importantly, they provide health care for 35 million Americans.

I appreciate the invitation to testify and I share the urgency of this committee and the fellow panelists that health care ***reform*** must be addressed now. Today I want to focus on three key messages; ***first***, we need to get health care costs under control; second, we must preserve the coverage for those a 132 million Americans who receive that coverage from their employer. And third, we need to ***reform*** the insurance marketplace so that individuals and small employers can afford and find affordable coverage.

Let me address the draft legislation that you have before the committee. ***First***, let me thank you and the committee for moving forward on health care ***reform***. We view that as very positive and necessary and we want to be constructive in what we believe will work and what we believe will not.

We support the provisions that ***reform*** the insurance market so that there are more affordable coverage options. The bill also includes a requirement that all Americans get health insurance coverage and includes auto enrolling for individuals into SCHIP or Medicaid if indeed they are eligible. We support both of those provisions and also support offering subsidies to low-income Americans who cannot afford coverage.

The changes that you've included in the Medicare programs and other efforts to make our health care system more efficient are very positive. Medicare payments do need to be adjusted and we'll provide the committee with comments on these and other issues. We do however, have significant concerns about two major issues in the draft legislation and hope that the committee will consider some -- revisions.

First, ERISA should not be changed if ***reforms*** are to be built on the employer-based system. The ***proposal*** before you would change some of the ERISA rules, for example, it would impose minimum benefit packages on our employees. Large employers designed innovative plans, including wellness and prevention initiatives that have been tremendously successful in helping employees ***take*** greater control over their own health.

And yet such programs, which we believe are critical to the success of health care ***reform***, would be jeopardized by a new federally mandated benefit law. Second, we're very concerned about public plan ***proposals*** that would compete in the private marketplace. As large employers, we're concerned that our employees will suffer from additional cost shifting that come from an adequate government repayment to the providers. For that reason we're concerned that the kind of cost shifting that we're dealing with now would be exacerbated.

Further, the government plan could erode existing worker coverage if employees seek the subsidized lower priced public option. That would diminish the people in our plans and would leave employers' sponsored coverage with more expensive, more costs for both employers and employees.

Innovation, which we think is the key to modernizing our health care system and getting our costs under control benefits improvements and how best to care for patients we believe come best from the private marketplace. We need to preserve the energy and the commitment to improve our health care market. And we're concerned that government plans cannot do that as well as the private sector. We urge the committee to instead create even stronger rules to make the private insurance marketplace more competitive and we want to help in that effort.

Business Roundtable believes that the search for bipartisan consensus can begin by honoring the principles that we've outlined in our written testimony and by crafting ***reform*** that is consistent with the uniquely American principles that drive our economy: competition, innovation, choice and a marketplace that serves everyone.

On behalf of our members, we pledge to work with you, and all the members of the committee to find workable solutions that let people keep what they have today and a ***reformed*** health care system that works better for everyone. Thank you.

REP. PALLONE: Thank you.

Mr. Sheils.

MR. SHEILS: Hello. Good afternoon, Mr. Chairman. My name is John Sheils. I'm with the Lewin Group and I have specialized over the years in estimating the financial impact of health ***reform proposals***. We got your bill on Friday and immediately went about doing some preliminary estimates on coverage and the impact on provider incomes.

Allison's (ph) going to help me with some slides. Are they up? All right. Well, I don't see them but the ***first*** slide, the system that the bill would establish begins with -- it'd be the next page, please, next page. There you are. We have a new health insurance exchange. The exchange would provide a selection of coverage opportunities that most of them are private coverage that we now are familiar with but they would also offer a new public plan.

The number -- the impact that this program will have on coverage is going to be driven by a -- the groups that you permitted to enroll. The program would allow individuals, self-employed and small firms, at least in the ***first*** year, to go through the exchange to obtain their coverage. In the second year -- in the third year the newly established commissioner would have the authority to open the exchange to firms of all sizes.

The new public plan we predict would -- will attract great many people because the premiums in the public plan will be much lower than for private insurance. And because of that we think that a great many people are going to be attracted to it. Let's discuss that a little bit.

On the next slide we show the -- summarize some of the payment rates on the left side. You're using the Medicare hospital reimbursement methodology and under Medicare payments are equal to about 68 percent of what private payers have to pay for the same services. For physicians care you pay about well, Medicare pays about 81 percent of what private insurance pays. You're going to be adding another 5 percent to that. So we're ***looking*** at about 85 percent of private payers.

And there's also -- we also have some information here on what happens to insurance administrative costs. In the exchange, public plan will not have to worry -- need an allowance for profits and it will not have -- pay commissions for brokers and agents.

The next chart shows what happens to premiums. For family coverage for the "Enhanced" benefits package described in your legislation in the private sector it would cost about $917 per family per month. Under the public plan it would cost about $738 per family per month. That's savings of about $2,200 a year and we think that is going to draw a lot of people into the public plan.

And the next page? On the right-hand side we have an -- we illustrate what happens to coverage when the plan is open to all firms. The program would reduce the number of uninsured by about 25 million people. There'd be an increase in Medicaid enrolment of about 16 million people. But we'd find a 123 million people going into the public plan. That's a reduction in private coverage of about a 113.5 million people that's about 66 percent of all privately insured persons. This, of course, is if the plan -- if and when the plan is open up to firms of all sizes. If it is limited to just firms of less than 10 workers as in the ***first*** year you still get a reduction of about 25 million people uninsured, still 16 million people with Medicaid coverage but private coverage would drop by about 20 million people, public plan coverage would be 29 million people.

Next chart, please. This chart summarizes what happens to provider incomes under the plan. On the right-hand side we have the scenario where all firms are eligible to participate in the program. Hospital margin which is hospital profit, net income basically would be reduced by about $31 billion because of that -- that's about a 70 percent reduction in the hospital margin.

Physician net income would go down by about 11 million -- $11 billion that comes to, in terms of net income, that's an average of about $16,000 per year reduction in net income per physician. On the left-hand side we show what's happening under the small firms and this is really interesting because under this scenario provider incomes actually go up, for instance, hospital margin goes up by about ($)17 billion. Much of this has to do with the fact that it will

have reduced uncompensated care. They'll be paid for services they were providing for free before. And there will be new services they'll provide to newly insured people.

The physician net income would go up by about ($)10 billion and the increase in income there has -- is largely driven by the fact that you're going to increase payments for primary care under the Medicaid program. That's about -- that sums it up and I'm out of time so I turn it over to my colleague here.

MR. REISER: Mr. Chairman, and members of the committee, I want to thank you for the opportunity to testify about ***proposals*** to ***reform*** the U.S. health care system. I am here today on behalf of the National Coalition on Benefits, a coalition of a 185 business trade associations and employers that have joined together to work with Congress to strengthen the employment-based system.

The NCB supports health care ***reform*** that improves health care quality and reduces costs. The NCB recently wrote to President Obama applauding his commitment to comprehensive, bipartisan health care ***reform***. We expressed our shared view that a strategy to control costs must be the foundation of any effort to improve the health care system. I have included that letter in my written testimony.

For many years, the American people have sent two clear messages to elected officials. ***First***, Americans want to see change and improvements in both cost and access to health care. And, second, Americans like the health benefits they receive through their employer. The NCB believes the American people are right on both points: we do need change. However, such change should not erode the part of the health care system that is working.

The employer-sponsored model works well because it allows the pooling of risks and because group purchasing lowers health care costs, enabling those who are less healthy to secure affordable coverage for themselves and their families. ERISA and its federal framework allows employers to offer equal, affordable, and manageable benefits regardless of where their employees live and work and without being subject to the confusing patchwork of mandates, restrictions and costly rules that vary from state to state.

Yet as good as it is this system is increasingly at great risk. As President Obama has said, "soaring health care costs make our current course unsustainable." The National Coalition on Benefits completely agrees. Unfortunately, we are concerned that the legislative ***proposal*** released last week does not provide meaningful cost savings for the overall system. In an effort to expand coverage, cost containment has not received the priority it demands.

For several years employers have worked to make clear the issues that health care ***reform*** must properly address to preserve the employment-based system, control costs, and lead to our support. To date, we have not seen legislative ***proposals*** where each of these core issues have been adequately resolved.

I will briefly discuss our concerns on ERISA, the employer mandate, and the public plan. If the objective is to build upon the employer-based system that successfully covers more than a 170 million Americans, then employers must have the ability to determine how best to meet the needs of their employees. Legislation should not include changes to ERISA or other laws that would risk hurting those who are highly satisfied with the health care coverage they currently receive.

The NCB opposes provisions that alter the federal ERISA law remedy regime. The existing structure encourages early, out-of-court resolution of disputes, and provides a national uniform legal framework to provide both employers and employees with consistency and certainty. The draft of the legislation would replace this successful structure with differing remedy regimes depending on where employers and employees obtain health coverage.

All these different -- differing bodies of law are likely to result in contradictory decisions about plan determinations and would expose employers who obtain coverage through the exchange to unlimited state law liability. In other words, these legislative provisions would weaken the employer-based system.

We are also concerned about ***proposals*** that would limit the flexibility of employers at a time when our country needs employers to create jobs and invest in future growth. Employer mandates, including requirements to "pay or play" are not the answer to the health care problem because they undermine our ability to address two keys -- key goals of health ***reform***: coverage and affordability.

On the public plan, we do not believe a public plan can operate on a level playing field and compete fairly if it acts as both a payer and a regulator. A public plan that would use government mandated prices would result directly in a cost-shift to other payers and thus would do nothing to address the underlying problems that make health coverage unaffordable for many. We already experience that cost-shift today as Medicare, the largest payer in the United States, consistently underpays providers.

In summary, we remain concerned about any provisions that that would make health care more costly for employers and employees, destabilize our employer-based system of health coverage, or restrict the flexibility of employers to provide innovative health plans that meet the needs of their employees. As Congress moves forward to formal consideration of the legislation, we want to continue to work with all members of Congress to enact ***reforms*** that not only allow Americans to keep the coverage they have today if they like it, and for most Americans, that means their employer-based coverage, but make it possible for them to count on it being there tomorrow when they need it.

REP. PALLONE: Thank you and thank you all. I'm going to start and I'm going to try to get a lot in in my five minutes here. So bear with me if you don't mind.

Mr. Shea, you expressed concern about taxing health care benefits. And you know I -- you know and you acknowledge in your testimony this came from the Senate not from the president, not from the ***House***, needless to say. My concern is that, you know, a stated purpose of this ***reform*** is to let people keep what they have and that to keep what they have and, of course, that implies employer -- not only for employer benefits but whoever has health insurance policy that they have.

