CALL TO ACTION
HEALTH REFORM 2009
SENATE FINANCE COMMITTEE CHAIRMAN MAX BAUCUS (D-MONT.)

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U.S. Senator Max Baucus (D-Mont.)
Chairman, Senate Finance Committee

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REFORMING AMERICA'S HEALTH CARE SYSTEM: A CALL TO ACTION

It is the duty of the next Congress to reform America's health care system. In 2009, Congress must take up and act on meaningful health reform legislation that achieves coverage for every American while also addressing the underlying problems in our health system. The urgency of this task has become undeniable.

In preparing to act, I led the U.S. Senate Finance Committee in holding nine hearings on health care reform this year and hosted a day-long health summit in June 2008 to explore in greater depth the problems plaguing our health system. I have spent a good deal of time talking to colleagues on both sides of the aisle and to stakeholders in the health care industry to get their perspectives on the issues that matter. And perhaps most importantly, in listening sessions across the state of Montana, I have heard from many Americans about the challenges so many patients and families face in getting access to affordable health coverage and paying medical bills.

This paper — this Call to Action — represents the next step. It is not intended to be a legislative proposal. Nor is it an exhaustive exploration of every health care issue that should or needs to be addressed, or that will be considered. Rather, it details my vision for health care reform. The plan outlined here addresses health care coverage, quality, and cost. Many components would require an initial investment but, over time, would vastly improve the quality of the health care that Americans receive and reduce the cost of that health care, ultimately putting our system on a more sustainable path. The policies in this paper are designed so that after ten years the U.S. would spend no more on health care than is currently projected, but we would spend those resources more efficiently and would provide better-quality coverage to all Americans.

The health system is so complex that any solution will demand time and attention to make sure that we get it right. This plan is most certainly a work in progress. But this Call to Action is intended to encourage constructive input by policymakers, stakeholders, and health policy thought leaders to move us forward. I look forward to discussing this plan with President-Elect Obama, with my colleagues in Congress, and with stakeholders in the health care system, working collaboratively with all to enact effective health reform.

Americans who care deeply about the future of our health system and our economy must take up the fight together for comprehensive health care reform. My door is open and I seek partners with "can do" spirits and open minds. I believe — very strongly — that every American has a right to high-quality health care through affordable, portable, meaningful health coverage. And I believe that Americans cannot wait any longer.

Max Baucus
Chairman
U.S. Senate Committee on Finance

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EXECUTIVE SUMMARY

The link between health care costs and the economy is undeniable. Reforming the health care system is essential to restoring America's overall economy and the financial security of our working families.

The case for reform is strong. The U.S. is the only developed country that does not guarantee health coverage for all its citizens, with 46 million uninsured and another 25 million underinsured. As a result, families are struggling to keep up with out-of-pocket costs for medical care. American businesses are straining to absorb rising health care costs while staying competitive at home and around the world. Despite high levels of spending on health care, research documents poor quality of care received by patients in the U.S. Studies show, for example, that adults receive recommended care for many illnesses only 55 percent of the time. Children fare even worse.

Americans are acutely aware of problems in the country's health care system, and they are ready for change. They are not alone. The nation's health care stakeholders — consumers, businesses, labor, providers, plans, manufacturers, and state and local governments — are signaling that they are ready and willing to engage in serious and comprehensive reform of a health system in crisis. They recognize that the status quo of high costs, unacceptable numbers of the uninsured and underinsured Americans, and far less than optimal quality and value is unsustainable and intolerable. And, notably, the nation's economists concur that system reform is not only necessary to rationalize our health care system, but to sustain our economy, our ability to compete internationally and, over the long haul, to deal with our long-term fiscal challenges.

A high-performing health care system would guarantee all Americans affordable, quality coverage no matter their age, health status, or medical history. Today, the costs of care for the uninsured are largely borne by those with insurance; providers charge higher prices to patients with private coverage to make up for uncompensated care, and these costs are passed on to consumers in the form of increased premiums. Requiring all Americans to have health insurance will help end the shifting of costs from the uninsured to the insured.

Covering all Americans would also ensure that the insurance market functions effectively. Insurance works because policyholders pay into their plans when healthy, and have their medical bills paid when they are sick. If a significant portion of Americans does not purchase coverage until sick, then premiums for all enrollees will increase to cover insurer outlays, and the problem of unaffordable coverage will persist. Finally, covering all Americans is essential to effective prevention and wellness efforts and managing chronic illnesses. Efforts to guard against and better manage illness are an effective tool to improve health and contain costs but, without every American in the system, those efforts will fall short of their full potential.

In a high-performing health care system, employers, individuals, health providers and plans, as well as government would all bear responsibility and contribute to fulfilling the goal of covering all Americans. Wellness and prevention would be prioritized. And

increased quality would result in lower costs so that employers could afford to continue to offer health coverage and still compete in a global marketplace. Our public health programs would be on a more fiscally sustainable path. Ensuring that every American has coverage would make health care truly portable, so that Americans are no longer locked into a job based on a need to retain their health coverage. This Call to Action outlines a vision for creating that high-performing health care system.

Like a sturdy stool, the Call to Action has three equally important legs: (1) a policy that ensures meaningful coverage and care to all Americans; (2) an insistence that any such expansion be coupled with an emphasis on higher quality, greater value, and — over time — less costly care; and (3) an absolute commitment to weed out waste, eliminate overpayments, and design a sustainable financing system that works for taxpayers as well as for the nation's recipients and providers of health care.

Ensuring Health Coverage for All Americans. The Baucus plan would ensure that every individual can access affordable coverage by creating a nationwide insurance pool called the Health Insurance Exchange. Those who already have health coverage could keep what they have. But for those who need affordable, guaranteed coverage, the Exchange would be a marketplace where Americans could easily compare and purchase the plans of their choice. Private insurers offering coverage through the Exchange would be precluded from discrimination based on pre-existing conditions. Premium subsidies would be available to qualifying families and small businesses. By making health care more affordable and universally available to all Americans, the Baucus plan would take a major step toward eliminating racial and ethnic health disparities.

While the Exchange is being created, the Baucus plan would make health care coverage immediately available to Americans aged 55 to 64 through a Medicare buy-in, and it would begin to phase-out the current two-year waiting period for Medicare coverage for individuals with disabilities. The plan would provide every American living below the poverty level with access to Medicaid. This policy is consistent with the original intent of Medicaid, and it is the quickest and most cost-effective way to cover every American living in poverty. The Baucus plan would also ensure that all states use the State Children's Health Insurance Program (CHIP) to cover children at or below 250 percent of the Federal poverty level, putting help within reach for more needy children. Finally, recognizing that America cannot keep its promise to provide care to Native Americans and Alaska Natives with the current level of Indian Health Service (IHS) funding, the Baucus plan calls for additional funding for IHS.

Once affordable, high-quality, and meaningful health insurance options are available to all Americans through their employers or through the Exchange, individuals would have a responsibility to have health coverage. This step is necessary for insurance market reforms to function properly and to end the cost shifting that occurs within the system. It is expected that the vast majority of American employers would continue to provide coverage as a competitive benefit to attract employees. Except for small firms, employers that choose otherwise must contribute to a fund that would help cover those who remain uninsured.

The Baucus plan would immediately refocus our health care system toward prevention and wellness, rather than on illness and treatment. Those who are uninsured — and therefore less likely to receive preventive care and treatment for major conditions — would be given a "RightChoices" card that guarantees access to recommended preventive care, including services like a health risk assessment, physical exam, immunizations, and age and gender-appropriate cancer screenings recommended by the U.S. Preventive Services Task Force. Individuals without private coverage and not eligible or enrolled in a public health coverage program, but whose RightChoices screening detected and diagnosed one or more of the most common, costly chronic conditions, would qualify to receive treatment on a temporary basis until viable coverage options are available under the Health Insurance Exchange. Current Medicare, Medicaid, and CHIP beneficiaries would receive recommended preventive services with little or no co-payment. Preventive services would be covered by all insurance options offered through the Health Insurance Exchange.

Improving Health Care Quality and Value. Recognizing that any attempt to cover the uninsured and reduce health care spending must address the perverse incentives fostered by current payment systems, the Baucus plan includes delivery system reforms that would improve quality and, over time, lower costs. The plan strengthens the role of primary care and chronic care management. Primary care is the keystone of a high-performing health care system. Increasing the supply and availability of primary care practitioners by improving the value placed on their work is a necessary step toward meaningful reform.

The plan would refocus payment incentives toward quality and value. Today's payment systems reward providers for delivering more care rather than better care. A redefined health system would realign payment incentives toward improving the quality of care delivered to patients. Fixing the unstable and unsustainable Medicare physician payment formula is a necessary step in this process. The plan would promote accountability and coordination among providers by encouraging providers in different settings — physician offices, inpatient hospitals, post-acute care settings, and others — to collaborate and provide patient-centered care in a way that would improve quality and save money.

To facilitate the proposed delivery system reforms, the Baucus plan would improve the health care infrastructure by investing in new comparative effectiveness research and health information technology (IT). Health IT is needed for quality reporting and improvement and to give providers ready access to better evidence and other clinical decision-support tools. Reinvesting in the training of a twenty-first century health care workforce is necessary for many delivery system reform goals to be realized.

Achieving Greater Efficiency and Sustainable Financing. The U.S. spends $2.3 trillion per year on health care, and economists warn that rising health care costs represent a serious threat to our long-term fiscal security. According to the Congressional Budget Office, up to one-third of that spending — more than $700 billion — does not improve Americans' health outcomes. Excess spending must be eliminated and dollars put to better use, not only to correct the imbalances of the current health care system, but to offset the high costs of much-needed comprehensive reform.

Beyond measures to refocus the system on primary care, reward quality care, and invest in critical research and technology, the Baucus plan would endorse direct steps in five additional areas to curb excess health care spending. The plan would invest more to detect and eliminate fraud, waste, and abuse in public programs. The plan would address overpayments to private insurers in the Medicare Advantage program. The plan would increase transparency of cost and quality information and would require disclosure of payments and incentives to providers by drug or device makers that may lead to biased decision-making. The plan also considers careful reforms of medical malpractice laws that could lower administrative costs and health spending throughout the system, while ensuring that injured patients are compensated fairly for their losses.

Long-term care services and supports are both a significant share of national health expenditures and a driver of cost. Considering policies to shift the focus from institutional care to services provided in the home and community could improve the quality of care delivered and reduce costs. Finally, the plan would explore targeted reforms of the tax code to make incentives more efficient, distribute benefits more fairly, and promote smarter spending of health care dollars by consumers themselves.

Conclusion. I believe it is the duty of the next Congress to reform America's health care system. In 2009, Congress must take up and act on meaningful health reform legislation that achieves coverage for all Americans while also addressing the underlying problems in our health system. The urgency of this task has become undeniable.

In the short term, health care reform would cost taxpayers more than the government can achieve in savings from all reforms and financing changes. Congressional leaders and the public must be realistic about the timeframe in which the fiscal success of reform is measured. If we fail to act, however, we will double our current national expenditure on health care from $2 trillion to $4 trillion, continue to witness the plight of tens of millions of our citizens without health insurance cost shifting to those who do, continue to tolerate poor quality that leads to nearly 100,000 deaths a year, and watch our businesses become less competitive and our nation go further into debt. In short, we all must realize that the costs of inaction, both in human and financial terms, will eventually be far greater than any initial outlays. We must choose to invest now in a health care system that will richly repay the nation with greater health and economic stability in the long term.

CHAPTER I THE CASE FOR REFORM

At a day-long health reform summit hosted by the Senate Finance Committee this year, Federal Reserve Chairman Ben Bernanke said, "Improving the performance of our health-care system is without a doubt one of the most important challenges that our nation faces."[1] With a world financial crisis demanding a significant investment of government resources, some have asked whether the time is right for a large — and likely expensive — effort at comprehensive health care reform in the United States. But the link between health care costs and the economy is incontrovertible. Health care reform is not a distraction from addressing our economic challenges; health care reform is an essential part of restoring America's overall economy and the finances of our working families.

Health care concerns are closely tied to economic anxiety. Sixty-two percent of voters in the 2008 elections agree that it is more important than ever to take on health care reform in light of the economic downturn.[2] This moment in history is not unlike that faced by President Franklin D. Roosevelt and the New Deal generation as they sought a path out of the Great Depression. Now, as then, solving America's economic challenges will require a multifaceted response. Reforming the nation's health care system will be an essential part of shoring up the nation's long-term economic strength.

The key challenges facing our health care system are lack of access to care, the cost of care, and the need for better-quality care. Each of these challenges has a direct effect on family budgets, on U.S. businesses, on government spending, and on the country's ability to compete globally. A better understanding of each of these key issues demonstrates the need for immediate action by the next Congress.

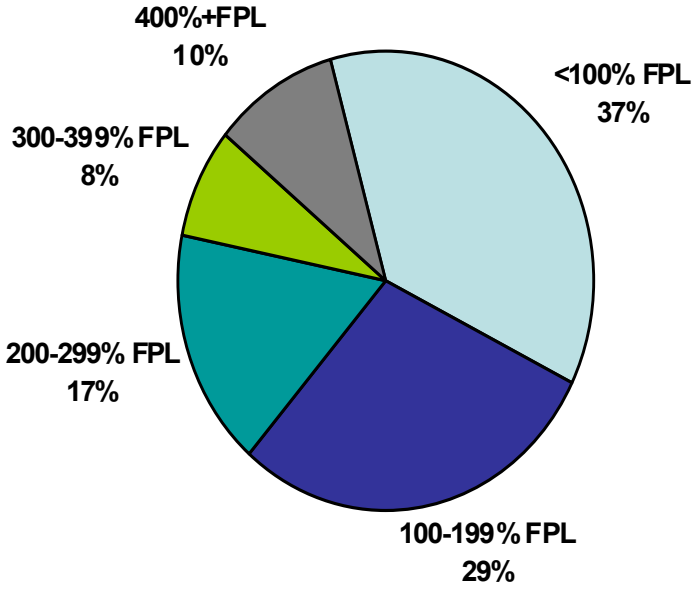
ACCESS—MILLIONS OF AMERICANS LACK COVERAGE

The U.S. is the only developed country without health coverage for all of its citizens.[3] An estimated 45.7 million Americans, or 15.3 percent of the population, lacked health insurance in 2007 — up from 38.4 million in 2000.[4] Those without health coverage generally experience poorer health and worse health outcomes than those who are insured. Twenty-three percent forgo necessary care every year due to cost. And a number of studies show that the uninsured are less likely to receive preventive care or even care for traumatic injuries, heart attacks, and chronic diseases.[5,6,7,8] The Urban Institute reports that 22,000 uninsured adults die prematurely each year as a direct result of lacking access to care.[9]

A majority of the uninsured has low or moderate incomes (see Figure 1.1). About two-thirds have family incomes less than twice the Federal poverty level (FPL).[10,11] Only one in ten have incomes higher than four times the Federal poverty level.

Eight in ten of the uninsured come from working families.[12] But these workers are either not offered coverage by their employer and cannot access it through a family member, or they do not qualify for employer-offered coverage. For example, they might not be eligible because they work part-time.

Figure 1.1. Uninsured by Federal Poverty Level



Source: KCMU/Urban Institute analysis of March 2008 CPS.

In addition to the uninsured, another 25 million Americans are "underinsured," without enough coverage to keep their medical bills manageable. According to a recent study by The Commonwealth Fund, 79 million Americans are unable to pay their medical bills[14] — and of those, more than 47 million were insured when the expenses were incurred.[15] Despite their insurance coverage, medical debt keeps these Americans from feeding their families, paying their rent, or heating their homes. Medical debt contributes to half of all filed bankruptcies, and affects approximately two million people a year.[16]

REAL PEOPLE, REAL REASONS FOR REFORM:

In 2006, Lisa Kelly was diagnosed with acute leukemia.[13] She had insurance—an AARP Medical Advantage plan, underwritten by UnitedHealth Group Inc. with a monthly premium of $185. Unfortunately, the policy had a $37,000 annual limit. And due to the flimsy coverage provided by her policy, the hospital, M.D. Anderson Cancer Center, requested an up-front cash payment of $105,000 before it would start providing chemotherapy treatment.

Ms. Kelly enrolled in a high-risk insurance plan administered by Blue Cross Blue Shield of Texas in February 2007, with a monthly premium of $633. Since her cancer was a pre-existing condition, she had to wait one year for the new plan to cover her treatment. Although Blue Cross started paying her new hospital bills earlier this year, Ms. Kelly is still personally responsible for more than $145,000 in bills incurred before February 2008, and she is paying $2,000 each month for those bills. In June, she learned that after being in remission for more than a year, her leukemia has returned.

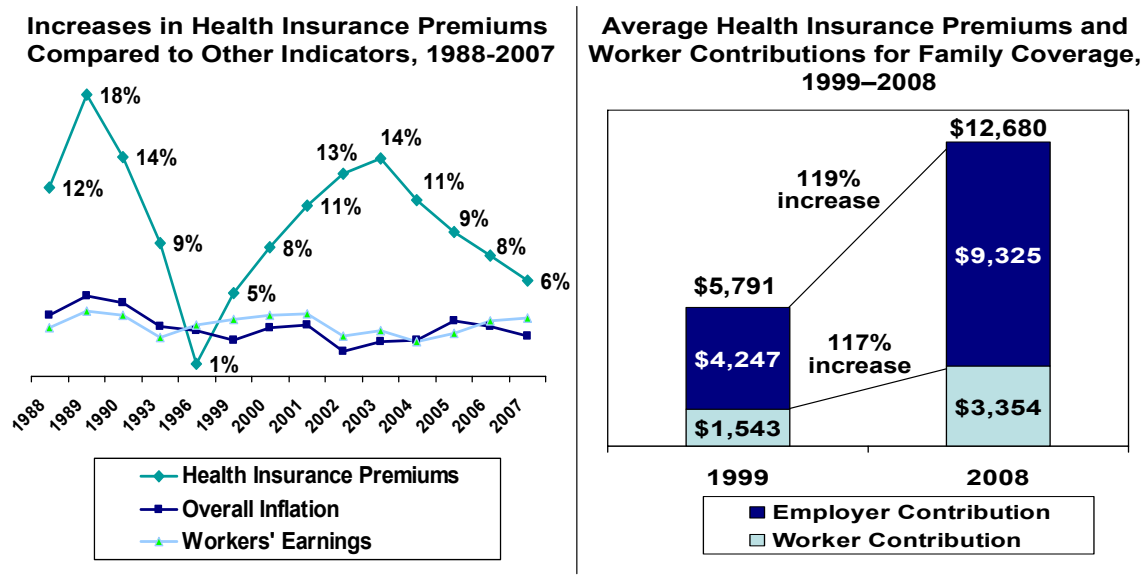
COST— GROWTH IN HEALTH CARE SPENDING IS UNSUSTAINABLE FOR FAMILIES, BUSINESSES, AND THE FEDERAL GOVERNMENT

American families are struggling to keep up with out-of-pocket costs for health care. American businesses are straining to absorb rising health care costs while staying competitive at home and around the world. Federal and state budgets — as well as taxpayers — are bearing an ever-increasing burden as entitlement programs such as Medicare and Medicaid consume a larger share of public expenditures.

Failure to address problems in the health care system could undermine current efforts to restore the economy. Ultimately, Congress cannot help American families' finances or address America's economic woes in a lasting, meaningful way without health care reform.

Even before the current economic crisis, working families and individuals found their health care in jeopardy as the cost of employer-sponsored coverage rose beyond the means of businesses — particularly small businesses — and workers alike. As Figure 1.2 shows, health insurance premiums have increased faster than wages and inflation for most years between 1988 and 2007. Premiums have increased 117 percent for families and individuals and 119 percent for employers between 1999 and 2008.

Figure 1.2. Illustrations of Health Insurance Premium Increases



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2008; KPMG Survey of Employer-Sponsored Health Benefits, 1993, 1996; The Health Insurance Association of America (HIAA), 1988, 1989, 1990; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 1988-2007; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1988-2007.

Why are premiums rising so fast? A recent synthesis of studies found that greater use of medical technology is a driving force — contributing between 38 and 65 percent to health care cost increases.[17] Other factors, including obesity, demographics, and productivity, also contribute to growth in the cost of health care.

Additionally, hospitals and clinics provide an estimated $56 billion in uncompensated care every year to people without health insurance,[18] and those who have health coverage pay the bill through higher health care costs and increased premiums. A study of this "hidden tax" estimated that ten percent of California health care premiums are attributable to cost shifting due to the uninsured.[19]

Even if workers can afford their portion of a premium, employers may not be able to afford the rest. Because employers are the principal source of health insurance in the U.S., providing health benefits for more than 158 million people,[20] erosion in employer-sponsored coverage is a serious problem.

REAL PEOPLE, REAL REASONS FOR REFORM:
Phoenix Products, Inc., an Ohio firm, has operated for 31 years, growing from a youthful start-up company into an established business with 47 employees. As recently as 2003, Phoenix Products could afford to provide a comprehensive health plan at a reasonable cost. But as its employees grew older and health costs increased, the company had to dramatically alter the health plan benefit structure to keep providing any coverage at all. The company moved away from comprehensive benefits to a limited catastrophic coverage plan. Even then, premiums increased ten percent each year from 2003 to 2007.

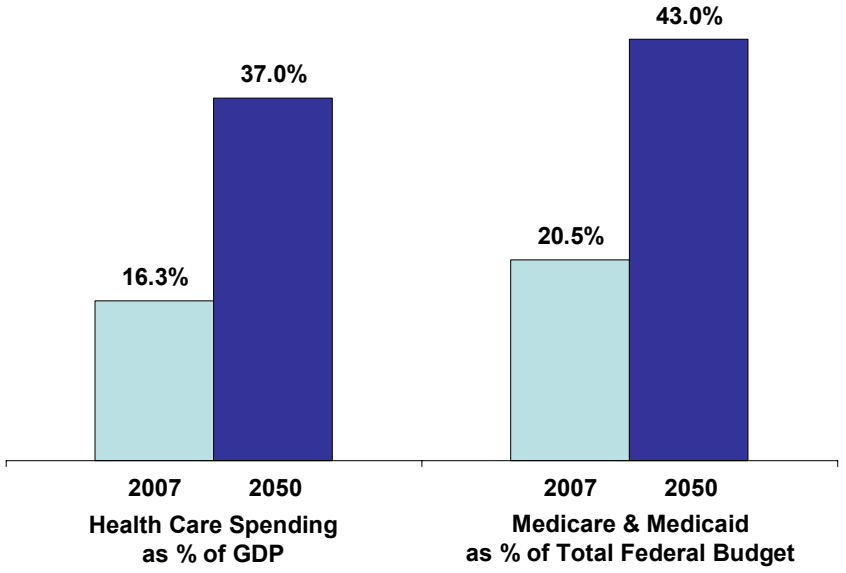
Renewing coverage in 2008 cost the company 35 percent more than in 2007; the maximum increase allowed under Ohio law. Quotes from other plans were 2½ times higher than the current rate. The company is on the verge of losing its ability to offer insurance.

Small business owners have increasingly been forced to decide among several painful options to offset increasing health care costs — raising health insurance premiums, limiting raises or reducing bonus pay, eliminating family health benefits, or providing less-than-comprehensive health coverage.

The story of Phoenix Products (left), relayed to the Senate Finance Committee at a June 2008 hearing,[21] is far too common in the U.S. In 2000, 68 percent of small to mid-size businesses (3-199 workers) offered health benefits, but today that figure is 62 percent.[22]

As rising health care costs threaten the stability and competitiveness of American businesses, they threaten to destabilize the fiscal health of the country itself. Peter Orszag, Director of the Congressional Budget Office, has appropriately noted that rising health care costs represent the "single most important factor influencing the Federal Government's long-term fiscal balance."[23] The U.S. spends more than 16 percent of our gross domestic product (GDP) on health care — a much greater share than other industrialized nations with high-quality systems and coverage for everyone. By 2017, health care expenditures are expected to consume nearly 20 percent of the GDP (see Figure 1.3), or $4.3 trillion annually.[24] Spending for Medicare and Medicaid, due to many of the same factors found in the private sector, is projected to increase by 114 percent in ten years.[25] Over the same period, the GDP will grow by just 64 percent.