So I mean, if you just want to tell me briefly what the consequences would be, I mean, I know everything's on the table but this is something that I'm concerned about, just briefly.

MR. SHEA: What was it that somebody said about some things are moving off the table? But we hope this is in that category. The main thing that would happen to it was to destabilize employment coverage which is as I said is exactly the opposite direction from where we need to go because it would change the relationship between employees and employers around this very important part of their compensation.

Some employees who are younger might say, well, jeez, I don't really need to be part of that group plan. I'm going to go off and since it's now tax money. Secondly, it would penalize certain groups of workers because of their health status essentially. We've ***looked*** at health funds --

REP. PALLONE: I'm going to stop here because I --

MR. SHEA: Okay.

REP. PALLONE: -- you know I appreciate what you're saying but I'm going to ask Mr. Rivera a question. He stressed the pay to play requirements for businesses and you know, of course, we get criticisms of this and you know suggestion that, you know, it's going to hurt business. Why do you think the pay or play requirement is necessary for you know -- I mean why do you think it's a good idea basically?

MR. RIVERA: Because we believe that at this moment if some of the employers -- the employers who basically are providing health care are basically subsidizing those who are not providing health care, for example, on an average the health insurance is about between ($)1,300 to ($)1,500 more for the cost of a family insurance. And those who don't provide health care coverage to their employees are basically on a free ride here. That's basically I've to say.

REP. PALLONE: Okay. And what about the public option? You know, you said you are supportive of it. Obviously, it's in the discussion draft.

Are insurance market ***reforms*** enough to drive down cost and assure coverage for all, or you think the public option is an essential piece of the ***reform***?

MR. RIVERA: We believe that it is an essential part of the ***reform***, sir. And we believe that it will be a very important contribution to lowering the cost of health care. And basically, this is America where we all can compete, and this is another way of competing to lower the cost, sir.

REP. PALLONE: Okay. Mr. Sheils, I'm going to go -- I'm going to you last here. I've got about two minutes left. You've criticized the public option, and you know, just for purposes of full disclosure the study you mentioned, my understanding and tell me if I'm wrong, is it was completely funded by an insurance company.

You said in your written testimony you are the senior vice president of the Lewin Group and your group is -- my understanding is your group is 100 percent funded by UnitedHealth Group, one of the largest insurance companies in the country. Is that accurate?

MR. SHEILS: We are owned by UnitedHealth. Two, we have a 36- year tradition of doing --

REP. PALLONE: But it's 100 percent owned by UnitedHealth.

MR. SHEILS: I'd like to finish.

REP. PALLONE: Well, let me get to the next thing. You probably can respond to it.

MR. SHEILS: Anyway that -- the -- we were bought two years ago. And at that point, we are on there. But our work is completely independent. We have complete editorial control over our work.

REP. PALLONE: But I mean, the group is 100 percent funded by the UnitedHealth, right?

MR. SHEILS: Well, we are a consulting firm. We are funded by the work we negotiate with the clients. So I work for the Commonwealth Fund. I work for Families USA. I've worked for Blue Cross Blue Shield.

REP. PALLONE: But what about this study?

MR. SHEILS: This study?

REP. PALLONE: Yeah.

MR. SHEILS: This study was done on our own nickel.

REP. PALLONE: But who funded it?

MR. SHEILS: Well, we just did it on our own nickel. We did it out of, you know, our firm's overhead.

REP. PALLONE: Did UnitedHealth directly or indirectly pay for it, because they are funding you? I'm just trying to get an answer here.

MR. SHEILS: You could say it that way. But UnitedHealth did not review any of our materials before they --

REP. PALLONE: Okay. I mean, the only reason I mentioned it is our committee conducted an investigation of UnitedHealth. And we found that the company had incredible profitability.

In 2004, the net income was ($)2.6 billion, 2005 accrued a ($)3.3 billion, 2007 it went up to ($)4.7 billion. Even last year, at the height of the financial collapse, the company's net income was $3 billion.

And then in -- Mr. Sheils, in 2000 -- I mean, not you, in 2005, the CEO of UnitedHealth, William McGuire was the third highest paid CEO in the country according to Forbes magazine. He resigned in 2006 after the SEC launched an investigation involving the backdating of stock options.

But UnitedHealth gave him a severance pay of $1.1 billion, which was stunning to me. I mean, do you think it's appropriate for UnitedHealth to pay the CEO more than $1 billion severance?

MR. SHEILS: I don't have -- if I were at the big level that would -- where I wouldn't even know this stuff, I'd be at much different spot. We work for a firm that was bought by Ingenix which is owned by UnitedHealth.

We don't get involved in anything like that. And there's nobody in our firm who ever sees income of that type.

REP. PALLONE: Okay.

MR. SHEILS: You can only imagine how surprised we were when two years ago we were bought. But they quickly assured us that they wanted us to maintain editorial control of our work to consider our -- continue our 36-year tradition of non-biased, objective, non-partisan way of work.

REP. PALLONE: All right. Thank you.

MR. SHEILS: That's all I'm about.

REP. PALLONE: Now, I appreciate that, thank you.

Mr. Whitfield?

REP. ED WHITFIELD (R-KY): Thank you, Mr. Chairman. And I want to thank all of you on the witness ***panel*** for being with us today. We genuinely appreciate your testimony as all of us attempt to get through this legislation and understand as best we can on what the ramifications and implications of the legislation will be.

We hear a lot of discussion about the public plan, the public option. And I note some of you are opposed to it, some of you support it. What I hear most of all from member of the committee, the concern is that if you have a public plan, many people will leave the private plan, their employer plan, and go join that plan because the cost are lower, which is certainly understandable.

But eventually, you can basically destroy the employer plans, because everyone is going to leave. And then you are in up with one big government plan. And maybe that's okay except the Medicare system can be criticized in many ways, particularly because of the cost escalations.

And I'm saying that because Medicare is basically a U.S. government plan. And if this public option goes the way some people will say, that's going to be a big government plan. And I make one comment.

In 1965, when they started the Medicare program, the Congressional Budget Office did a forecast that in 1990, that plan would cost $9 billion. It turned out to be almost $200 billion by 1990. So that is an astronomical miscalculation.

So Mr. Shea, you represent the AFL-CIO?

MR. SHEA: Yes, sir.

REP. WHITFIELD: Okay. Well, tell me, do you -- the argument that I made that if it's less expensive, more people are going to move over there, and it's going to weaken the private system. Does that concern you, or do you think that that argument has a merit?

MR. SHEA: Well, as I said, Congressman, we start out saying that we need to address cost containment just like others on the ***panel*** said. That's job number one. If we don't control these costs, nothing else is going to be done in health care. So how do you do that? Well, there are several ways to do it, but the public health insurance plan is one.

You can calibrate the rates in the public insurance plan. You could -- this plan ***proposes*** Medicare rates. You could do Medicare plus 10 percent or you could halfway between private. That would all affect this. But the notion is to put some competition in an insurance market that now doesn't display any competition.

What we have are really close relationships, in my view, between insurers and providers. And that's the problem that we have to change. It was what Mr. Conklin was talking about.

We're just trapped by this.

REP. WHITFIELD: Okay.

MR. SHEA: So there maybe -- there are other ways to do it. But this is what the competitive model is.

REP. WHITFIELD: Yeah. Okay, thank you. There are other ways to do it.

And Mr. Reiser, would you make a comment to the argument that I put out there that people are making?

MR. REISER: You know, the concern that we have about the public plan option is Medicare currently underpays, and there is a significant cost shift on to the private employers, which is a big problem in the current system.

A public plan option, we believe, would exacerbate that, particularly a public plan option as outlined in the ***proposal*** that would pay Medicare rates. That would just exacerbate the system.

The second problem that we see with it is if people do leave the employer pool, that is going to weaken our risk pool and leave the higher cost for the remaining employees, and over time will weaken and potentially destroy the employment based system.

REP. WHITFIELD: Yeah. Yes, sir. Mr. Rivera.

MR. RIVERA: Yeah, the -- one of the things that, for example, we have, in New York State, a health care plan which provide health care for health care workers in the greater New York metropolitan area, and we pay at about $8,500 for family insurance.

Upstate New York, we are only one of the insurance company, basically dominates the market. We pay up close to $17,000. So basically the idea of the public plans is to come into market where basically are concentrated by only one insurance company, and there is a case of Maine, New Hampshire, and you could see a high cost areas where basically the lack of competition or -- that basically insurance company don't come into those areas and the cost of health care goes up.

REP. WHITFIELD: Yeah.

Mr. Castellani -- how do you pronounce it?

MR. CASTELLANI: Castellani.

REP. WHITFIELD: Castellani. I know the Business Roundtable is comprised of very large companies.

MR. CASTELLANI: Yeah.

REP. WHITFIELD: But what are your views on the pay or play provisions of this bill?

MR. CASTELLANI: Well, pay or play is almost an academic for -- issue for us, because indeed we are in the surface. All of our members provide health care. And we want to continue providing it.

The problem that we see with the concept of pay or play is that we need to bring into the health care system all those people who are currently not covered or can't afford to be covered, because we are paying for them through the kind of cross-subsidies that Mr. Reiser referred to.

We do not see the merit of forcing companies to buy something that they cannot afford, particularly the small businesses. And so pay or play, we think, can be dealt with if we provide the kind of competition that both Mr. Rivera and I think all of us would agree on. But we think it is best provided through ***reforms*** in the insurance market, because in addition to what Mr. Reiser said, that is the public option plan exacerbates the cost shift.

It potentially erodes our risk pool and leaves -- and causes younger, healthier people to leave quite frankly, who can get a lower premium, but it also does something else that hurts what we all want and we all talk about.

And that is we see much more innovation in terms of delivery, in terms of wellness, in terms of prevention, in terms of quality, in terms of information technology, the kinds of things that will reduce costs and increase quality coming out of the private sector.

We are concerned that a government-run program, as we see now in Medicare and Medicaid, just hasn't -- doesn't have the ability to innovate. So we also lose out on the ability to gain from those innovations.

REP. WHITFIELD: Thank you. I see my time has expired.

REP. PALLONE: Ms. Capps, our vice chair.

REP. CAPPS: Thank you to each of you for your presentations. It has been a good ***panel*** and you waited a long time, many of you, because it's been a very long day of presentations and different ***panels*** on this topic of health care ***reform***.

I have questions for two of you because there is not enough time, only five minutes, and my ***first*** question will be for Mr. Rivera with SEIU.

In your testimony, Mr. Rivera, you expressed that individual responsibility must be augmented by measures to ensure affordability. It seems fair to think that our health care system should meet hardworking Americans halfway.

For this reason, SEIU supports affordability credit for families between 133 percent and 400 percent of the federal poverty line. Why do you believe it's necessary to offer these credits for families up to 400 percent of the poverty level?

MR. RIVERA: Well, part of the problem that we have is the incredible costs of health care these days, and then, for example, in the case of SEIU almost 50 percent of the members of our union basically live on very meager means, less than $35,000.

So when you ***take*** into account on one hand the high costs of health care and the disposable income, you see that basically in order to make it meaningful you'll have to have subsidies.

REP. CAPPS: So for you -- this -- you're talking about your work force?

MR. RIVERA: Yes.

REP. CAPPS: Hardworking men and women with raising their family and trying to have a quality of life in this country, not at all luxurious, but still they are doing essential work in their communities and they should have a decent health care system and so you're paying -- you're wanting to buy that for --

MR. RIVERA: As a matter of fact, the overwhelming majority of Americans who don't have health care coverage, are working people who are -- who make more money than to qualify to Medicaid and are not all enough to qualify for Medicare and then there -- the question that they have here --

REP. CAPPS: Which shows you one of the disparities that the premiums are so expensive that you really, if you're going to have your own private insurance plan, if self-employed or whatever, you have to be upper middle class or wealthy --

MR. RIVERA: That's correct.

REP. CAPPS: -- In order to pay for it and that's one of the major challenges that we face in this country right now. I'm sure you would say that.

Are -- what -- are there some other protections? We're talking about middle class, right, or at least what we want to consider as the middle class, the working class, the hardworking people who keep this country going whether in small businesses or in large companies providing labor or providing management.

What other projections do you believe are necessary to make health care more affordable for the middle class?

MR. RIVERA: Well, I think that --

REP. CAPPS: This is a big question that I want to also move on to another --

MR. RIVERA: I think the fundamental question that we have is that we're spending 17.5 percent of our gross domestic product in health care. I think we do not -- and I think my colleague, Mr. Shea, was talking about it, if we don't resolve the problem of the cost controls, this is -- we're not going anywhere.

REP. CAPPS: I see other people nodding your heads. I mean is this sort of a given that this is one of the major challenges that and one of the reasons that we -- that you're participating is because we need ***reform*** to deal with this in some aspect.

I really -- I appreciate that and you are a very diverse group, I might add. I think there is a quite cross-section here and that's interesting.

I would like to now turn for the last couple of minutes to you, Mr. Sheils. Just some particular questions about what you were talking about. Your analysis suggests that a public option can get lower premiums than private plans.

Some of our colleagues are making the -- come to the conclusion that this disparity that a private plan is not even going to be able to compete with the public option.

Does your model assume that private insurers and large employer purchases are simply price takers with no ability to add value or change behavior in a competitive market? In other words, is it so monolithic in that private world that there is no ability to compete?

MR. SHEILS: Well, we don't conclude that they cannot compete. We conclude that there are only certain types of plans that could compete --

REP. PALLONE: Mr. Sheils, if you want to turn that on and bring it closer to you.

MR. SHEILS: Okay. There are only certain types of plans that could survive and those would be integrated delivery systems like some of the better HMO-type models. A lot of --

(Off mike discussion.)

REP. PALLONE: Out of order.

REP. CAPPS: This is -- I'm sorry. There is a little glitch over here I think.

MR. SHEILS: Fascinating glitch.

(Laughter.)

The -- so we really don't --

REP. CAPPS: Let's not ***take*** that off my time either, okay.

(Laughter.)

MR. SHEILS: I would like to explain that though because --

REP. CAPPS: Please.

MR. SHEILS: -- there are some key issues here. Right now a lot of the insurers get price discounts with providers.

REP. CAPPS: Right.

MR. SHEILS: Having to do with the fact that they make volume discounts. They say to a hospital, I'll bring you all 100,000 of my people for their hospital care if you'll give me a break.

Now, if everybody goes to the public plan and the health plan -- private health plan only has 10,000 people left in it --

REP. CAPPS: well, the public plan is not going to be able to offer that, is it? I mean that's pretty competitive.

MR. SHEILS: I wanted to finish my point.

REP. CAPPS: Sure.

MR. SHEILS: My point is that there is only 10,000 people left in the private insurance plan and they are not going to be able to negotiate discounts that are as deep.

REP. CAPPS: And that's the only --

MR. SHEILS: That's what they can get today.

REP. CAPPS: And that's the only way they can be competitive.

MR. SHEILS: Right. There is --

REP. CAPPS: I would hope that there would be a lot more creativity within the private sector and I will get to you, but I'll own -- but you said I could have a little more time because of that terribly disruptive moment there.

(Laughter.)

Anyway I -- maybe you or someone else would comment about some of the larger markets like Los Angeles, New York City, and private plans bidding below Medicare fee-for-service levels. How do you factor that into them all? And then I'll open it up if there is time.

MR. SHEILS: Well, there are places where there are smaller disparities between Medicare and private. And then there are places where there is much larger disparity.

REP. CAPPS: Well, there is -- that's a hint to some of those private plans.

MR. SHEILS: Really in those areas where you have large disparities we get quite a bit of shake up. In areas where there is little disparity, it doesn't really show us very much of a change.

REP. CAPPS: Some -- another comment on this or the other question.

MR. SHEA: Just on the whole dynamic, I think what's important to bear in mind about the lieu in analysis is that it is based on the prices. Your point is just price ***taking***.

Employers -- and you could ask people on this ***panel***, employers make decisions based on more than price and health care. This is a very important --

REP. CAPPS: And my -- is that a valid point, may I ask --

(Cross talk.)

REP. PALLONE: We've got to move on.

REP. CAPPS: -- for corroboration?

REP. PALLONE: One more, and I think we've got to move on.

REP. CAPPS: Okay. I would hope so. Because I would hope that we would have a little more creativity in the private market. We actually need that competition because this is too big for any one response.

Many of us feel that way and I think that's a feature of the public option is that it will be competition and it will be a competitive marketplace. In my congressional district, it isn't competitive at all. It's rural and there is only one private provider. So, you know, this is a thoroughly needed situation.

I'll yield back, Mr. Chairman.

REP. PALLONE: Mr. Gingery.

REP. GINGREY: Mr. Chairman, thank you.

Let me direct my question to Mr. Castellani of the Business Roundtable. Mr. Castellani, could you explain to us how the public plan ***proposals*** would undermine the private insurance industry that many Americans are very happy with.

And I'm not -- quite honestly I've read some of your testimony and I'm not sure where you are on this public plan ***proposal***. In the interest of full disclosure, I'm concerned about it.

MR. CASTELLANI: It doesn't --

REP. GINGREY: So that's the reason for my question.

MR. CASTELLANI: Yes, sir. What we're concerned about is not that it would undermine, although it would, the private insurance, but it would undermine our ability as employers to provide health care for our employees through the private insurance market.

And it is for the reasons that we have discussed here and it's primarily three. We do agree with competition, but what Congresswoman Capps was addressing is what we think is part of the solution. We need greater competition, but that competition has to be on a level playing field.

If a government plan exists and it has all of the elements of a private plan except it is not required to pay its investors back a fair return on their investment, the taxpayers in this case, then it can and will by definition have a

lower premium cost. So the ***first*** effect is we would lose people who could qualify and would move to that lower premium from our plans.

As a result of that, they will tend to be younger and tend to be healthier employees. Our costs go up, because we would lose that spectrum of our risk pool that allows us to provide an affordable -- affordable product for all of our employers.

REP. GINGREY: Now, you are -- Mr. Castellani, you are speaking from the perspective of the Business Roundtable?

MR. CASTELLANI: From the payers, yes.

REP. GINGREY: From the Business Roundtable?

MR. CASTELLANI: Correct.

REP. GINGREY: And we are talking about the payers and what -- there are probably 270 million lives covered through employer provided health insurance. These -- my numbers here say most of the 177 million Americans who have employer based coverage say they are happy with the coverage they receive.

President Obama, God bless him, has promised to ensure that those folks can keep what they have. I think that is almost a quote. He likes the word "folks." "So folks can keep what they have." I've heard him say it many times. Do you think that the public plan could lead to Americans loosing their current coverage because of an unfair playing field that would be established by a public plan?

MR. CASTELLANI: Yes, I think it runs that risk.

REP. GINGREY: All right. Well, I tend to agree with you. Now, what -- describe for the committee and for everyone in the room, what are some of the unfair aspects that could be attributed to a public plan that we are concerned about, that you are concerned about, that the Business Roundtable is concerned about?

MR. CASTELLANI: Well, as I had answered previously, a lower premium cost would be attractive to some of our own employees for which we provide coverage now. If they leave the system, we have a reduced risk pool and the nature of that risk pool, the nature of our employees, could leave us with a more costly and fewer number of lives to cover.

The second thing that it does is by its design in this draft legislation, it does not fully reimburse for costs. So another large player, in addition to Medicare and Medicaid, that does not fully reimburse for costs gives us a situation with -- if you -- for example, you are a hospital. The government is not going to pay anymore, Medicare and Medicaid is not going to pay anymore, the uninsured can't pay anymore.

There is only one person left paying, and that is the employers. So it exacerbates the cost shift, makes our costs potentially greater rather than what we are all trying to achieve which is more affordable health care at lower cost trajectories than we have now.

The third thing it does is that it hurts us in the long-term. And that is that fundamentally government programs are not able to innovate at the kind of rates and with the kind of creativity that we see in the private sector with competition. And we need that kind of innovation to bring down the trajectory of costs. So it hits us three ways in raising our costs.

REP. GINGREY: Well, I had one more. Mr. Chairman, I can't see the clock. I don't know how long --

REP. PALLONE: I know. It goes going off. Go ahead with your question.

REP. GINGREY: Okay. All right.

REP. PALLONE: Go ahead.

REP. GINGREY: Thank you Mr. Chairman. I appreciate your indulgence.

Just one more question, Mr. Castellani.

Under this bill, I'm sorry -- under this draft ***proposal***, a tri- committee draft ***proposal***, did you see anywhere that describes what would happen if the public plan did not set the premiums and the cost sharing high enough to cover its costs? Was there a provision that describes what happens if the public plan, if their reserves are not high enough for example? And in indeed, was there anything in the draft that describes where those reserves would come from and how they would compare with the reserves that were required of the private insurance -- health insurance plans that they are competing with?