Figure 1.3. Health Care Spending Poses Long Term Challenges for U.S. Economy and Federal Budget



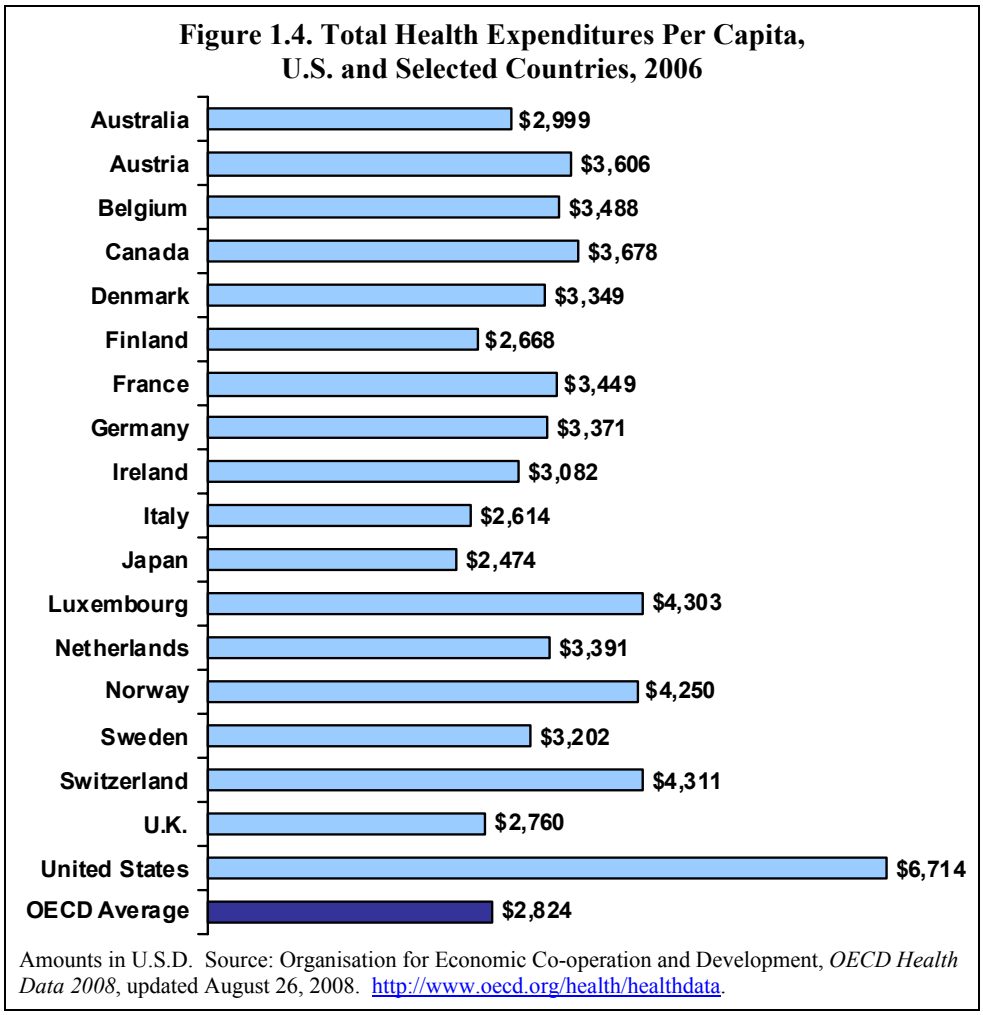
Sources: Keehan, "Health Spending Projections Through 2017"; CBO, The Long Term Budget Outlook (Dec. 2007)

States face fiscal challenges ALSO. On average, states already spend 22 percent of their budgets on Medicaid.[26] One effect of rising unemployment rates will be increased eligibility for and enrollment in Medicaid. Many state governments are struggling to meet balanced budget requirements.[27] In response, at least 29 states have already taken action to reduce their budget deficits for fiscal year 2009.[28] States face limited choices in trying to meet budget shortfalls; they can raise taxes or cut spending on Medicaid and other vital services.

Finally, in the 21st century, when the economies of the world are ever more interconnected, the strength of our health care system is increasingly important. Our international competitiveness depends on the health of our workforce. Although polls show that many Americans believe the U.S. health care system is better than other industrialized nations,[29] the numbers do not demonstrate this to be true.

As mentioned, the U.S. spends a greater percent of GDP and almost twice as much per person on health care compared to other major industrialized countries (see Figure 1.4).[30]

In a study of global health care systems, journalist and author T.R. Reid found startling cost differences with the U.S. In Japan's largely private system, the cost for magnetic resonance imaging (MRI) is less than $100, compared to $1,200 in the U.S. In Switzerland, home to profitable insurance companies and influential pharmaceutical companies, administrative costs represent 5.5 percent of total costs, compared to about 22 percent for coverage purchased in the private insurance market in the U.S.[31] While there must be a uniquely American answer to the question of containing health care costs, other countries demonstrate the possibility of success.



QUALITY— POOR RETURN ON OUR HUGE INVESTMENT

Despite high levels of spending on health care, the U.S. ranks last out of 19 industrialized countries in unnecessary deaths.[32] America ranks 29th out of 37 countries for infant mortality — tied with Slovakia and Poland, and below Cuba and Hungary.[33] The United States has almost *double* the infant mortality rate of France or Germany.[34] A recent study by the Institute of Medicine concluded that the current health care system is not making progress toward improving quality or containing costs for patients or providers.[35]

Research documenting poor quality of care received by patients in the U.S. is shocking. A 2003 RAND Corporation study found that adults received recommended care for many illnesses only 55 percent of the time. Needed care for diabetes was delivered only 45 percent of the time and for pneumonia only 39 percent of the time. Patients with breast cancer fared better, but still did not receive recommended care one-quarter of the time.

The same researchers at RAND found that children received recommended care only 47 percent of the time.[36] Recommended preventive services were provided just 41 percent of the time, and children with chronic illnesses received about 53 percent of needed services.

Even more disturbing is the finding that all patients are at risk for poor quality care — gender, age, race, income, and insurance status do not provide any advantage. Although many patients do receive excellent care, many more receive uncoordinated, fragmented care, are unable to access care when needed, or obtain care through hospital emergency departments after their condition has worsened due to lack of timely intervention. Beyond the known medical risks that low-quality care poses for individual Americans, the lack of quality across our health care system contributes to the problem of rising costs.

In short, Americans are not getting their money's worth when patients receive services of little or no value[37,38] — such as hospitalizations that could have been prevented with appropriate outpatient treatment, duplicate tests, or ineffective tests and treatments. Yet the current system does little to steer providers toward the right choices. Even though more care does not necessarily mean better care, Medicare and most other insurers continue to pay for more visits, tests, imaging services, and procedures, regardless of whether the treatment is effective or necessary, and pay even more when treatment results in subsequent injury or illness.[39] Providers are not consistently encouraged to coordinate patients' care or to supply preventive and primary care services, even though such actions can improve quality of care and reduce costs. Rewarding providers that furnish better quality care, coordinate care, and use resources more judiciously could reduce costs and, most importantly, better meet the health care needs of millions more American patients.[40]

WHAT AMERICANS WANT FROM THEIR HEALTH CARE SYSTEM

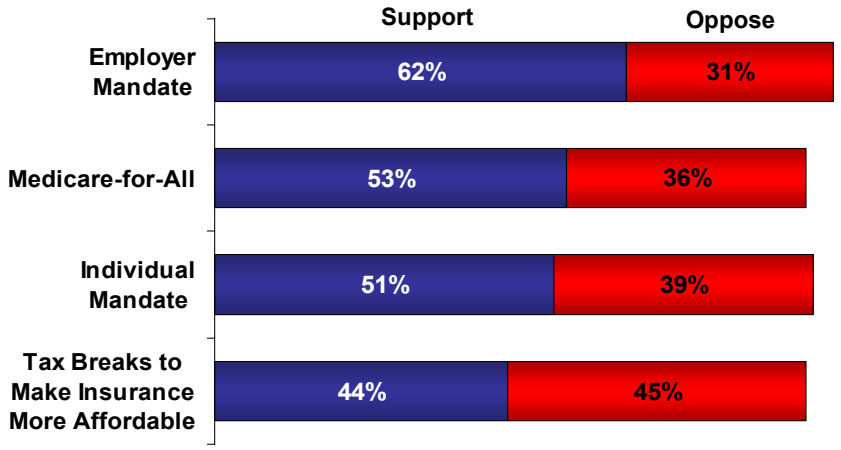
Americans are acutely aware of problems in the country's health care system, and ready for change. Polling repeatedly demonstrates that Americans want and deserve better access to care, better quality care, and better value from their health care system. More than 70 percent of Americans rate our health care system as "fair" or "poor."[41] When asked whether our health system needs a complete overhaul, major repairs, or minor tinkering, 90 percent of Americans respond that the system should be "completely rebuilt" or that "fundamental changes" are needed.[42]

At the same time, those who currently have health coverage do not want to lose those benefits. Many people are satisfied with their personal providers or their current coverage and do not want to jeopardize those connections to the system.

The majority of Americans also believes that coverage should be provided for the uninsured, calling the issue of the uninsured a very serious problem.[43] Americans also want relief from rapidly rising premiums and medical debt. Sixty-five percent of those polled admit that it is "somewhat" or "very difficult" for them to afford health care and health insurance.[44] Three out of four say that, over the past five years, the amount of money that they have paid out of pocket for their own health care has increased.[45]

Despite widespread agreement on the need for reform, the task remains difficult because Americans do not necessarily agree on how to achieve it (see Figure 1.5). Although a majority of respondents would support a mandate on employers to provide coverage, a "Medicare-for-all" single-payer option, or a mandate that all individuals purchase coverage, opposition to each of these options is also somewhat substantial. Moreover, some of this support erodes when respondents are asked whether they would be willing to have more government responsibility or higher taxes — though half of all surveyed in 2007 said they would support reform even under these circumstances.[46]

Figure 1.5. Lack of Consensus on Reform Options



Source: Los Angeles Times/Bloomberg poll, Oct 19-22, 2007

Policymakers need to sift through the options and combine the best of American's desires for a new health care system to ensure health coverage for every American, increase the quality of care for all, and reduce costs to make our system sustainable for the future.

BAUCUS PRINCIPLES: THE VISION FOR OUR HEALTH CARE SYSTEM

While there may be differences of opinion on the solutions, most Americans agree on the principles that health reform should embrace. These principles form the foundation of this Call to Action.

There is widespread agreement that *every American should have health coverage*. This does not mean that a government program should provide the coverage. Such a system may not be viable in a country that values individuality, choice, and a preference for market-based solutions. A mix of public and private solutions must be found to keep our system from leaving millions of Americans behind.

There is also agreement that our health care system must do a better job of *containing costs*. Any serious health reform proposal must include policies that will slow the rate of growth in health spending over time. The sustainability of the nation's public programs, America's businesses — and the economy — depend on it. Along with efforts to rein in

health spending, the quality of care must improve, and payment systems should better align incentives to foster a focus on providing better care rather than more care. Our system must also encourage wellness and the prevention of disease through early detection, modification of risk factors, and encouragement of healthy lifestyle choices. When illness cannot be prevented, the focus should be on care coordination.

Another critical principle in health reform is the recognition that health care is a *shared responsibility*. Employers, individuals, and government all have a role to play — and a contribution to make — to the system. Employers should contribute toward health insurance choices and financing. Individuals have the responsibility to get coverage, to take better care of their own health, and to play a larger role in health care treatment decisions. Providers should improve their performance to ensure consistent, high-quality health care. Society, through state and Federal governments, should help those who lack the means to buy insurance on their own and ensure that the insurance market is fair and transparent.

With these principles in mind, it is possible to envision a high-performing health care system in the future. Such a system would guarantee Americans the choice of a health plan that they can afford. Employers, individuals, and government would all bear responsibility and contribute toward fulfilling that goal. Wellness and prevention would be encouraged. The costs of health care would be more manageable so that employers could afford to offer coverage to their employees and still compete in a global marketplace. Our public health programs would be on a more fiscally sustainable path than they are today. Providing coverage to all Americans would make health care truly portable and allow Americans to change jobs when they wanted, rather than remaining locked in by their need for health coverage. This Call to Action represents a vision for creating that high-performing health care system.