MR. CASTELLANI: I don't believe they were -- at least in my reading of it and the analysis of it, they weren't specified. They say there are reserves. Reserves would be provided for. But the one thing that is missing, even whatever levels they would be provided at and the networks that would be provided at in the public plan -- the one thing that is missing is a fair return on the people who invest in the capital that allows that private -- that public option to exist.

If you don't have that, you always have a cost advantage.

REP. GINGREY: Well, I thank you very much. And I'm sure my time is probably already expired.

Mr. Chairman, thank you for your indulgence. I appreciate and I yield back.

REP. PALLONE: Sure. Thank you. I think we are -- I think that is the end of our questions.

Thank you very much, we appreciate it. I know it keeps getting later. We have one more ***panel***, but -- you may get -- as I think you know, you may get some addition written questions within the next 10 days and we would ask you to get back to us on those. Thank you very much.

And we will ask the next ***panel*** to come forward.

I think our ***panel*** is seated. We'll ask those who are talking in the back to please leave the room. Sirs? Thank you.

And I know the hour is late, but we do appreciate you being here. And I'm told we may also have another vote. So we will see. We will try to get through your testimony.

This is the ***panel*** on "Insurer Views." And beginning on my left is Howard A. Kahn, who is chief executive officer for L.A. -- I assume that is Los Angeles -- Care Health Plan.

MR. KAHN: (Off mike.)

REP. PALLONE: L.A. -- okay.

Karen L. Pollitz, who is project director for the Health Policy Institute at Georgetown Public Policy Institute. Karen Ignagni, who is president and CEO of America's Health Insurance Plans. And Janet Trautwein, who is executive vice president and CEO of the National Association of Health Underwriters.

I don't think I have to tell anyone here that we try to keep it to five minutes. And your written testimony will be included complete in the record. And I will start with Mr. Kahn.

MR. KAHN: Thank you Chairman Pallone. Members of the committee, thank you. The need for national health care ***reform*** has never been greater. As the CEO of L.A. Care Health Plan, America's largest public health plan,

I'm here to provide information about our model and how a public health plan option has worked in California for more than a decade.

L.A. Care is a local public agency and health plan that provides Medicaid managed care services. We opened our doors in 1997 as the local public plan competing against a private health plan, Health Net of California, Incorporated.

L.A. Care strongly supports the concept that public plans can provide choice, transparency, quality and competition. L.A. Care competes on a level playing field against our private competitor. Plans must have enough funding to ensure provider payments and operate under the same set of rules.

L.A. Care has always been financially self-sustaining and has never received any government bailout or special subsidy. L.A. Care serves over 750,000 Medicaid beneficiaries and has 64 percent of the Medicaid market share in Los Angles.

The competition between L.A. Care and Health Net has resulted in better quality and system efficiencies. For example as part of our efforts to distinguish ourselves in the marketplace, L.A. Care attained an excellent accreditation from NCQA, validation that it is possible to provide quality care to the poorest and most vulnerable in our communities.

There are seven other public plans like L.A. Care in California providing health coverage to Medicaid beneficiaries. In all of these counties, the public plans compete against private competitors. Two- and-an-half million Medicaid beneficiaries are provided health services through this model.

California has other public plan models as well. Congresswoman Eshoo, a member of this subcommittee, is very familiar with the enormously successful county organized health system which she and I helped create within her district.

Our provider network includes private and public hospitals and physician groups, nonprofits, for-profits, federally qualified health centers, and community clinics. Our subcontracted health plan partners include some of the biggest private health plans, Anthem Blue Cross and Kaiser Permanente as well as smaller local plans. In addition to Medicaid, L.A. Care operates a CHIP program, a Medicare Advantage Special Needs Program and a subsidized product for low- income children.

What makes L.A. Care a public health plan different? L.A. Care conducts business transparently. We're subject to California's public meeting laws. So all our board and committee meetings are open to the public.

L.A. Care answers to stakeholders, not stockholders. Its 13- member board includes public and private hospitals, community clinics, FQHCs, private doctors, Los Angeles county officials and enrollees. Our enrollees actually elect two of our board members resulting in a strong consumer voice. Part of our omission is to protect the safety net. When Medicaid managed care began, there was fear that FQHCs and public hospitals would lose out.

Through several strategies, over 20 percent of L.A. Care's enrollees have safety net providers as their primary care home. In Los Angeles, large numbers of people will remain uninsured under even the most ambitious health care ***reform proposals***, and the safety net will continue to need our support.

Local public plans like L.A. Care protect consumer choice. Since we started, three private health plans serving this population in Los Angeles have gone out of business. L.A. Care's stability has insured that Medicaid beneficiaries continue to have continuity and choice.

Local plans raise the bar on performance and quality in their local communities. L.A. Care offers a steady calendar of provider education, opportunities that improve provider practices, and quality of care. Our family resource centers serves over 1,200 people a month, most of whom are not our plan members.

While defining a public plan option is still under way, we recommend against creating a monolithic national public plan. Health care is and will continue to be delivered through local markets which vary in terms of population and competition, infrastructure, community need, and medical culture.

California recognized years ago the need to lower costs and improve quality, and developed local public plan options for Medicaid that have been supported by each successive administration, both Democrat and Republican. With regards to the Health Insurance Exchange, L.A. Care supports allowing states to create their own exchange.

We appreciate the recognition that Medicaid beneficiaries have special needs, and so are not included at ***first***. However, we strongly recommend excluding Medicaid beneficiaries completely as they are among the most vulnerable to care for and present unique challenges.

California's local public plans are a successful local model that should be considered. Let's build on what's working in health care and focus on fixing what's broken. Thank you.

REP. PALLONE: Thank you.

Now, let me mention that we do have votes. But I'd like to at least get one or possibly two of the testimony. And so let's see how it goes.

Ms. Pollitz, next.

MS. POLLITZ: All right. Thank you, Mr. Chairman and members of the committee.

First I'd like to congratulate you on the tri-committee draft ***proposal***. It contains the key elements necessary for effective health care ***reform***. And this time I'm sure you're going to get the job done.

The ***proposal*** establishes strong new market ***reforms*** for private health insurance with important consumer protections - A minimum benefit package, guaranteed issue, modified community rating, elimination of preexisting condition exclusion periods. These rules apply to all qualified health benefit plans including those purchased by midsized employers with more than 50 employees.

Today, midsized firms have virtually no protection against discrimination. When a group member get sick, premiums can be hiked dramatically at renewal forcing them to drop coverage. And with no guaranteed issue protection, finding new coverage is not an option.

I commend you for not including in the bill exceptions to the employer non discrimination role that would allow employers and insurers to substantially vary premiums and benefits for workers through the use of so-called wellness programs. Clearly, wellness is an important goal, but ill-advised regulations issued by the Bush administration cynically hid behind it to allow discrimination against employees who are sick through the use of non-bona fide wellness programs that penalize sick people but do nothing else to promote good health.

Another good feature of the tri-committee bill is the requirement of minimum loss ratios of 85 percent which will promote better value in health insurance. The bill grants broad authority to regulators to demand data from health plans in order to monitor and enforce compliance with rules. And it creates a health insurance ombudsman that will help consumers with complaints and report annually to the Congress and insurance regulators on those complaints.

Another key feature in the bill is the creation of a health insurance exchange and organized insurance market with critical support services for consumers. The exchange will provide comparative information about plan choices and help with enrolment, appeals and applications for subsidies. The exchange will negotiate with insurers over premiums to get the best possible bargain, and importantly consumers and employers who buy coverage in the exchange will also have that choice of a new public plan option.

I know you've talked today about the cost containment potential of such an option. It's also important that a public option would offer consumers an alternative to private health plans that for years have competed on the basis of discriminating against people when they are sick.

Just last week, your committee held a hearing on health insurance recessions that discussed people who lost their coverage just as they started to make claims. And at the Senate Commerce Committee hearing yesterday, a former officer of Cigna Insurance Company testified on common industry practices of purging employer groups from enrolment when claims costs get too high. I would like to submit his testimony for your hearing record today.

When consumers are required to buy coverage, having a public option that doesn't have a track record of behaving in this way will give many peace of mind. And I left the rest of my statement in the folder, isn't that terrible? There we are. I got it, I got it. I'm so sorry.

Second, a public plan will promote transparency in health insurance market practices. In addition to data reporting requirements on all plans, with a public plan option, you will be able to see directly and in complete detail how one plan operates. And if private insurers continue to dump risk after ***reform***, it will be much easier to detect and sick people will have a secure coverage option while corrective action is ***taken***.

Mr. Chairman, in my written statement I offer several recommendations regarding the draft bill and will briefly describe just a few of them for you now. ***First***, the benefit package, the benefit standard in your bill does not require a cap on patient cost sharing for care that is received out of network and it really needs one.

Also the benefit standard does not specifically reference as a benchmark the Blue Cross Blue Shield plan that most members of the Congress enjoy. Many have called on health ***reform*** to give all Americans coverage at least as good as what you have. It's not clear whether your essential benefits package meets that standard, but if it doesn't, it should. And if that raises the cost of your ***reform*** bill, it will be a worthwhile investment to raise that standard.

Over the next decade, our economy will generate more than $187 trillion in gross domestic product. And we will spend a projected $33 trillion on medical care. The stakes are high and it is important to get this right.

Second, rules governing health insurance must be applied equally to all health insurance. As drafted in your bill, some of the rules that will apply in the exchange might not apply outside of the exchange. Further, there is no requirement that insurers who sell both in and out of the exchange to offer identical products at identical prices.

If the rules aren't parallel, risk segmentation can continue. As an extra measure of protection, the tri-committee bill provides for added sanction on employers if they dump risks into the exchange and similar added sanction should apply to insurers.

Another problem with non-parallel rules is the exception for non- qualified health benefit plans and limited benefit policies called accepted benefits. Health care ***reform*** is your opportunity to end the sale of junk health insurance and you should do it.

And finally Mr. Chairman, with regard to subsidies, the bill creates sliding scale assistance so that middle income Americans with incomes up to 400 percent of the poverty level won't have to pay more than 10 percent of income toward their premiums. But as charts in my written statement shows, some consumers with income above that level could still face affordability problems, especially those who buy family coverage and baby boomers who would face much higher premiums under the 2:1 age rating. I hope you'll consider phasing out the age rating and also setting an affordability premium cap so that no one has to spend more than 10 percent of income on health insurance.

Thank you.

REP. PALLONE: Thank you. I don't want to cut you short, Mr. Ignagni. So you can all wait until we come back. Hopefully, we won't be too long. I'd say about 20 minutes, 20 minutes or so.

Thank you.

(Recess.)

REP. PALLONE: The hearing will reconvene and we left off with Ms. Ignagni. Thank you for waiting.

MS. IGNAGNI: Thank you very much. Thank you, Mr. Chairman, members of the committee. It's a pleasure to be here and having watched the hearing all day, I just want to congratulate you, it's a wonderfully diverse group of people that you have assembled and you all should be congratulated. It was terrific to watch it.

REP. PALLONE: Thank you.

MS. IGNAGNI: I think in the interest of time, recognizing you have been here all day, I want to make just a couple of points. ***First***, on behalf of our industry, we believe that the nation needs to pass health ***reform*** this year. We don't believe that the passionate debate on which direction or form that should ***take***, should ***take***, in any way, should deter getting this done. It needs to happen.

And to that end, I think it's somewhat disappointing that the focus generally in the press, and here in Washington has been, almost exclusively, on the question of whether to have a government sponsored plan or not.

And I think, in many ways, one could say that it's obscuring the broad consensus that exists and indeed that, I believe, you build on in the legislation in several important areas. ***First***, we see a consensus on improving the safety net and making it stronger; second, providing a helping hand for working families; third, a complete overhaul of the market roles.

We have ***proposed*** an overhaul, you have embedded it in this legislation; we firmly support it and congratulations for it. We think it's time to move in a new direction and we are delighted you are doing that. Next, a responsibility to have coverage; we think that's very important because, in fact, the market and many of the questions today about how the market works today really can't be answered because until Massachusetts pass legislation requiring everybody to participate. The industry grew up with the rules that are no longer satisfactory to the American people and the opportunity to get everyone in and participating is an opportunity to chart a new course.

Next, the concept of one-stop shopping for individuals and small employers; next, investments and prevention in chronic care coordination; next, addressing disparities; bending the cost curve. A number of the witnesses have talked about that today. We believe it's is integral to moving forward. And, finally, improving the workforce, creating new opportunities and ***looking*** at where we have deficits in attending to them.

The committee's draft contains many and all -- actually all of these elements and we commend you for it. Moreover, we feel that we have to seize the moment as a country and build on this consensus that will accomplish what has eluded the nation for more than 100 years, and that is to pass health care ***reform***.

The government sponsored plan shouldn't be a roadblock to ***reform***. And the key concept of introducing a government-run plan is that it would (complete ?) on a level playing field but that's not what would happen. And Mr. Chairman, as I sat here today, I thought of an analogy.

And just to reduce it to a clear and hopefully very direct way to explain our concerns, I want to make an analogy to a race between two people. One that makes the rules and at the same time says to the other competitor, "This is my 50 pound backpack and I want you to carry it."

Cost shifting for Medicare and Medicaid is that backpack for our health plans. And we can't ***take*** it off in this race. The government plan will run without that encumbrance. Moreover, it will add weight to the backpack. We now pay hospitals 132 percent on average, nationally, of costs about 46 percent above Medicare rates.

That has implications for preserving the employer based system. We believe you cannot, under those circumstances, implications for hospitals and physicians who have long expressed concerns about Medicare rates and the adequacy or not adequacy -- not being adequate and the implications for the deficit, which are not being ***taken*** into account.

We believe that the most important message we can convey is that we have tools and skills to provide, indeed we have pioneered disease management and care coordination, we have pioneered opportunities for individuals to be encouraged when their physician finds it acceptable to substitute generic drugs, we are recognizing high quality performance in hospitals and physicians and we're moving down a path of showing results.

Embedded in our testimony are some of those results which are very specific and very measurable about where we are doing and how we are doing a better job. We can help with traditional Medicare, we can bring more of those tools but it -- we hope that you will recognize the 50-pound backpack and the weight, as we explain our concerns with a government sponsored program.

The most important message I can convey to you today is not to let what people disagree on, threaten the ability to pass ***reform*** this year. Our members have ***proposed*** and are committed to a comprehensive overhaul of the current system.

We have appreciated the opportunity to discuss key features of the bill with your staff and we pledge our support to work to achieve legislation that protects consumers and provides health security to patients.

Thank you very much.

REP. PALLONE: Thank you. You know, can you turn your name tag, it's sort of twisted -- (laughs) -- thank you. Thank you.

Ms. Trautwein.

MS. TRAUTWEIN: Well, thank you very much. And being the last witness of the day, I will try to not repeat everything that everyone else has said. What I'd like to do is, you know, I agree with everything Ms. Ignagni has just said except that I do want to say one thing and that is that the details do matter.

And one of the things that our members do for a living is we ***look*** at a lot of the details. And I feel it incumbent to bring up a couple of those, because I think we do need to make sure that we get these things straightened out before we move forward. And I do want to stress that we don't want to not move forward, we want health ***reform*** and we want it done correctly.

But I do want to mention a couple of things to illustrate to you that we've got to get some of these things that may appear to be small straight because they could have huge implications. ***First*** of all, I want to mention the rating provisions in the bill. And I want to stress, I'm not talking about the no preexisting conditions, I'm not talking about the no health status rating, I'm not talking about anything like that. I'm talking about specifically the modified community rating provisions.

Now, currently, the bill uses something called an age band of 2 to 1. I am not going to go on to details about that, except to tell you that it's too narrow. And Mr. Chairman, I would like to use your own state for an example of it being too narrow. New Jersey, this year, recently went to 3.5 to 1 age bands because what they had was too narrow already and it wasn't affordable for people.

The gentleman on the last ***panel*** that talked about New Jersey rates of $13,000 they are in a situation of 2 to 1 age bands and that's one of the reasons why it's too expensive. So we want to make sure that we establish bands that allow wide enough adjustments to make it affordable for more people so that we don't end up losing a lot of the young person participation.

In addition, one of our very specific concerns has to do with the fact that this bill tends to lump all groups that have -- that are what we call fully insured together whether they are a group of 10 people, 50 people or 200 people. And the modified community rating provisions apply to all of them.

Today, groups of over 50, on a gradual basis, use their own claims experience. And when I talk about claims experience, I don't mean prospective health status rating where they fill out a health statement in advance. I mean that the group develops community rates based on the experience of their own group of employees.

It's very cost effective, it allows them to keep their low over time and I would point out this is not a market that has problems today. These are not the people that are knocking on your doors, telling you that they have a problem.

And I would encourage you to not eliminate that ability for them to do that because the rate chart to the employers, the employees in that category will be fairly significant.

I would also like to point out that the grandfathering provisions really need to be improved and there are a couple of areas that I'm thinking are probably just mistakes, it's a draft inside the bill that ought to be changed.

You know, the provision, ***first*** of all, is of too strict for individuals it only allows them to add family members and frequently these policies are reviewed on an annual basis and other minor adjustments need to be made.

For example, a person that has an HAS-qualified plan has a legal adjustment to be made relative to the deductible on an annual basis and the bill doesn't really allow for that.

And then groups, of course, are not really grandfathered, they have a phase-in period over five years and we would be hopeful that groups could keep their coverage longer than that period of time.

The one thing I want to talk about that I don't think anyone else has mentioned has to do with risk adjustment. This is something that we ***look*** at a lot, we are very involved with risk adjustment and reinsurance inside plans to make sure that they are stable.

I'm very concerned that the risk adjustment that is suggested is not adequate for starting up this program. The risk adjustment suggested is more something you would do once your exchange had been in effect for a period of time and it would adjust risk among the plans inside the exchange.

It doesn't account for what's going to happen initially when we have lots of people entering the system many of whom may have serious health conditions. For example, the way that your bill is written today, on day one of guarantee issue every single person in this country that's in a high risk pool will come immediately into that pool. So if we've got to have something to mitigate the cost of those high risks coming in so that you don't end up with something you don't want, which is a pool that results in costs that are higher, instead of lower. And so some -- again, these details are important that we get them straightened out correctly.

I would be remiss if I didn't say something else about the public program. Like many of the people that have talked here today, we are very worried about a government-run public program. I want to talk specifically about the cost shifting.

There are a lot of things that we have -- concerned about but we are -- we do definitely see the impact of cost shifting. You know, we have all heard the statistic but I think it bears repeating again. Almost $1,800 a year for the average family of four is a direct result of today's cost shifting, without a new public program.

And I want to mention one other thing. I see that I am out of time but I want to mention this very quickly. We have heard state premium taxes mentioned here, many times today. But I want to kind of put a face on that because in New Jersey alone state premium taxes are $503 million annually to the state. And they are not dedicated to insurance; they fund other programs.

We have programs in North Carolina, Connecticut, Kentucky, Pennsylvania, and North Dakota that where state premium taxes fund fire firefighter programs. They buy equipment to fight fires.

And so, these funds -- I don't think the states can do without this revenue source, and it's another example of how we are not going to have a level playing field and we need to think this through a little bit more carefully. And I have additional information, but I'm out of time so I will go ahead and stop now.

REP. PALLONE: Thank you and, you know, as I mentioned earlier, I think I did that whatever your written testimony is or, you know, data that's attached to it, we will put it in the record in its entirety.

I wanted to -- let me start with Ms. Pollitz. The discussion draft ***takes*** the step of prohibiting discrimination in insurance based on a person's health status, things such as disability, illness, or medication history.

However, you know, as we are trying to close the door on that with this bill, there are -- some are ***proposing*** others, and I'm not entirely sure what you said but I know that you said that or at least in your written testimony that insurers should -- I'm talking about Ms. Trautwein now -- that the insurers should continue to be able to alter premiums based on a person's past claims experience.

And the way I understand it, that employers will be permitted to change a person's premium not necessarily on their health status but on certain activities like wellness programs and those kinds of things. I don't want to put words in your mouth.

MS. TRAUTWEIN: I will explain, what I meant is that --

(Cross talk.)

REP. PALLONE: Sure, go ahead.

MS. TRAUTWEIN: We are -- we want health status rating to go away --

(Cross talk.)

REP. PALLONE: Right. But you said that the employers --

(Cross talk.)

MS. TRAUTWEIN: We are talking about employer groups where they ***look*** at all of their employees, the identified information --

REP. PALLONE: Right.

MS. TRAUTWEIN: And they calculate what their anticipated claims are for the next year. This is done all the time, and then they figure out how much they need for reserves and things like that and they develop a rate based on their particular group.

And it's a very, very cost effective way of doing it; it results in a lower rates for the employees, not higher that's we were asking for that.

REP. PALLONE: I just want to make sure and I'm not trying to put words in your mouth, Ms. Trautwein. I'm just trying to understand that, yeah, I want you know employers to be able to have wellness programs certainly but it's just -- it just seems to me we have to insure the persons who are, you know, unable to achieve a specific physical or other goal are not penalized and therefore somehow health status comes back again.