The system envisioned here guarantees access to affordable coverage for every American. To ensure that affordable options are available to all, assistance must be provided to small businesses, families, and individuals who currently struggle to find and afford health coverage. This approach will allow every American to be enrolled in some form of health care plan, either private or public. Those who like their current coverage arrangements could keep what they have. Others, including the uninsured, would have options, and all Americans would gain the ability to leave a job or start a new business without worrying about prospects for future coverage. Providing coverage to all Americans would lower costs by including the healthiest individuals in the risk pool to offset the costs of the sickest individuals — and maintaining wellness rather than treating illness.

The system envisioned here would ensure that every individual could access affordable coverage by creating a nationwide insurance pool, precluding discrimination by insurers based on health status, and providing subsidies to low-income families. It also aims to lower costs by improving the quality of the care that all Americans receive, promoting better value for our dollar, and reforming the delivery system.

The passage and implementation of comprehensive health care reform will not happen overnight. The health system is so complex that any solution will demand time and attention to make sure that we get it right. But Americans without health insurance — as well as those in need of better coverage or in danger of losing their coverage — need the process to start now.

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CHAPTER II BAUCUS PLAN: INCREASING ACCESS TO AFFORDABLE HEALTH COVERAGE

Achieving health coverage for every American has proven an elusive goal for decades, dating back to the first attempt at national health reform in the early 1900s by the Progressive Party.[1] That effort failed, as did the Wagner-Murray-Dingell bill and attempts by President Truman in the 1940s, the plan proposed by President Nixon in the 1970s, and the Health Security Act proposed by President Clinton in 1993. Each was unsuccessful for its own unique reasons.

Over the years, the U.S. health system has become very complex, with deeply entrenched interests. Significant changes will take time to approve and implement. But the series of changes and reforms envisioned in this Call to Action can eventually remake the current system to ensure every American has access to high-quality health care through affordable, portable, and meaningful health insurance.

The Baucus plan incorporates six important elements as it moves towards covering all Americans:

- **Individual Responsibility.** Covering all Americans means the enrollment of every individual in some form of health care plan, private or public. But the principle of individual responsibility can be applied only when affordable options are available to all.

- **Strengthening the Employer-Based System.** We must ensure the continued viability of the employer-based system — the principal source of health coverage for most Americans — to allow workers to keep the insurance that they currently have and value. Eliminating employer-based coverage, as some have proposed, would upend health care for more than half the American people — 158 million in all.[2] This plan envisions a role for employers to contribute to employees' access to health care.

- **Guaranteed Access to Affordable Coverage for Individuals and Small Business.** Additional assistance must be available to families, individuals, and small businesses who currently struggle to find and afford health insurance. A mechanism must be established to allow health care consumers to find and obtain health coverage that best meet their needs.

  This mechanism — the Health Insurance Exchange — will connect individuals and employers to insurance offered at local, state, regional, or national levels. Insurers offering coverage through the Exchange would need to meet certain requirements established by a new Independent Health Coverage Council.

  Reforms enacted through the Exchange could improve access to health coverage for all. In order to make insurance affordable, the existing insurance market must be reformed. The lack of appropriate standards and regulation in certain markets

fails far too many Americans who need health care. Requirements of the Exchange would be extended to improve fair price and quality competition in the insurance market as a whole so that coverage would be more affordable and available to more Americans.

Creation of the Exchange would take time, but more immediate steps could provide relief to Americans most in need of health coverage and begin to improve the health of the country overall.

- **Strengthening Public Programs.** Existing public programs represent an effective and efficient way to increase access to coverage and decrease the number of uninsured. Offering individuals approaching age 65 the chance to buy into Medicare early and eliminating the requirement that disabled individuals wait two years to enroll in Medicare would ensure coverage to populations that the private market is under-serving. Improving Medicaid and the State Children's Health Insurance Program (CHIP) could provide coverage quickly to additional low-income Americans while serving current beneficiaries better. Increased attention and funding for the Indian Health Service (IHS) could improve care for Native American and Alaska Native populations. We can strengthen public health care programs promptly, though the impact on state and Federal budgets must also be considered.

- **Focusing on Prevention and Wellness.** Increased access to preventive care and wellness is another step that could be accomplished in the short term. Increasing the availability and effectiveness of primary care coverage could create a national focus on maintaining wellness, rather than treating illness — which would improve quality and reduce costs across the health care system.

- **Addressing Health Disparities.** In our current health care system, racial and ethnic minorities disproportionately lack ready access to high-quality medical care. This gives rise to differences in both health status and health care among various groups in our diverse population. Our system also prohibits certain legal immigrants from getting health care for five years. Though medical advances benefit much of the population, health disparities continue to worsen for others. These disparities must be addressed and ultimately eliminated. Americans want and deserve a system that provides equal access to health coverage and health care for all — regardless of age, race, ethnicity, or income — and that is what this Call to Action would give them.

These six elements combine to give every American a role and a responsibility in reforming our health care system to ensure coverage for every individual. The remainder of this chapter provides additional detail on these elements.

A. INDIVIDUAL RESPONSIBILITY

Once affordable, high-quality, and meaningful health insurance options are available to all Americans, it will be each individual's responsibility to have coverage. This step is necessary to make the entire health care system function properly.

Today, the costs of care for 46 million Americans without health insurance are largely borne by those with insurance; providers charge higher prices to patients with private coverage to make up for uncompensated care, and these costs are passed along to consumers in the form of increased premiums.[3] The cost of that uncompensated care is also unnecessarily inflated because patients without insurance often wait to receive care until they have to go to the emergency room. Requiring all Americans to have health coverage will help end the shifting of costs of the uninsured to the insured.

Requiring all Americans to have health coverage would also ensure that the insurance market functions effectively. Insurance works because policyholders pay into their plans when healthy, and have their medical bills paid when they are sick. If a significant portion of Americans does not purchase coverage until sick, then premiums for all enrollees will increase to cover insurer outlays, and the problem of unaffordable coverage will persist. Finally, covering all Americans is essential to effective prevention and wellness efforts and managing chronic illnesses. Efforts to guard against and better manage illness are an effective tool to contain costs, but without every American in the system, those efforts will fall short of their full potential.

Implementation of a responsibility for all individuals to have coverage would be fair as long as every consumer has a reasonable avenue to find and purchase affordable health care coverage. The Exchange envisioned in this plan, described more fully below, would be the primary path for those shut out of or underserved by today's health care system. The Exchange would provide standardized information and a single, standard, simple form for enrollment in a plan of the consumer's choice. Available to all, the Exchange would also allow individuals to enroll in health care plans in various convenient locations, including physicians' offices, local hospitals or schools, Departments of Motor Vehicles, and local Social Security Offices.

The responsibility for all Americans to obtain coverage would be enforced possibly through the U.S. tax system or some other point of contact between individuals and the government. Every individual would receive a certificate of coverage from their insurer to demonstrate that they are meeting their responsibility.

Enforcement of a responsibility to have health care through the tax system has advantages. The biggest advantage is that most Americans already have contact with the IRS through the annual filing of a tax return. Monitoring health insurance coverage through the tax code would take advantage of this existing relationship. One issue to be addressed, however, is how to deal with individuals who do not file a tax return due to their low tax liability. If a premium subsidy for health care was administered through the tax code, the

non-filer issue would be significantly decreased because a number of current non-filers would voluntarily file in order to get the assistance.

The Commonwealth of Massachusetts has had success with this approach. In the first year of Massachusetts' individual insurance requirement, 98.6 percent of taxpayers required to file insurance information with their tax returns complied.[4] In fact, the health care reform effort in Massachusetts generally has been extremely popular even with the requirement for individual coverage. At the end of 2007, the majority of working-age adults in Massachusetts — 71 percent —supported the state's health reform efforts.[5]

B. STRENGTHENING THE EMPLOYER-BASED SYSTEM

American employers, large and small, are instrumental in providing meaningful insurance coverage to million of workers and their families. Employer involvement in the purchase of health insurance provides many distinct advantages. The average employer contributes 84 percent of premiums for individual coverage and 73 percent of premiums for family coverage.[6] Health insurance also costs less when purchased through an employer rather than in the individual market, because employers provide a natural mechanism for pooling risk by covering healthy and less healthy workers.[7] And because employers pool coverage for an entire group, economies of scale can reduce administrative costs. Employers may also have greater negotiating power with insurance companies and more sophistication in evaluating benefits.

Besides lower premiums, participants in employer-based coverage enjoy other advantages. Current law prevents them from being disqualified for pre-existing conditions or charged higher premiums based on their medical histories. Standards already in Federal law govern certain aspects of their insurance, as well as provide opportunities to remain covered after losing group coverage. Additionally, the ability to pay premiums through payroll deduction provides an easy and convenient way to purchase coverage.

The Baucus plan proposes to extend and build on the tradition and success of employer-sponsored insurance. In a recent Gallup poll, 67 percent of Americans said that they were either completely or somewhat satisfied with the health insurance benefits that their employer offered.[8]

To strengthen the connection of insurance to the workplace, all except the smallest employers would offer a Section 125 plan under the Baucus plan. Section 125 plans allow employees to pay their health insurance premiums through their employer's payroll deduction and with pre-tax dollars. Premiums paid with pre-tax dollars are not subject to Federal and state taxes. By offering Section 125 plans, employers would make it easier and cheaper for their workers to purchase insurance.

Large employers — especially firms paying high wages — have the greatest capability to provide coverage to their employees. The vast majority of American employers in this category would probably continue to provide coverage as a competitive benefit to recruit employees. If these employers choose not to provide coverage, under the Baucus plan they

would have to contribute to a fund that would help to cover those who remained uninsured. The contribution would likely be based on a percentage of payroll that took into account the size and annual revenues of each firm. Mid-sized and small employers would also have the option of providing adequate coverage or paying into the general coverage fund, but the required contribution would be less for them than that for larger firms.

Businesses with the fewest workers and the lowest wages would be offered a new tax credit to purchase health insurance for their employees (described below), and would be exempt from contributions to the general coverage fund if they were still unable to offer insurance to employees.

Workers prefer the support of employers and the convenience that employer-sponsored health coverage provides. Health care reform must enable employers large and small to continue providing coverage to workers, and to share the responsibility of maintaining a healthy, productive, globally competitive workforce.

C. GUARANTEED ACCESS TO AFFORDABLE COVERAGE FOR INDIVIDUALS AND SMALL BUSINESSES

Individuals and small businesses seeking health insurance on their own frequently encounter serious challenges in obtaining coverage. For small businesses, the primary obstacle is the cost of offering coverage to employees. For individuals, cost is also the most significant factor, but individuals with pre-existing conditions may be denied coverage at any price.

The Baucus plan envisions that the Health Insurance Exchange would offer a new opportunity for individuals and small businesses to easily compare private coverage options and a public plan and to purchase the policy that would work best for them. Eligible individuals and small businesses would receive subsidies to make sure that coverage would be affordable. Insurance companies would be prohibited from denying coverage due to pre-existing conditions and from discriminating against individuals solely due to their health status.

Health Insurance Exchange. The Baucus plan would establish the Health Insurance Exchange through which individuals and small businesses in the market for insurance could obtain affordable health care coverage. The Exchange would be an independent entity, the primary purpose of which would be to organize affordable health insurance options, create understandable, comparable information about those options, and develop a standard application for enrollment in a chosen plan.

Participating employers must enroll all employees through the Exchange — not only the sickest and most costly to insure.

Insurance plans participating in the Exchange could operate nationally, regionally, state-wide, or locally. So that plans could be easily compared, qualifying insurers would have to offer products that could be classified as high-, medium- or low-benefit options. Benefit

packages could differ within reason, but all structures would have to be actuarially equivalent within benefit categories in order to prevent insurers from using benefit design to discourage enrollment by people with health conditions. Differences in premiums between packages would be due to the difference in benefits and not the differences in expected risk. Participating insurers would have to charge the same price for the same products inside and outside the Exchange.

Plans participating in the Exchange would be subject to oversight by states with regard to consumer protections (e.g., grievance procedures, external review, oversight of agent practices and training, market conduct). In addition, participating private plans would be subject to state regulation related to solvency, reserve requirements, and premium taxes.

The Exchange would have authority to implement mechanisms to ensure that plans enrolling sicker-than-expected people would not suffer a financial disadvantage compared to those enrolling healthier people. Offsetting some of the potential risk to insurance plans is intended to limit plans' incentives to enroll only the healthiest individuals.