But I'm not just talking about Ms. Trautwein's testimony, I am just talking about in general that we are trying to eliminate a lot of these things.

Let me just say to this, Ms. Pollitz. Can you discuss the role of employer wellness programs and what sorts of protections we can be sure to include to promote the positives without allowing this discrimination and what it would mean for people if insurers were able to use claims experience in ratings.

MS. POLLITZ: Sure.

REP. PALLONE: Again, I'm not entirely clear on what Ms. Trautwein was saying so maybe this is not fair but you hopefully between the two of you, you can answer my question.

MS. POLLITZ: Well, I think those are two separate things --

REP. PALLONE: Okay.

MS. POLLITZ: -- so just very quickly on the wellness programs, and you are right, I think there is a lot of interest I mean in Georgetown there are a lot of great programs sponsored walks, time off, free exercise classes in the buildings, stuff like that. So I think there is a great deal of creativity and good intentions and good results in a lot of employer-sponsored wellness programs.

But there are other programs that even ***take*** on the name in-center (ph) care that all they do is just apply health screenings, make you ***take*** certain health tests and if you flunk them, that's it; your benefits get cut, your deductible gets raised or your premium gets hiked, by a lot. And there is nothing else. There's no classes, there is no help, there is no nothing.

So I think a return to the original notion under the old Clinton administration regs for non discrimination established some standards for bona fide wellness programs, you know, some indication that there actually is wellness promotion, disease prevention, activities going on, opportunities to participate, giving employees opportunities to participate that doesn't kind of under the OHI privacy considerations.

Employers are not covered entities under HIPAA privacy rules all that health screen information that goes in people are very worried about that.

And so that's the ***first*** thing. And then whatever rewards there are, I think it's important to just keep that separate from the health plan.

REP. PALLONE: Well, let me -- do you --

MS. POLLITZ: Otherwise it invades.

REP. PALLONE: Do you agree with her, Ms. Trautwein, or -- because if you do, then I don't need to pursue this any longer.

MS. TRAUTWEIN: Well, I sort of agree with her that the plan that she talked about, you know, that doesn't -- it's not a real wellness program, we are not in favor of those, that's not what we are talking about --

REP. PALLONE: Okay.

MS. TRAUTWEIN: We are talking about very unique programs where each person designs their own goals. You know somebody might be in a wheelchair and the other person might be a marathon runner. That would be silly --

REP. PALLONE: Okay. I don't want to prolong it. I think we --

MS. TRAUTWEIN: I think it is a -- it think we agree. But I do think you could have some incentives relative to people meeting their goals that they have established for themselves though.

REP. PALLONE: Okay. Now let me get -- let me ask Karen the second question and then I will quit. Mr. Shadegg, -- no, he is not here, I hate to mention him with his not being here, but I'm -- Mr. Shadegg and others have suggested that it would make sense to allow insurers to get license in one state and sell those licensed products in others.

I have always been worried about that and I know insurance commissioners don't like it. Can you tell me under this new national marketplace, what would your thoughts be on a ***proposal*** like that?

Well, I was going to ask -- did I say Karen, either one of you. I meant Ms. Pollitz, but you can answer it, too Ms. Ignagni.

MS. IGNAGNI: Oh, thank you Mr. Chairman. I didn't mean to step in if you -- I thought you were directing --

REP. PALLONE: No, go ahead. I will ask -- hear from both of you.

MS. IGNAGNI: Actually, just on the last question, I do think there is a combination as you were suggesting. I do think that it makes a great deal of sense to have a permissible corridor of activities that could be done in the context of wellness, and I think you are right to pursue it. There have been some major advances in the employer context that I think we could ***take*** advantage of.

In -- excuse me -- and if you would like Ms. Pollitz --

REP. PALLONE: No, go ahead, you can if -- why don't you start with Karen then we will -- I mean with Ms. Pollitz, and then we will come back to you.

(Cross talk.)

MS. IGNAGNI: I will be happy to answer after she does.

REP. PALLONE: All right.

MS. POLLITZ: Sorry, still in, cross state lines, is that where we were, okay.

REP. PALLONE: Well, is this idea that you would allow insurers to get licensed in one state and sell the products in another. I have always thought that was a dangerous thing. You know she --

MS. POLLITZ: It has been -- the experience has been that that is a dangerous thing. In association health plans, this is where you see this happening a lot, and it is very dangerous and it creates opportunities for --

REP. PALLONE: But in addition, now we have this national ***proposal*** in the drafts and how does that all fit in with that.

MS. POLLITZ: Right. So now you got -- well, now you have got a national ***proposal***. But in your ***proposal***, a requirement to sell anywhere outside or inside of the exchange, the ***first*** requirement that's listed is that you have to be state licensed. So there you still need to -- you need to have the license, you need to work with licensed agents, you need to meet solvency standards. All of those things are established at the state level. You don't need to replace those at the federal level and you haven't in your bill so, but I think you need that close accountability.

So someone needs to be watching them -- watching the health plans all the time otherwise there is great nervousness about selling back and forth. Just the last thing, I would mention and I think it was mentioned in some of the written testimony. I think there maybe a little bit of drafting imprecision about sort of what are the federal rules that apply across the board.

And then what other sort of state rules or rules under the old HIPAA structure that apply and that you probably need to straighten out a little bit in the next draft, but you don't want a situation where a health plan can be licensed in one state and operate under one set of rules, but then be able to sell some where else under a different set of rules.

If your national rules become completely across the board, always the same, you still need to be state licensed, but then this whole notion of selling across state lines I think won't matter.

REP. PALLONE: And if you want to comment on -- (cross talk.)

MS. IGNAGNI: Thank you, Mr. Chairman. I think this is a tremendous opportunity to ***look*** very carefully at the regulatory structure and ***take*** a major leap forward. Having everyone in allows the complete overhaul that is baked in to the ***proposal*** now guarantee issue, no preexisting conditions, no health status rating.

We ought to specify those guidelines at the federal level, have uniformity and consistency, not re-regulate them at the state level which is causing a great deal of confusion now in the market with different -- same function regulated at different levels by different entities.

We should ***take*** this opportunity to make it clear so that consumers can feel protected and know that the health plans will be accountable. We are very comfortable with that, we would have this enforced at the state level, states have done a very good job at maintaining solvency standards, consumer protections et cetera. We think that's the right balance.

We don't believe that and we have some advice in our testimony about the drafting of the legislation in terms of these regulatory responsibilities. We think it's absolutely clear and key for consumers to understand how they will be protected, where they will be protected, and what the standards are.

And we have such duplication and confusion now in the system, it's very, very difficult for consumers to feel protected, so I think this is an opportunity to ***take*** a major step forward and really respond to that.

REP. PALLONE: Okay. Thank you.

Mr. Burgess is next.

REP. BURGESS: Let me just be sure I understand something. Now, the new public government-run program is going to have to be licensed in every 50 -- all 50 states?

MS. : I don't know.

REP. BURGESS: I guess that's a maybe. This new public plan, this new government plan.

MS. POLLITZ: I would defer to your own staff on that, it is a federal program.

REP. BURGESS: Right, Medicare is a federal program, it's not -- it's sold across state lines and it is not -- it's not licensed individually in every state.

MS. POLLITZ: I don't believe -- I don't see the requirement that it has to be licensed by states. It is a federal program.

REP. BURGESS: Right, so it seems to me that if Ms. Ignagni's group wants to develop something that meets certain criteria that it ought to be afforded the same courtesy to be sold in every state.

MS. POLLITZ: Well, I don't know that that's a courtesy, I think it's just an administrative --

(Cross talk.)

REP. BURGESS: The same administrative faculty then. But, then we'll not call it a courtesy. It just strikes me is we've got two sets of rules here. One for the public sector, and one for the private that seems inherently unfair.

This is not what I intended to talk about, but it is just that I am not following, where is the inherent fairness in the -- Ms. Ignagni's already talked about carrying a 50 pound weight on her back, but she's got to carry the freight that -- the cross subsidization from the federal programs.

And the freight they're not paying in the ***first*** place and then on the other hand you're -- are we creating a product that is just by definition she can't compete with it because it is something that can be sold without regard to state insurance regulation.

MS. POLLITZ: No, I think --

REP. BURGESS: Is -- Ms. Ignagni, is that your understanding?

MS. IGNAGNI: I am sorry.

REP. BURGESS: Is that your understanding of this new public plan?

MS. IGNAGNI: I think, I know the remedies. I would yield to counsel, but I understand that the remedies are federal remedies and I think the entity is chartered at the federal level, but I wouldn't want to be presumptuous in that regard. We've --

REP. BURGESS: Ms. Trautwein, you are one of the national organization here what -- do you have an opinion about this?

MS. TRAUTWEIN: Oh, yes, sir. We have a very -- that's why I said in my testimony that we are very concerned about the fact that a playing field would never be level. And one is the payment which I spoke about in my oral testimony, the other is the rules. Its regulation at the state level is what we have to meet. Having state premium taxes, state regulations, state remedies --

REP. BURGESS: Okay.

MS. TRAUTWEIN: -- that's not the way the bill reads at present.

REP. BURGESS: And maybe I'll figure out a way to say this more clearly and submit it -- submit it in writing. Ms. Ignagni, I just have to say, you know, maybe I'm a little bit disappointed after the group of six met down at the White ***House***.

And I know my own professional organization was part of that. And we came out of there with what was it, $1 trillion, $2 trillion in savings over 10 years. And part of those savings was administrative streamlining --

MS. IGNAGNI: Yes, sir.

REP. BURGESS: -- which presumably once -- one claim form instead of 50 or 60 --

MS. IGNAGNI: Yes, sir.

REP. BURGESS: -- which we have to deal with now.

MS. IGNAGNI: Right.

REP. BURGESS: -- I did see it reported, but I am also going to assume that perhaps there is one credential form --

MS. IGNAGNI: Yes.

REP. BURGESS: -- rather than filling out 50 different credentialing forms every January and ***taking*** two or three fulltime equivalence to have them --

MS. IGNAGNI: Exactly.

REP. BURGESS: -- do that in a five doctor practice. Why the hell didn't we do that a long time ago?

MS. IGNAGNI: Well, sir that's a fair point. And we have been working now over a four year period as you probably know, we set up a separate entity to actually ***take*** on this issue of simplification in the way the banks ***took*** on the ATM technology.