All plans participating in the Exchange would be subject to the same rating rules included in the insurance market reforms described later in this chapter.

The Exchange would also include a new public plan option, similar to Medicare. This option would abide by the same rules as private insurance plans participating in the Exchange (e.g., offer the same levels of benefits and set the premiums the same way). Rates paid to health care providers by this option would be determined by balancing the goals of increasing competition and ensuring access for patients to high-quality health care. A number of options could be considered to determine who runs the plan, who is eligible for it, and how to ensure that the public-private insurance competition lowers costs and improves quality. The Independent Health Coverage Council, described below, would inform these decisions.

Federal funds would be needed to start up the Exchange, but it would be self-sustaining within a few years. One option for making it so is a small assessment on premiums to fund activities of the Exchange, as done today by the authorizing board of the Commonwealth Connector in Massachusetts. Insurers would include the assessment as part of their premiums and could remit it on a monthly or quarterly basis. Keeping insurance premiums in the Exchange affordable must be the guiding principle in setting any assessment.

Independent Health Coverage Council. Reforming the health care system to cover all Americans through a mix of private and public means involves complex decisions that must be responsive to rapid changes in the health system. Such a system would require oversight, but Congress cannot make all necessary decisions to guide it. For that reason, the Baucus plan authorizes a board of directors — called the Independent Health Coverage Council — to inform decisions that would help to guarantee that affordable health insurance options were available. The President would appoint members of the Council with the advice and consent of the Senate for set, staggered terms. The President would choose Council members who were geographically diverse and have expertise in

insurance, health benefit design, actuarial science, economics, medicine, business, and consumer protections.

The new Independent Health Coverage Council would define key terms in a reformed health system. For example, it would define what "coverage" and "affordability" mean. In doing so, it would, among other activities, consult with the Institute of Medicine and review existing state laws. The Council would ensure that coverage would be affordable, clinically appropriate, provide access to necessary health services, and protect enrollees against high health care expenses. Specifically, the Council would ensure appropriate, income-related annual limits on out-of-pocket costs so that families were not at risk of bankruptcy by their medical expenses. The Council would also play a major role in ensuring that the public plan option meets its goals of delivering high-quality and cost-effective care.

The Independent Health Coverage Council would also set standards for chronic care management and quality reporting. Insurers in the Exchange would collect and report on the performance of providers in their networks. The Council would make care management and quality reporting requirements consistent with those used by Medicare to the extent practicable. Consistent measures of quality would make performance rating more robust and better able to help Americans make decisions about their own care.

Input by the Independent Health Coverage Council would keep the activities of the Exchange on track and insulated from the political process. The Council and the Exchange would both be subject to regular reviews and oversight by the Comptroller General, however, so that Congress—and the public—can closely monitor their activities.

Insurance Market Reforms. Currently, insurance companies can discriminate against older and sicker patients by charging significantly higher premiums or denying coverage altogether. Individuals with pre-existing conditions such as cancer, heart disease, and asthma are at particular risk of being denied coverage by insurance companies or being offered a policy that is unaffordable. In fact, a recent Commonwealth Fund study found that insurance companies turned down one out of every five people who applied for individual coverage due to pre-existing conditions.[9]

While states have the authority to restrict this type of discrimination, very few have used that authority. Under the Baucus plan, insurance companies could not deny coverage to any individual nor discriminate against individuals with pre-existing conditions. Rules for rating insurance policies — which have to do with how an insurer can determine a policyholder's premium based on various criteria such as age, tobacco use, previous illness, or factors that encourage healthy lifestyles — will be specified in statute after consultation with the National Association of Insurance Commissioners, consumer advocates, plans and others. The ability of insurance companies to rate on age would also be limited. In order to avoid severe adverse selection — a scenario under which the sickest patients gravitate toward one part of the insurance market — the rating rules for the Exchange would apply in the Exchange as well as in private non-group and small group markets.

Small Business Tax Credit. As health care coverage becomes more expensive, many small businesses simply cannot bear the additional cost of providing health coverage for their employees. And for this reason, the number of small businesses offering their employees health care coverage is declining. To help small businesses, the Baucus plan would provide a targeted tax credit that small firms could use towards the cost of purchasing health care coverage.

There are a number of ways that such a tax credit could be structured. One option is to make the tax credit available to any small business, for both individual and family coverage. Initially, the credit would be available to qualifying small businesses that operate in states with patient-friendly insurance rating rules. After the initial implementation, the tax credit would be available to small businesses that purchase coverage for all of their employees in the Health Insurance Exchange and make a meaningful contribution towards the cost of the premium for their employees' health care.[10]

In order to target the tax credit most efficiently, the credit would be based on a firm's size and earnings per employee. The smallest firms with the lowest average earnings will be eligible to receive a credit equal to half of the average total premium cost for employer-sponsored insurance in the firm's state. This credit will be phased down as firm size and average earnings increase. The employee and earnings phase-outs work together, until the credit is fully phased-out.

Premium Subsidies. In order to make health coverage affordable for all Americans, refundable tax credits would be available to individuals and families with incomes at or below four times the Federal poverty level. These tax subsidies would be available to individuals and families who purchased coverage through the Health Insurance Exchange.

The Independent Health Coverage Council would define what an "affordable" premium is, taking into account the reasonable percent of income to be spent on health care coverage. The premium subsidy would make up the difference between the amount suggested by the Council and the premium amount charged by the plan. The amount of the subsidy could be based on a benchmark that would be equal to a locally adjusted, average premium in the Exchange. This construct would encourage individuals to be prudent purchasers of health care policies.

D. STRENGTHENING PUBLIC PROGRAMS

Medicaid and the State Children's Health Insurance Program (CHIP) represent cornerstones of America's health care system. These programs provide access to health care for approximately 67 million low-income Americans. Both programs have an important role to play in health care reform, so the Baucus plan envisions specific improvements to Medicaid and CHIP that ensure these programs function effectively and efficiently in a reformed health care system. The Baucus plan also would improve Medicare by providing an option to buy into the program for individuals who are near but

not yet 65, and who lack other insurance. The plan also would allow disabled individuals access to Medicare without a waiting period. Finally, the plan would increase funding for the Indian Health Service.

Medicare Buy In. The Baucus plan would make health care coverage immediately available to Americans aged 55 to 64 through a Medicare buy-in. People in this age group face greater risk of illness than their younger counterparts. And while they may require increased access to medical care, they continue to have fewer and fewer affordable insurance options as retiree health care coverage erodes and pre-existing conditions make private insurance prohibitively expensive or impossible to obtain altogether.[11]

In 2007, over four million people aged 55 to 64 were uninsured, or about 12 percent of the total population in that age group.[12] This figure represents an increase of one million since 2000. While this age group tends to be one of the least likely to be uninsured, those who do not have employer-sponsored benefits or retiree coverage through a former employer, have fewer options for coverage than other age groups.

The individual insurance market can provide a source of coverage for this population, but health insurance offerings in that market are often unaffordable — or even unavailable to those with pre-existing health conditions. The average annual premium for those aged 60 to 64 was more than $5,000 for single coverage and $9,200 for family coverage in the individual market in 2006-2007.[13] By contrast, coverage for a person aged 18 to 24 was $1,360 for single coverage in the individual market and $2,850 for family coverage.

Declining health status and lack of affordable health insurance affect not only the health and wellbeing of Americans aged 55 to 64, but also their pocketbooks. Nearly 12 percent of those aged 55 to 64 report annual medical expenditures of more than $10,000.[5] Uninsured individuals in this age group find it increasingly difficult to cover their medical bills as declining health can affect their ability to work and earn income. Uninsured Americans aged 55 to 64 are twice as likely as their insured counterparts to report having to delay seeking medical care, including needed surgeries.[14]

To fill this gap in coverage, the Baucus plan would allow individuals aged 55 to 64 to buy Medicare coverage. The option would be available to any individual in this age group who otherwise did not have access to health coverage through a public plan or a group health plan. The benefits would be the same as those available to current Medicare beneficiaries.

This new Medicare buy-in option is temporary. It would be available until the Health Insurance Exchange was established. Once that new infrastructure is in place, Americans 55 to 64 years old who had not obtained coverage through the Medicare buy-in would be able to buy insurance in the new marketplace. Those already enrolled in the Medicare buy-in would have the option to remain in Medicare.

Medicare would charge enrollees electing the buy-in option an annual premium. The premium amount would be calculated so that the total costs for the buy-in population

would be budget neutral. Thus, this option would not create new costs for the Medicare program or for taxpayers.

Providing immediate assistance to the Americans aged 55 to 64 would benefit not only individuals in this age group, but the Medicare program overall. An option for those 55 to 64 to buy into Medicare could enable individuals to remain healthy and continue working, prevent disabling conditions, and provide protection from catastrophic medical costs.[15] It would also help to ensure that individuals would not experience a break in coverage during this age period, which could lead to improved health status upon Medicare eligibility at age 65. The Medicare program might also benefit through reduced costs for this population relative to what might have been spent if these individuals were uninsured in the decade prior to becoming Medicare eligible.[16]

Phase Out of Disability Waiting Period. In 1972, the Congress expanded Medicare eligibility to include people with disabilities.[17] At that time, Congress created a "Medicare waiting period," which requires people with disabilities to receive Social Security Disability Insurance (SSDI) for 24 months prior to becoming eligible for Medicare coverage. As a result of the 24-month Medicare waiting period, an estimated 400,000 Americans with disabilities are uninsured and many more are underinsured.[18] Forcing Americans with disabilities to wait two years for Medicare coverage results in these people having inadequate health care, falling into poverty or, ultimately, in death.

The Baucus plan would begin to phase-out the current two-year waiting period for Medicare coverage for people with disabilities. It is anticipated that people with disabilities would also eventually be able to purchase coverage in a reformed health insurance market.

Medicaid. Established in 1965, Medicaid is a program intended to serve low-income Americans and those with serious health conditions or disabilities. The Federal government and the states share responsibility for funding and administration of Medicaid. Medicaid currently covers approximately 61 million Americans[19] and is the source of health insurance for 14 percent of non-elderly Americans (age 64 and below).[20] A modernized Medicaid program is an essential component of health reform.

Federal law establishes certain categories of beneficiaries to which states must offer Medicaid benefits as a condition for Federal financial participation. The mandatory beneficiary populations are:

- Children under age six who are in families below 133 percent of the poverty level;
- Children over age six in families below 100 percent of the poverty level;
- Pregnant women with incomes below 133 percent of the poverty level;
- Elderly and poor individuals who receive cash assistance from the Supplemental Security Income (SSI) program;
- Families who meet financial requirements of the former Aid to Families with Dependent Children (AFDC) cash assistance program.[21]

States have discretion to cover populations beyond those that Federal law mandates. In fact, all states provide Medicaid benefits to optional populations.[22] Medicaid enrollment in 2007 is displayed in Table 2.1 below.

Table 2.1. Medicaid Enrollment in 2007

Population	Number enrolled (in millions)	Percent of total Medicaid enrollment
Children	29.2	48.0
Adults	16.2	26.6
Blind/Disabled	9.5	15.6
Elderly	6.0	9.9
Total	**60.9**	**100**

Source: Center for Medicare and Medicaid Services (CMS).[23]

Federal law does not require states to cover adults under Medicaid, unless they are disabled, elderly, or pregnant — regardless of income. Many states cover adults as an optional population, though coverage is very limited. Twenty-seven states have eligibility levels for non-working adults with incomes below the poverty level and 26 states have eligibility levels less than the poverty level for working adults. All states except Alaska and Connecticut have eligibility levels for disabled optional populations of less than the poverty level.[24] Thus in most states, Medicaid coverage is limited to very low-income Americans.

Medicaid is a vital source of coverage for low-income Americans, but existing state Medicaid programs have not reached everyone living below the poverty level. The Baucus plan aims to solve that problem by extending Medicaid eligibility to every American living in poverty. Reducing the number of uninsured by increasing Medicaid enrollment has been embraced by a diverse coalition, including the Commonwealth Fund[25] and the insurance industry.[26] Making this change would provide at least 7.1 million low-income people with access to health coverage.[27]

Providing Medicaid to everyone below the poverty level is both consistent with the original intent of Medicaid, and the easiest and quickest way to provide insurance to those living in poverty. Building on the existing Medicaid program is also efficient. Moreover, those at the bottom of the income scale are least likely to be able to purchase coverage on their own, least likely to have employer-sponsored coverage, and if such coverage is offered, least likely to be able to afford it.