We have worked with physicians, we've worked with all, all the specialty societies, we've worked with hospitals, the different types of hospitals to make sure that we were going to get the language right. We have ***taken*** our time doing it to make sure we had that language right in a way that physicians, physician groups, and hospitals felt satisfied that we are actually solving the problem.

So now that we did that we were able to step forward and say we're not only ***taking*** the responsibility of moving forward, we're not going to be doing it voluntarily. We are totally, we're very committed to legislation, we've said that. We want to make sure its uniform across our industry, we're comfortable with that, and we will help you draft it.

REP. BURGESS: Let me ask you this because you -- I mean, you've been up here a long time and you know -- you know the rules we live under for the Congressional Budget Office. And $2 trillion score, whatever it is, over 10 years, Congressional Budget Office was going to ***look*** at that and it says, well, if this is something you were supposed to be doing anyway then we just calculate it into the baseline. And there in fact is no new money to spend, how are you going to deal with that?

MS. IGNAGNI: This is a very important question you are asking. ***First***, until we made the announcement no one said, from our industry that we were going to be regulated for this. That it would be not only committed to legislation, we would support it and help draft it. So that's a material difference, number one.

Number two, for the $2 trillion goal to be achieved as you know well, it's going to ***take*** an interdependence among all the stakeholders to achieve that. There are four key areas of savings that is if we are going to bend the curve as a nation we have to ***take*** seriously.

One is the administrative simplification. We need to make sure that not only everything we've committed to, but where we go in the future is the right direction for hospitals and physicians that they can achieve the intended --

(Cross talk.)

REP. BURGESS: And you have no argument from me about that. I do wonder how we're actually going to get the dollars savings score by -- we all know when we talked about the Medicare prescription drugs rate it's much more cost-effective to treat something at the front end --

MS. IGNAGNI: Yes.

REP. BURGESS: -- than when the target organ is destroyed. And yet the Congressional Budget Office is never going to score that as an actual savings. It actually scores it as an expense because you're going to treating more people by virtue of the fact you're treating disease at an earlier point.

MS. IGNAGNI: Well, we have some ideas on both. Let me just quickly --

REP. BURGESS: Well I've a -- we're running out of time -- I am going to submit some other questions in writing. I would just say this, I mean you see what a fluid situation it is --, and please forgive me Mr. Chairman just close your ears for a minute, pay no attention to the man behind the curtain.

Things are in such flux, don't be quick to give things up. By all means work with us, but don't go to the White ***House*** waving the white flag as the ***first*** volley. That's a -- in fact, it can be counterproductive, just my opinion. I'll return it to the chairman.

MS. IGNAGNI: Sir, if you allow me to answer just, Mr. Chairman just a quick point.

REP. PALLONE: Sure.

MS. IGNAGNI: -- I'd be delighted to -- you've asked some very important technical questions, I'd be delighted to submit that for the record. But you've asked, now, the last point you've made is a more of a -- in the category of a right road, wrong road. So let me give you a very direct answer.

If you ***look*** at the Council of Economic Advisers report, unless we truly bend the cost curve in a sustainable way, not only will we not be able to afford the new advances we want to make in getting everybody covered, we won't be able to afford the current system.

We participated in an effort with the hospitals, the physicians, as you know, with the SEIU, with pharma and the device companies to ***take*** our seat at the table, to say as stakeholders, as private sector entities, we could ***take*** part of the responsibility of stepping up and saying we have skills, we can bring to the table to get this problem solved. That's what our plans do, that's the point that we are making here.

Ms. Capps had asked a question earlier to Mr. Castellani about what is the legacy of the private sector. The legacy of the private sector is that we have brought disease management care coordination. We're now recognizing physicians and hospitals as you know recognizing high quality performance. We have bought the skills to do that.

Patient decision support, personnel health records helping physicians not have to sort through loads of paperwork. We are proud of that. We've pioneered those tools, we are implementing it. And similarly with administrative simplification we are the key domino to make that happen. We've ***taken*** that very seriously which is why we participated in this effort to try to contribute to this major goal.

REP. PALLONE: It sounds like a good --

(Cross talk.)

REP. BURGESS: Briefly reclaiming my time. It is not as if there have --

REP. PALLONE: You don't have any left.

REP. BURGESS: -- not been people willing to work with you on that for the last seven years that I have been here.

MS. IGNAGNI: Yes, sir.

REP. BURGESS: And I just cannot tell you how distressed I am that there was never this willingness to work when our side was in power, when a different president was in the White ***House***. I feel personally affronted by this.

And it is ironic that you were just at the point now where your industry is going to be delivering on the promise that we all knew it could do. And I don't know what the future holds for you because there are many people and we've heard it over and over again in this committee, in this week that a single payer system is what is down the road for the United States of America.

REP. PALLONE: All right, let's get moving.

REP. BURGESS: -- and all of the things that you've done with care coordination, disease management that maybe something you've developed only to find this never really fully implemented --

REP. PALLONE: All right.

REP. BURGESS: -- and used in the private sector.

REP. PALLONE: All right, Dr. Burgess.

REP. BURGESS: But that's okay, we could have done a much better job with this. I'll yield back. Thank you.

REP. PALLONE: I don't want to be tough because I kind of liked the dialog, but we need to move on.

Ms. Capps.

REP. CAPPS: I find it interesting too, but I really want to commend you all for the last ***panel*** of the day and think there is -- ought to be some kind of medal. Did we design medals for the last ***panel***, we should have. This is our fourth day of hearings too so if we seem a little kind of flat, you'll understand I hope.

But this is the one I wanted to stay for, particularly because you're so key, you and what you represent to us getting this right and that is the goal and that is exactly where we all are.

And Ms. Ignagni, I appreciate your ***taking*** us down saying we've got so much we can agree on unless -- at least to agree, we don't agree. I don't agree with you on many things and you know that, but that's okay, we can talk.

I want to tell you Ms. Pollitz, you hold the bar very high and we are going to try to get as close as we can to the standards you're giving us. And believe me, I have constituents who are reminding me of that every single day when I go home which is a good thing. This is all across the map, but everybody's attention is now focused on health care and I salute that it's about time.

Mr. Kahn, I am -- a suburb -- I have suburban counties that are north of your region, but I am a big fan, as you know, because now, I can boast that each of the three counties --I represent part of the three -- now has a county-operated program. And that yesterday, we were able to get Mr. Freeman who speaks very highly of you to testify as a provider, it's now called CenCal, it used to be Cen (ph).

And they were one of the ***first*** to get a waiver and there are some really exciting options that can be brought to the table now, call them what you want, but they are going to help us deliver care. I have a tough -- I want to share what it's like to be member of Congress and have the phone ring and hear a story and you know this. But I just want to bring it out and make sure that it's on the record.

This ***panel*** gives me the chance to relate the story of a constituent whose situation really illustrates why we need to bring honest competition into the insurance market. I have a -- I represent a little town called Carpinteria, a rural part of Santa Barbara County.

A young woman is -- a good member of a non -- a part of a nonprofit community organization. She has a 12-year-old daughter who was born with spina bifida and needs surgery to replace a stent in her brain.

Her mother's income places her mother just over the threshold to -- she's not able to qualify for Medicaid, we call it the healthy families, the SCHIP expansion in California. Though her mother's employer does provide coverage, the young girl is covered under the plan, but this plan specifically states that it will not cover the surgery she needs for her life because spina bifida is a preexisting condition.

Ms. Ignagni, I am going to start with you. I'd like to have comment for as much time as I have and I don't want to go overtime. But this plan that this mother has in rural parts of my district there are -- there is one option in much of it,

one private plan and there are at most in Santa Barbara County I think two maybe three at the moment. So she can't shop around very much.

She called my office because she's beside herself. This denial is for a condition that this young woman was born with and this surgery is needed to relieve the pressure of fluid on her brain. And people have been talking about preexisting conditions in the private sector for a very long time, this is real time, this is happening today in my constituency.

MS. IGNAGNI: And Ms. Capps, I think there is no legitimate answer to your question, but to say this is why we've worked so hard to ***propose*** change and the comprehensive ***proposal*** --.

REP. CAPPS: But it hasn't happened yet.

MS. IGNAGNI: It has not happened yet because we have a system now where people purchase insurance if they are doing it individually when they feel --

REP. CAPPS: No, this is part of her employment, but let me --

MS. IGNAGNI: If it's part of an employer then the guarantee issue is --

(Cross talk.)

REP. CAPPS: -- a nonprofit organization with very minimal amount that they can spend for employee covered care, but let me see what some other comment is.

Maybe, Mr. Kahn, what would -- if this young mom was working for this nonprofit, which abounds in Los Angeles as well, what option might she have?

MR. KAHN: Well, Congresswoman, and by the way you have a beautiful area that you cover, your district is beautiful. And you did have the ***first*** of all of the county organized health systems there.

The problem is a structural one, which is that the way our regulations and our markets are set up right now that an individual or if they are in a very small group perhaps because usually preexisting conditions are not excluded from group coverage. It maybe such a small group however that it is that could be the --

REP. CAPPS: Less than 10 employees.

MR. KAHN: -- without knowing situation that could be the case. And there is -- under the current system, to be perfectly honest with you, there is no good answer for that situation for the individual or in a small group like that. That's the problem with the system right now and why I think we all agree we have to change this system. Now, depending on her income level it's possible --

REP. CAPPS: Not very high.

MR. KAHN: Not very high. They could actually become eligible for Medicaid if they spend down enough depending on what her income level is.

REP. CAPPS: That's a pretty big price to pay.

MR. KAHN: And its a very big price to pay, but that's the problem is that we have a broken system right now that needs to be fixed and that's why we are all here because of those kinds of situations covered, but not covered is --

(Cross talk.)

REP. CAPPS: Do you see our ***reform*** legislation being a remedy?

MR. KAHN: That -- absolutely, I think that the solutions that are being addressed --

REP. CAPPS: From both the private sector and this public option of course.

MR. KAHN: Well, I think that what we are talking about is ***reform*** of the rules around coverage. And indeed you would accomplish that because once everyone's covered then the preexisting conditions' issue should really go away. The problem, right now, is that -- and we don't do individual coverage, we serve only low income people of course --

REP. CAPPS: Right, right, right.

MR. KAHN: -- but the problem with the system right now is that where people are not covered they decide once they get sick they need coverage and that's why there is underwriting. I am not defending it, its just -- there are no bad guys in this -- in this play unfortunately, its bad structure, its a bad system.

REP. CAPPS: Right, which is why it calls for intervention from us. Would you -- I mean I am not ***looking*** for support for that, but -- and I applaud -- this is finally the moment that every, all the stars are aligned, I think we could all agree that we are going to -- not everybody is going to be maybe pleased with the outcome, but we're going to make progress. And I am just so hopeful that we can do it in a very bipartisan way.

MS. IGNAGNI: And Ms. Capps, I would be happy if you think it appropriate to help with your office and see if we can ***look*** into the case and see if there's anything that can be done. I would be delighted -- as a mother, I would be delighted to do that.

REP. PALLONE: Thank you.

Mr. Whitfield.

REP. WHITFIELD: Thank you, Mr. Chairman, and thank you all for your testimony. One of the common reasons given for having a public option is the fact that there is not a competition and particularly in rural areas. And there's probably an obvious reason for this that I don't understand.

But in the prescription drug benefit under Part D of Medicare, in my rural district of Kentucky there were like 42 different plans offered to Medicare beneficiaries. So why are there so many plans offered under the prescription drug benefit, but not plans competing with each other and other sector? Would someone answer that for me?

MS. POLLITZ: Prescriptions are a little different, just because you don't need the provider network. I mean, if there are pharmacies near by or even mailer to pharmacy, it's easier to ensure the class of prescription drugs --.

REP. WHITFIELD: So it is just the fact that there is a lack of a provider network and putting that together is so difficult.

MS. POLLITZ: I would expect -- I'm not familiar with your district but that would -- prescriptions are more kind of a national market than other health care.

REP. WHITFIELD: Okay.

MS. IGNAGNI: I think, Mr. Whitfield, one of the things that we have observed is that often there are products available, but in -- particularly in rural areas if they, individuals don't have a broker for example, they haven't been presented with the information they don't know where to go.

Which is why one of the ***first*** things that we've suggested is this concept of having an organized display on a site, it could be a state site, of the health plans that are available in every part of every state.

REP. WHITFIELD: Right. Okay.

MS. IGNAGNI: An organized, and so people can understand what is available.

REP. WHITFIELD: Okay.

MS. IGNAGNI: That would be, I think, a major step forward.

REP. WHITFIELD: Mr. Kahn, would you want to say something?

MR. KAHN: Thank you, Congressman. I would just add that the challenge in rural communities, beyond the pharmacy situation is that if you are the one hospital in town, you probably don't have to negotiate.

REP. WHITFIELD: Yeah, right.

MR. KAHN: So, it's not very attractive for a health plan and that is why you don't have competition. Now, I will say though that in California, we have a number of our public plans that compete with private plans, and some of those are in rural areas as well; Kern County, for example.

And so there is competition, but again, it's -- by the nature of that market, because all health care is local, still. And it probably will be for the most part under the ***reform***. And so, it depends on that market.

REP. WHITFIELD: Ms. Ignagni and Ms. Trautwein, you are both involved in associations that represent companies that I'm sure provide a lot of group insurance plans to rather large employers. Are you at all concerned that employers, because of this public option being available, might just say, you know, to save money, we are just not going to provide health insurance anymore?

MS. IGNAGNI: We are concerned about that, sir. And we are also concerned about employers seeing the differences in the numbers, as I indicated in my oral testimony, that there would be very little available or left in the private sector because the incentives are so compelling.

And I think that there is a strong value in having the best of both; doing a better job and the safety net, and then doing a better job, as we've talked about, improving the rural --

(Cross talk.)

REP. WHITFIELD: But does this draft bill provide the protection that is necessary to protect the private sector?

MS. IGNAGNI: Well, I think that it's not. We are concerned as we indicated that we would not see a private sector sustained, because the playing field isn't level. If you pay at Medicare rates it's such a major differential that that is -- there is no way to sustain a private sector.

REP. WHITFIELD: Okay.

MS. POLLITZ: But Congressman, just to add. Under the bill, if an employer buys through the exchange they have to agree to let their employees pick the plan. And if they elect not to offer coverage and to pay the fee then the employees still get to pick the plans.

So, there is no sort of -- there is no way that employers can opt to put people in any of the plans available in the exchanges. It's always up to the individuals.

REP. WHITFIELD: Are you saying that employers cannot just decide to refuse or to offer the plan?

MS. POLLITZ: Employers ***first*** make an election, are they going to play or pay, are they going to offer a plan or are they going to pay.

And if they are outside of the exchange, they could offer a plan and they would only have the choice of buying private plans. And then, if they come into the exchange, they -- it becomes kind of a defined contribution, but the employees get to pick the plans.

REP. WHITFIELD: Yes.

MS. POLLITZ: -- which -- that are offering between public and private.

REP. WHITFIELD: Ms. Trautwein?

MS. TRAUTWEIN: I just wanted to add to that, that there is language in the bill that after a period of time even employees that are part of a program, where there is an employer sponsored plan can elect to spin off of that plan to go into the exchange.

This is a direct threat to employer sponsored coverage. And we are very concerned about this because you have to maintain a decent participation level inside an employer group to have that balance of risk that I was talking about earlier. So I think that that is something that we should really ***look*** at whether that is a good idea to keep that in the bill language.

REP. WHITFIELD: Yeah. I guess my time has expired.

I was only -- can I just ask one other question. I know you've been here for hours, but just one other question. Ms. Trautwein, in your testimony you talked about, it's critical that there would be a financial backstop to accompany ***reforms*** of the individual and group insurance markets. And I was curious -- then what do you mean precisely by backstop?

MS. TRAUTWEIN: Well, it could ***take*** many different forms. It's kind of what I talked about earlier, this idea of reinsurance. You know, some states today use a high risk pool to backstop. They are individual market, but it doesn't have to be that. It's just something to make sure that we address the cost of high risk individuals.

This is a particular problem during the ***first*** five years. I'm guesstimating that amount, because it is going to ***take*** us awhile to get the hang of this individual mandate and enforcing it. We won't have everybody in overnight. And so there will still be initially adverse selection, the same that we have today in this market.

And we've got to do something to make sure that those high cost cases don't make the cost of coverage go up for everybody else. So, we are not trying to wreck the ***proposal***. We are saying you need to add this thing in here, to stabilize your ***proposals*** so you will not have these unintended consequences.

REP. WHITFIELD: Thank you, Mr. Chairman.

REP. PALLONE: Thank you. And I know different members mentioned that they were going to submit written questions. And we asked them to get them to you within the next 10 days or so and get back to us as soon as you can.

MR. : Mr. Chairman, I was also supposed to ask unanimous consent that the Blue Cross and Blue Shield data be made part of the record.

REP. PALLONE: Yeah, let me see it. I have something too here. I sure am glad you mentioned that. I almost forgot.

So you have -- what is this Blue Cross Blue Shield you called it?

MR. : Yes, Ms. Fox testified to -- as part of her testimony.

REP. PALLONE: I'm told that it already has been, but if it hasn't then we will do it. And I also have to submit for the record this study by Health Care for America Now, showing that 947 of the -- 94 percent of the country has a highly concentrated insurance market. This is from the American Medical Association. So without objection, we will enter both of these in the record.

Thank you very much. I thought that this was very worthwhile -- it's a complex issue. But we appreciate your input and your optimism as well, very important. So thank you very much. And the three-day marathon of the subcommittee is now adjourned. Without objection is adjourned. (Sounds gavel.)

Classification

Language: ENGLISH

Publication-Type: Transcript

Subject: EXECUTIVES (95%); ASSOCIATIONS & ORGANIZATIONS (92%); HEALTH CARE ***REFORM*** (90%); NURSES & NURSING (90%); HEALTH CARE POLICY (90%); PHYSICIANS & SURGEONS (90%); US FEDERAL GOVERNMENT (89%); PUBLIC POLICY (89%); MEDICARE (89%); NATIONAL HEALTH INSURANCE (89%); HEALTH DEPARTMENTS (89%); TESTIMONY (89%); INSURANCE ASSOCIATIONS (78%); PUBLIC HEALTH (78%); ETHICS (78%); FAMILY (78%); PHARMACISTS (78%); PUBLIC HEALTH ADMINISTRATION (77%); DISEASES & DISORDERS (76%); ECONOMICS (75%); CARDIOLOGY (71%); COMMUNITY HEALTH PROGRAMS (70%); BUSINESS ETHICS (70%); BUSINESS & PROFESSIONAL ASSOCIATIONS (70%); SMALL BUSINESS (65%); PHARMACEUTICALS ASSOCIATIONS (52%)

Company: XEROX CORP (93%); BLUE CROSS & BLUE SHIELD ASSOCIATION (93%)

Organization: NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS (91%); AMERICAN NURSES ASSOCIATION (91%); AMERICAN COLLEGE OF CARDIOLOGY (91%); AMERICAN ACADEMY OF FAMILY PHYSICIANS (91%); AMERICAN HEALTH CARE ASSOCIATION (91%); US DEPARTMENT OF HEALTH & HUMAN SERVICES (91%); NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS (84%); BUSINESS ROUNDTABLE (84%); AMERICA'S HEALTH INSURANCE PLANS (84%); AFL-CIO (84%)

Ticker: XRX (NYSE) (93%)

Industry: HEALTH CARE ***REFORM*** (90%); NURSES & NURSING (90%); HEALTH CARE POLICY (90%); PHYSICIANS & SURGEONS (90%); INSURANCE UNDERWRITING (89%); INSURANCE (89%); MEDICARE (89%); HEALTH INSURANCE (89%); NATIONAL HEALTH INSURANCE (89%); HEALTH DEPARTMENTS (89%); INSURANCE ASSOCIATIONS (78%); FAMILY PRACTICE (78%); PHARMACISTS (78%); ACADEMIC MEDICAL CENTERS (78%); PHARMACIES & DRUG STORES (76%); HOSPITALS (76%); CARDIOLOGY (71%); CLINICS & OUTPATIENT SERVICES (70%); PHARMACIES (67%); RETAIL PHARMACEUTICALS (54%); PHARMACEUTICALS ASSOCIATIONS (52%)

Person: FRANK PALLONE JR (89%); BARNEY FRANK (58%)

HEARING OF THE HEALTH SUBCOMMITTEE OF THE HOUSE COMMITTEE ON ENERGY AND COMMERCE; SUBJECT: COMPREHENSIVE HEALTH REFORM DISCUSSION DRAFT, DAY THREE; CHAIRED BY: ....

Geographic: NORTH DAKOTA, USA (79%); NORTH CAROLINA, USA (79%); CONNECTICUT, USA (79%); KENTUCKY, USA (79%); NEW JERSEY, USA (79%); DISTRICT OF COLUMBIA, USA (79%); UNITED STATES (97%)

Load-Date: August 12, 2009

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