Establishing a national eligibility minimum of 100 percent of the Federal poverty level would help to streamline Medicaid. States currently have dozens of eligibility categories, many with different poverty levels.[28] Determining eligibility under the Baucus plan would be much easier than in the categorical eligibility system currently in place. This would result in more equitable treatment for all Americans living in poverty.

Additional efforts to streamline Medicaid eligibility and enrollment are also part of the plan. Uniform and simplified verification and renewal rules should be established to help minimize the "churning" that typically occurs within Medicaid. States should get help from the Federal government to engage in outreach to potentially eligible individuals and to modernize their eligibility and enrollment data systems because the current systems are so antiquated that they are unable to meet today's data demands. Simplifying eligibility would expedite and lower the costs associated with states' eligibility determination processes.

Existing mandatory eligibility populations would be unaffected by this plan. The same is true for optional populations that states have elected to cover — because states would be required to maintain current eligibility levels (even those above 100 percent of the poverty level). Current Federal matching rates and other policies consistent with this policy would remain intact for any population with income eligibility that exceeds 100 percent of the poverty level. No one currently eligible would lose access to Medicaid.

The financial responsibility shared by the Federal and state governments is carried out through a matching system, called the Federal Medical Assistance Percentage, or FMAP, in which the Federal government and the state government each pay a certain percentage of total Medicaid expenses. Each state's FMAP rate is based on the state's per capita income level, thereby giving states with lower-than-average income levels a higher FMAP rate and thus a higher Federal percentage match. According to Federal law, FMAP rates range from 50 percent to 83 percent and there is no cap on the total Federal financial participation. Currently, 13 states receive the minimum 50 percent match, but the highest FMAP rate is 73 percent.[29]

The goal of covering all Americans is an opportunity for the Federal government to partner with states to reduce the number of low-income uninsured Americans. The Baucus plan would invest new Federal resources to help states, and is committed to finding ways for the Federal government and the states to share responsibility for the costs associated with increased Medicaid enrollment.

The Baucus plan includes an additional improvement to the Medicaid program. Medicaid must be strong and stable so that eligible individuals can rely on it, especially in times of economic distress. In order to strengthen and stabilize Medicaid, states require help managing the costs associated with unanticipated increases in Medicaid enrollment. When the national economy experiences a downturn, state revenues decrease and Medicaid rolls increase, as people lose jobs and health insurance. Every one-percent increase in the national unemployment rate, for example, results in an additional one million people enrolling in Medicaid.[30] One million new Medicaid beneficiaries increase state Medicaid spending by $1.4 billion.[31]

As all states (except Vermont) are constitutionally bound to balance their budgets,[32] the strain caused by decreased revenues and greater Medicaid participation forces states to reduce spending — often cutting back safety net programs like Medicaid at a time when they are needed most.[33]

To ensure that Medicaid is a reliable component of a reformed American health care system, this plan would increase FMAP rates when a predetermined combination of circumstances measuring the timing, duration, and depth of an economic downturn occurs. Creating this mechanism to maintain Medicaid's stability during nationwide economic slumps or significant downturns for individual states builds on recent success in addressing tough economic situations. In 2003, as part of the Jobs and Growth Tax Relief Reconciliation Act, Congress temporarily increased FMAP rates by 2.95 percent, so long as states agreed not to cut benefit options during the FMAP increase.[34] A study by Families USA found that for "every million dollars a state invests in Medicaid [it] will generate, on average, $3.35 million in new state business activity . . . $1.23 million in new wages, . . . and an average of 33.76 new jobs per state."[35]

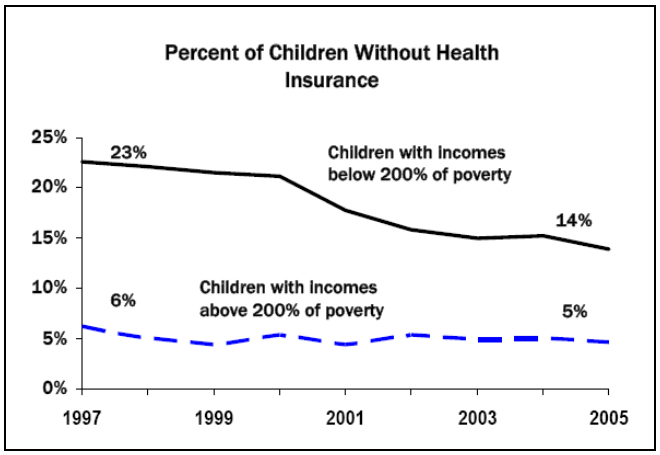
The details of an economic indicator-based trigger and the level of assistance must be responsible without being too rigid or too lax. In a 2006 report, the Government Accountability Office (GAO) recommended consideration of two factors — the number of states experiencing an increase in unemployment and the magnitude of that increase — in setting a trigger.[36] Determining the specific trigger requires careful construction in order to ensure that state economic distress is measured reliably and accurately. Similarly, the amount and duration of the FMAP increase must be calibrated to provide states with enough support for the right amount of time.

State Children's Health Insurance Program (CHIP). When the Children's Health Insurance Program (CHIP) was created as part of the Balanced Budget Act of 1997, it was the largest expansion of health insurance coverage for American children in more than 30 years.[37] CHIP was intended to provide health insurance to children whose families cannot afford to purchase health insurance in the private market, but earn too much to qualify for Medicaid.

Like Medicaid, CHIP is financed jointly by the state and Federal governments. The Federal government pays a higher percentage of the total program costs for CHIP than for Medicaid, averaging about 70 percent nationally.[38] Because CHIP is financed through a block grant to states, the total Federal financial participation in CHIP is capped regardless of rising costs or increased numbers of eligible children.

In its first ten years, CHIP helped to reduce the number of uninsured children by about one-third overall, from 23 percent to 14 percent.[39] CHIP has reduced by one-quarter the number of uninsured children with effective family incomes between 100-200 percent of the poverty level.[40] In 2006, more than 6.5 million children were covered through CHIP.[41] Despite this progress, more than one in ten children remains uninsured.[42]

Figure 2.1. Impact of CHIP on Uninsured Children



Source: Improving Children's Health, Center on Budget and Policy Priorities, 2007

CHIP gives states flexibility in establishing eligibility criteria, benefit structure, and cost-sharing. States have used this flexibility to craft programs responsive to their unique needs.[43]

The original intent behind CHIP was to provide access to health insurance for all low-income families who make too much to qualify for Medicaid, but not all CHIP programs have met that goal. The Baucus plan would require states to use CHIP to cover all children at or below 250 percent of the poverty level and who are not Medicaid eligible, putting help within reach for more needy Americans. States that currently cover children above 250 percent of the poverty level would continue to do so. Existing matching and other policies not inconsistent with a responsibility to have health coverage would remain in place for states with income eligibility that exceeds 250 percent of the poverty level.

With an expansion of CHIP, the Federal government and states would join together to reduce the number of uninsured children in America. Currently, capped Federal allotments to states combined with expanded eligibility lead some states to exhaust available Federal funding before the end of the fiscal year. In 2007, 14 states faced Federal funding shortfalls, and as many as 37 states were expected to face similar financial challenges for fiscal year 2008.[44] Under these financial constraints, some states are forced to cut back their CHIP programs by freezing enrollment, enforcing longer waiting periods, or lowering the income eligibility thresholds.[45]

The Baucus plan would help states with the costs associated with increased CHIP enrollment. The Federal government has several options to consider in helping the states.[46]

In addition, as our health care delivery system is modernized to improve quality and access to care, similar efforts should be encouraged in Medicaid and CHIP to assure that our

nation's most vulnerable populations receive the same high-quality care that is available to those with Medicare or private insurance.

Health Care for Native Americans and Alaska Natives. The Indian Health Service (IHS) currently provides health care services to an estimated 1.5 million Native Americans and Alaska Natives who belong to more than 562 federally recognized tribes in 35 states.[47] IHS provides free health care to eligible Native Americans and Alaska Natives, with the exception of certain urban programs or in circumstances where a tribe chooses to charge its members for health care.[48]

In a series of treaties and agreements forged with the tribes as sovereign nations, the U.S. government promised to provide health care to Native Americans. Currently, the IHS is responsible for making sure that promise is kept. IHS, however, is not the sole source of health care for Native Americans. Tribal members are eligible for, among other programs, Medicare, Medicaid, and CHIP. Native Americans also may have private insurance.

Native American and Alaska Native populations have unique health care concerns. Native Americans are three times more likely to die from diabetes. And Native Americans suffer from tuberculosis at a rate that is six times higher than the non-Indian population.[49] Many members of these populations also live in physically remote areas, making the delivery of care difficult and hindering the ability to recruit and retain health care professionals. Additionally, cultural concerns must be respected in providing health care for Native Americans and Alaska Natives.

The IHS health care delivery system is organized around 12 regional offices and 163 local service units, and provides various medical services, including inpatient and outpatient services, ambulatory, emergency, dental, and preventive health care.[50] In 2007, IHS provided approximately 58,000 inpatient admissions and over ten million outpatient visits.[51] IHS also contracts for medical services from local providers through what is known as contract health services.

Funding for IHS consistently falls short of the amount needed to provide care for the populations it serves. In fiscal year 2008, total funding for IHS was $4.3 billion, about 48 percent of estimated need. Current spending levels pale in comparison to those of other Federal health care programs such as the Bureau of Prisons, Department of Veterans Affairs and the Federal Employees Health Benefit Program (FEHBP).[52]

The IHS itself has stated that its funding does not allow it to provide all the needed care for eligible Indians. As a result, some services are "rationed," with the most critical care given first. IHS regulations require that, when resources or funds are insufficient, the agency must set priorities for both direct and contract health care based on "relative medical need."[53] The reality of this underfunding is that money for contract health services does not last the entire year, forcing IHS to limit services to circumstances involving a "loss of life or limb" circumstance. This predicament is so common in Indian Country that many tribal members fear that if they need care after June, they will be forced to go without.

IHS desperately needs additional funding. It is impossible to keep America's promise to provide care to Native Americans and Alaska Natives with the current level of IHS funding. The Baucus plan would increase funding for IHS, as well as encourage enrollment in other programs like Medicare, Medicaid, and CHIP for those who are eligible to defray the costs borne by IHS directly.

E. FOCUSING ON PREVENTION AND WELLNESS

Chronic diseases — such as heart disease, stroke, cancer, and diabetes — are the most prevalent and preventable of all health problems and also the most costly. Nearly half (45 percent) of Americans suffer from one or more chronic conditions,[54] and chronic disease accounts for 70 percent of all deaths (more than 1.7 million people).[55] In addition, increased rates of obesity and chronic disease are the primary cause of disability and diminished quality of life.

The economic impact of chronic disease in the U.S. is staggering. A Milken Institute study found that treatment of the seven most common chronic diseases, coupled with productivity losses, costs the U.S. economy more than $1 trillion annually.[56] About 78 percent of the nation's total health care spending is due to chronic illness.[57] Further, the number of Americans who have become obese has doubled since 1987, accounting for nearly 30 percent of the rise in health care spending between 1987 and 2005.[58] Despite the human and economic cost of chronic disease, the U.S. health system does little to address the underlying health problems that lead to these conditions.

For the sake of Americans' health, and to truly change the economics of our health care system, the U.S. must dramatically shift its health care focus toward preventing chronic disease. An estimated 80 percent of heart disease, stroke, and type-2 diabetes, and 40 percent of cancers, could be prevented if Americans stopped smoking, adopted healthy diets, and became more physically active.[59] Despite evidence that preventive services such as smoking cessation work,[60] our health system continues to emphasize expensive treatments. This approach is further complicated by a fractured delivery system in which individuals with chronic conditions often see more than one provider and take multiple medications.

Prevention must become a cornerstone of the health care system rather than an afterthought. This shift requires a fundamental change in the way individuals perceive and access the system as well as the way care is delivered. The system must support clinical preventive services and community-based wellness approaches at the Federal, state, and local levels. With a national culture of wellness, chronic disease and obesity will be better managed and, more importantly, reduced.

Guaranteed Access to Clinical Preventive Services and Referral to Community Resources. Those who are uninsured — and therefore less likely to receive preventive care and even treatment for major conditions — must be given a means to begin safeguarding and improving their health. This plan proposes "RightChoices," a temporary program to provide the uninsured with immediate access to a set of proven preventive

services such as a health risk assessment, physical exam, immunizations, and age and gender appropriate cancer screenings recommended by the U.S. Preventive Services Task Force. Based on a patient's risk, a care plan would be developed to maintain good health, and reduce the medical risks and costs of poor health. The RightChoices card would also provide referral to community resources such as smoking cessation and nutrition programs that have demonstrated success in changing and supporting healthy lifestyle choices.

Any individual eligible for RightChoices who is not eligible for or enrolled in a private plan or public program such as Medicaid or Medicare, but whose RightChoices screening detects and diagnoses one or more of the most common, costly chronic conditions would qualify to receive treatment for those conditions. Treatment would be provided on a temporary basis until viable coverage options are available under the Health Insurance Exchange. Individuals with incomes below 200 percent of the Federal poverty level could receive treatment at no cost.

To cover the cost of this care, states would receive a three-year capped allotment based on factors such as the percentage of uninsured and the prevalence of these chronic illnesses. These grants could also support the development of models to better manage, monitor, and treat these chronically ill individuals such as certified community care teams.[61] It could also be used for outreach to eligible, uninsured Americans.

Coverage for Prevention in Federal Health Programs and Private Plan Options. Evidence suggests that 96 cents of every Medicare dollar and 83 cents of every Medicaid dollar are used to treat chronic diseases.[62] Federal health programs must prioritize prevention to ensure that taxpayer dollars are used more efficiently and effectively. The Baucus plan would make prevention and wellness a priority in Medicare, Medicaid, and CHIP.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) took a step in this direction. MIPPA gave the Secretary of Health and Human Services the authority to identify new preventive services recommended by the U.S. Preventive Services Task Force for coverage under Medicare. The Baucus plan would do more, by reducing or eliminating co-payments for recommended preventive services under Medicare. New payment methodologies, combined with expanded use of health information technology, would increase appropriate use of these recommended preventive services and better manage the care of chronically ill beneficiaries.

Medicaid and CHIP beneficiaries would receive recommended preventive services without co-payments. Medicaid enrollees subject to cost sharing of even a one dollar co-pay per service used fewer physician services and received fewer preventive services including immunizations (a 45 percent decrease) and pap smears (a 21.5 percent decrease) compared to those not subject to a co-payment.[63]

In addition, Congress should explore evidence-based approaches for obesity prevention and treatment through demonstration projects in Medicare, Medicaid, and CHIP.

Demonstrations should test approaches that have shown clinical value in functioning settings.

The Health Insurance Exchange created under the Baucus plan would require participating plans to include certain preventive services in its benefit package. Such coverage would be based on recommendations by appropriate entities such as the U.S Preventive Services Task Force, the Advisory Committee on Immunization Practices, National Institutes of Health, Centers for Disease Control and Prevention, and Institute of Medicine.

A National Focus on Wellness. The plan would provide grants to states or communities to implement innovative, evidence-based prevention and wellness programs at the local level. The programs would employ best practices identified by the Department of Health and Human Services, the Institute of Medicine (IOM), and the Task Force on Community Preventive Services.

Grants would encourage local governments, employers, schools, health care systems, other community organizations, and individuals to work together and support healthy lifestyles.[64] Communities would be empowered and encouraged to identify and overcome barriers to healthy choices for all residents, regardless of health status, race or socioeconomic status. Interventions that could improve and maintain the health of pre-Medicare eligible individuals aged 55 to 64 would be explored. This investment makes sense. Healthier older Americans require less expensive care; and evidence suggests that this investment could result in less spending on future Medicare beneficiaries.[65]

The plan would also support efforts by small businesses to create healthier work environments with tax credits or other subsidies for proven wellness programs.[66] The support provided by targeted tax credits or other subsidies and community challenge grants would help lead individuals to make positive choices for their own health.

Finally, Congressional proposals have called for a more coordinated national strategy to prevent chronic disease and reduce obesity.[67] The health of Americans is affected by access to insurance, nutritious food and safe places to exercise among other factors. Congress should authorize a study to identify the various federal programs that can help prevent the development of chronic disease and suggest options to more effectively coordinate efforts going forward.

F. ADDRESSING HEALTH DISPARITIES

Racial and ethnic health disparities are characterized by persistent gaps in both health status and health care for minority populations. Disparities in the health status involve increased rates of mortality, level of chronic disease burden, and perception of one's health. For example, a larger share of African Americans has diabetes, high blood pressure, and heart disease than whites.[68] One of the most glaring differences in health status is reflected in infant mortality. African American infants die at a rate of 13.6 per 1000 live births — a rate that is higher than any other racial or ethnic group and twice that of

whites.[69] The African-American infant mortality rate is even higher than that of Slovenia, Poland, Kuwait, and Russia.[70]

Disparity in health care is characterized by differences in the quality of medical care that is provided and its availability to diverse populations. The landmark 2003 Institute of Medicine (IOM) study, *Unequal Treatment,* demonstrated significant quality gaps in the health care provided to African Americans and Latinos.[71] African Americans are 13 percent less likely to receive coronary angioplasty as whites.[72] African Americans are more likely to undergo leg amputation related to diabetes and to have complications following surgery.[73] In addition, Asians are less likely to receive timely antibiotic therapy while hospitalized.[74]

Lack of access is also a major factor affecting health care provided to racial and ethnic minority groups. Barriers to health care can result from lack of health insurance coverage, geographic location, language and cultural differences, and high cost. While only one-third of the U.S. population is made up of racial and ethnic minorities, they represent over half of the uninsured — over 30 percent of these two racial and ethnic groups are without health care coverage.[75] Medicare and Medicaid cover most of those insured among communities of color.

Language compatibility is also essential to ensuring quality health care for ethnically and racially diverse groups. The ability for patients to communicate their needs to a provider is critical. A lack of communication can mean an increased likelihood of medical errors and patients not adhering to a treatment plan. Latinos and Asians report having poor communication with their provider at a higher rate than other groups.[76]

The Baucus plan would make health care affordable and universally available to all Americans, a major step toward eliminating racial and ethnic health disparities. Subsidies for low-income individuals and families, in particular, would be critical to make health care obtainable by everyone. Currently, legal immigrant children and pregnant women are subject to a five-year waiting period before they can become eligible for Medicaid or CHIP. Not only does this exacerbate health disparities, but it increases the number of uninsured. The waiting period should be eliminated and eligible legal immigrants should have access to Medicaid and CHIP.[77]

Addressing access to health insurance coverage is not the only step in addressing disparities. Social determinants of health must also be addressed in the effort to eliminate health disparities. Lack of adequate housing, living wages, appropriate education, and clean environments adversely affect health status and well-being. All federal agencies that have jurisdiction over these types of social programs should collaborate together to improve the health and well-being of our communities.

The effort to document the extent of health disparities in the U.S. will require standard methods of collecting data. Data collection must also be more reflective of the target community from which data is gathered. Information must be reflected at the subpopulation level. The Baucus plan would require participating plans in the Exchange to

collect and report data based on race, ethnicity, and gender. The plan also proposes to include appropriate levels of funding to Federal agencies responsible for this type of data collection, such as the National Health Interview Survey (NHIS) and the National Health Care Survey (NHCS).

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CHAPTER III BAUCUS PLAN: IMPROVING VALUE BY REFORMING THE HEALTH CARE DELIVERY SYSTEM

Ensuring access to meaningful health coverage is a fundamental goal of health care reform, but there are also other vital priorities we must pursue. Among them is the critical need to improve the value of care provided in our health care system. We must take steps to ensure patients receive higher quality care, and do so in a way that reduces costs over the long-run. In short, the U.S. must get better value for the substantial dollars spent on health care.

Our nation's health care providers — physicians, nurses, hospitals, and others — work hard to provide life-saving and life-improving care to millions of Americans. The level of care provided is often excellent, but it has become increasingly evident that the way care is delivered and paid for in our health system does not always encourage the right care at the right time for each and every patient.

The Baucus plan includes initiatives to reorient America's health care delivery system toward services and activities that improve patient care and "bend the curve" of growth in national health care spending. At the same time, the plan invests in the health care infrastructure that is necessary for delivery reform to succeed. Many of the proposals in the plan are based in the Medicare program because of its unique ability to lead the way for system-wide changes. The expectation, however, is that public and private insurers will follow and continue to innovate as well. The Baucus plan considers delivery system reform with four key goals in mind:

- **Strengthening the role of primary care and chronic care management.** Primary care is the keystone of a high-performing health care system. Access to primary care that successfully manages and coordinates patient care, particularly for the chronically ill, is a proven determinant of high-quality, cost-effective care. Yet America's current system undervalues primary care relative to specialty care. This has caused fewer medical students to choose careers in primary care, and has created access problems that will only worsen as more Americans get health care coverage. Increasing the supply of primary care practitioners and redefining their role in the health system — by using Federal reimbursement systems and other means to improve the value placed on their work — is a necessary step toward meaningful reform.

- **Refocusing payment incentives toward quality.** Today's payment systems reward providers for delivering more care rather than better care. Under the current system, the more visits, tests, images and services providers deliver, the more they are paid — regardless of the quality or the health outcomes of the patient. The health system should refocus payment incentives toward improving the quality of care patients receive. Movement toward quality-based payment must start with fixing the unstable and unsustainable Medicare physician payment formula. The

current Sustainable Growth Rate (SGR) formula is fatally flawed and must be replaced.

- **Promoting provider collaboration and accountability.** Delivery system reform should also encourage providers in different settings — physician offices, inpatient hospitals, post-acute care settings, and others — to collaborate and provide patient-centered care in a way that improves quality and saves money. Under current payment systems, hospitals, physicians, and other health care providers are not encouraged to work together to improve patient care throughout the course of a patient's illness. In fact, they may be penalized financially — through lower revenues — if they successfully help patients avoid the need for additional health services. Congress should modify current payment systems to encourage — rather than discourage — collaboration and accountability among health care providers across treatment settings and sites of care.

- **Improving the health care infrastructure.** Efforts to improve the health care delivery system cannot succeed without taking other steps to modernize our system. These steps include investing in new research and tools, as well as the health care workforce. A national approach to comparative effectiveness research can help provide systematic, unbiased information about what treatments, technologies, and procedures work best. Health information technology (IT) can put comparative effectiveness research and other clinical decision-support tools at providers' fingertips in real time, as well as improve the delivery of care across settings and help providers to better coordinate patient care. Health IT can also facilitate initiatives to improve quality performance and data collection and aggregation. But gains from new research and health IT will be shallow unless we reinvest in the training of a 21st century health care workforce.

Like many other reforms, changes to the health care delivery system will take time. Moreover, these efforts will require continuing evaluation as the health system — and the health care needs of Americans — evolve.

A. STRENGTHENING THE ROLE OF PRIMARY CARE AND CHRONIC CARE MANAGEMENT

A strong emphasis on primary care is a common element of high-performing health systems.[1] International systems, and even parts of our own country, that deliver cost-efficient, high-quality care tend to have robust access to and use of primary care services.[2,3] Among other things, primary care practitioners should provide preventive care, help patients make informed medical decisions, and serve a critical care management and coordination role — especially for those with multiple chronic conditions who are the least healthy and most costly to our system. Yet today's payment systems place higher value on specialty care than primary care.

Strengthening the role of primary care will require a multi-pronged approach.[4] To this end, the Baucus plan includes several initiatives to improve our primary care system:

ensuring accurate prices for primary care services in Medicare, providing an add-on bonus payment for primary care services, and encouraging further testing and implementation of the medical home model. The plan would also ensure the viability of community health centers and rural health clinics that provide vital safety net functions and serve as a true medical home for thousands of patients across the country.

Ensuring Accurate Payments for Primary Care Services. Payments for primary care physician visits are undervalued, particularly compared to procedures and services furnished by specialists. In fact, the overvaluation of procedures in the Medicare physician fee schedule has both created financial incentives to provide unnecessary services and served as a disincentive for physicians to become primary care physicians. Primary care physicians are not trained in — and do not have the opportunity to bill for — procedures that generate extensive revenues for non-primary care physicians.[5]

In 1989, Congress enacted Medicare physician payment reform, which required a fee schedule based on relative values for approximately 7,000 services covered by the program. Private insurers often adopt the relative values set by Medicare, although they may use different payment rates for determining actual fees paid. The 1989 law also required periodic review — at least every five years — to ensure that the payment system reflects changes in the relative resources involved in furnishing physician services. Adjustments to relative values reflect changes in medical practice, coding changes, experience with new procedures, and other variables. Rapid growth in the volume of a service provided often represents evidence that the relative value for that service should be reviewed. [6]

The Centers for Medicare and Medicaid Services (CMS) has relied heavily on recommendations from the American Medical Association (AMA) Relative Value Update Committee (RUC) to determine needed changes to the value of services in the physician fee schedule. The RUC process has resulted in changes that have increased relative values in many areas but decreased values in very few. This result has worked against primary care services because primary care physicians bill for a relatively smaller and more static set of codes than non-primary care physicians. A recent increase in the relative values for primary care services by the RUC was a step in the right direction. The Baucus plan would seek a continued focus on the high value of primary care-related services, with corresponding reductions in relative values for overvalued services. Fee schedule rates must accurately reflect priorities that the health care system must adopt to bend the health care cost curve and improve quality over time.

Additional Payments for Primary Care Providers. The undervaluation of primary care services might also be addressed by the Baucus plan with increases in Medicare payments for services furnished by practitioners focused on delivering primary care.[7] Payments must be well-targeted, starting with careful identification of the list of services that qualify as primary care services — primarily evaluation and management visits. A second step involves identification of Medicare providers, including physician and non-physician practitioners, who truly focus on delivering primary care. Using claims history — rather than self-identification — is a more accurate approach to identifying appropriate providers.

In addition, bonus payments should also take into account the complexity of the provider's patient panel to ensure that underserved populations are not left behind. Finally, the task of setting a threshold for these services is best left to CMS, which can collaborate with stakeholders and other experts to strike the right balance.

To avoid cost inflation, this proposal should be made budget-neutral. Budget-neutral changes to Medicare payments mean that any increase to primary care providers requires a corresponding cut to specialist services. This approach has the potential to create significant controversy among physicians, however. Any reforms along these lines must be crafted in collaboration with the entire physician community and other practitioners to ensure appropriate valuation of, and access to, primary care services. Other means of redefining the value that the health system places on primary care, such as revisions to the SGR formula, are discussed below.

Patient-Centered Medical Home. Expanding Medicare's role in testing the medical home model — in which practitioners are paid explicitly for comprehensive care management services — is another way that the Baucus plan would promote quality and efficiency. A growing body of evidence suggests that medical homes may improve patient health and reduce costs.[8,9] In 2006, Congress required CMS to establish a demonstration program to test the medical home model in fee-for-service Medicare.[10] More recently, Congress provided additional funding for this demonstration and granted CMS authority to expand the program if quality and cost targets are met.[11]

Medical home expansions in Medicare should focus only on providers who are committed to ensuring that patients truly receive the primary care and care management services that the medical home is designed to deliver. Providers seeking to participate in a Medicare medical home expansion program should meet a set of stringent service and capacity criteria in order to qualify, such as those proposed by MedPAC,[12] and be willing to have additional payments based in part on the quality of care they deliver. The National Committee for Quality Assurance (NCQA) has also developed an assessment tool that tiers medical homes based on the implementation of particular capacities and patient services.[13]

In addition, careful consideration should be paid to the role of non-physician providers, such as nurse practitioners and home health aides, in the medical home model. Medical home expansions should also target the patient populations most in need of comprehensive care management and coordination, particularly those with multiple chronic conditions. As with other components of the medical home, though, these tools and criteria will evolve as results from ongoing demonstrations and input from patients, providers, other stakeholders, and experts are received and incorporated into the medical home model.

This plan would expand the medical home model by requiring collaboration between Medicare and ongoing demonstration sites that include private payers and Medicaid. Aligning incentives created by disparate payment models — for example, private payers and public programs — is crucial to achieving significant delivery system reform.

Building a qualified medical home may not be feasible for all providers, however. The required medical home criteria (particularly the necessary investments in infrastructure and staffing) can be challenging for the 36 percent of physicians who work in solo or very small-group practices, many of which are located in rural areas. One option is to invest in community health teams that include nurses, nutritionists, and social and mental health workers. These teams could link primary care practices with additional resources that would allow small or rural offices to participate in the medical home. The state of North Carolina has achieved preliminary success with the community health team model in its state Medicaid program.[14] Going forward, Medicare could join with other payers (Medicaid, private plans) in funding states to develop this capacity throughout the state, or in conjunction with other states in their region. Financial assistance for smaller primary care practices to adopt health information technology would also provide a strong incentive to collaborate with community health teams. Another option is to explore alternative payment models that do not require specific practice improvements but instead offer shared-savings bonuses for meeting aggressive cost and quality benchmarks.

In addition to the medical home, Medicare should test other primary care models that promote comprehensive care management and coordination, particularly for the chronically ill. Recent proposals to focus on caring for the sickest patients in their home, or those that rely on a geriatric assessment to qualify patients for comprehensive care coordination programs, show promise and should be examined in more detail.[15]

Vendor-based disease management programs, which typically involve phone-based care planning and follow-up by nurses, have found some success in the private market but have not fared as well in recent Medicare demonstrations.[16,17] While these approaches should not be jettisoned without consideration of new evidence from state and private payer programs, it remains an open question whether Medicare should make direct payments to vendors outside of a comprehensive care management model, such as the medical home.

The medical home and other care management concepts are works in progress, and the involvement of patient groups is critical to ensuring that these models remain patient-centered. A true medical home should serve as a central resource for a patient's ongoing care. Care management expansions under the Baucus plan will require ongoing evaluation to ensure they are truly patient-centered. And to encourage patient participation, co-payments for services provided in medical homes, for instance, could be reduced or eliminated. These models will only improve health care quality and efficiency if patients find that they provide needed health services in a consumer-friendly way.

Community Health Centers and Rural Health Clinics. Efforts to reestablish primary care as the backbone of the health care system should build on existing systems that work. For example, community health centers, which serve low-income and medically underserved populations, perform well on quality indicators, provide efficient care, and have in many cases implemented critical components of the medical home model.[18]

To shore up this important component of our nation's safety net, the Baucus plan would modernize the outdated Medicare system for paying Federally Qualified Health Centers

(FQHCs). The Baucus plan would establish a prospective payment system for qualifying FQHCs, mirroring the successful model that the Medicaid program uses for paying these centers and expand the role of health centers in providing preventive services. To qualify for PPS payments, FQHCs will be required to report on quality metrics and make investments in the infrastructure necessary to qualify as a medical home.

Mechanisms for compensating rural health clinics (RHCs) also are deficient and should be improved. In Montana and across the country, these facilities are instrumental in meeting the needs of patients when other access points to care are unavailable or inadvisable — for example, reliance on an emergency department. For these reasons, health reform should include policies that bolster community health centers, RHCs, and FQHCs as part of the larger effort to improve patient access to critical primary care services.

B. REFOCUSING PAYMENT INCENTIVES TOWARD QUALITY

Efforts to restructure provider payment systems to improve quality also represent a critical component of delivery system reform. Many private and public organizations have echoed the need to re-direct the health care system to reward higher quality and more efficient care. In its landmark 1999 report, *To Err is Human: Building a Safer Health Care System*, the Institute of Medicine (IOM) urged a heightened focus on quality initiatives.[19] Subsequent reports called for increasing payments for providers offering high-quality care[20] and the establishment of a national system for performance measurement and reporting.[21] MedPAC has also made multiple recommendations to Congress regarding the need for payment incentives based on quality for hospitals, physicians, home health providers, Medicare Advantage plans, and outpatient dialysis providers.[22,23]

Based on these recommendations, Congress and CMS have enacted and implemented policies to increase the focus on quality in the Medicare payment systems, particularly in the areas of inpatient hospital care and physician services. The Baucus plan will build on these efforts by establishing a pay-for-performance program for hospitals in Medicare and further strengthening physician programs that are focused on quality improvement. The plan will also encourage efforts to test pay-for-performance models related to home health and nursing home care, as well as bring pay-for-performance to the Medicare Advantage program.

Hospital Quality Reporting and Next-Generation Quality-Based Payment Reforms. In 2003, Congress set the Medicare program on a path toward quality improvement by establishing a hospital pay-for-reporting program.[24] As part of this effort, Congress asked hospitals to track and report to CMS their performance on a set of ten defined quality measures, such as how frequently a heart attack patient received aspirin upon admission. To encourage participation, Congress provided higher payments to hospitals that reported this information, and penalized those that did not. Ninety-eight percent of hospitals chose to participate.[25]

In 2005, Congress permanently extended the reporting program, directed CMS to incorporate additional performance measures into the initiative, [26] and increased penalties for non-participating hospitals.[27]

By most accounts, the Medicare hospital pay-for-reporting program has been an important first step in improving the quality of care provided to Medicare beneficiaries in the inpatient hospital setting. It provides better insight into the quality and performance of America's hospitals for policymakers and patients alike.

Alongside the Medicare pay-for-reporting program, CMS has been testing a more aggressive move to a "pay-for-quality" model. In October 2003, CMS contracted with Premier, Inc., a nationwide alliance of not-for-profit hospitals and health systems, to conduct a demonstration linking payment to the achievement of quality goals. This project, the Hospital Quality Incentive Demonstration (HQID), has involved more than 260 hospitals across the nation[28]. Under the demonstration, hospitals were asked to report process and outcome measures in five clinical areas related to heart attack, heart failure and pneumonia. Hospitals in the top 20 percent in each clinical area received a financial incentive payment.

Results from the HQID project demonstrate dramatic quality improvements in every measured clinical area, with an 11.8 percent average quality improvement among participating facilities over two years. These statistics translate into actual results for patients: 1,284 fewer heart attack deaths for patients who received more clinically appropriate care[29]. Based on these results, the HQID demonstration was extended for another three years (through 2009) and will be expanded to test other innovative pay-for-performance models.

The next step in quality-based payment reform is the adoption of a value-based purchasing (VBP) program in the hospital inpatient setting. In its November 2007 Report to Congress, CMS provided a roadmap for moving Medicare from pay-for-reporting to pay-for-performance.[30] In establishing a pay-for-performance program, providers would not only be rewarded for reporting quality activities, but their payment would also be increased or decreased depending on how well they perform on these quality measures.

Building on these recommendations and the other efforts outlined above, the Baucus plan includes provisions to improve quality care in the inpatient hospital setting through establishing a hospital pay-for-performance program, which is sometimes also referred to as value-based purchasing, in Medicare. The Baucus plan uses the following principles to guide this effort:

- **Transitions to value-based purchasing should be gradual.** Linking payments to performance represents a major shift in how Medicare pays for services. The plan would phase in value-based purchasing so that the amount of payment at risk would gradually increase to no more than two percent of base hospital operating payments.

- **A value-based purchasing program should build on the current reporting program.** A hospital value-based purchasing program should start with a set of quality measures that hospitals have already been reporting on through the pay-for-reporting program. Over time, the quality reporting program should continue to be a testing ground for evaluating new measures before they are subjected to pay-for-performance rules.

- **Quality measures should be endorsed by relevant stakeholders.** All measures must be evidence-based, statistically valid, and field-tested to ensure that they represent the best practices in improving quality. Measures should be selected through rulemaking and endorsed or considered by consensus-building organizations whenever possible.

- **Rewards should be provided to hospitals that achieve quality goals as well as to those that make significant improvements.** The value-based purchasing program should reward facilities that meet quality benchmarks and those who have made substantial quality gains in performance relative to prior years.

- **Every effort must be made to align hospital and physician quality goals.** As new quality measures for hospital and physician performance continue to be developed, every effort must be made to encourage providers to work together toward common quality improvement goals.

- **Safety net, low-volume, and rural hospitals should be given special consideration.** The hospital value-based purchasing program must be structured in a way that would allow smaller, rural facilities to participate and include protections for safety net hospitals that may face unique challenges in meeting the requirements of a value-based purchasing program.

- **Quality performance and the process to reward hospitals must be transparent.** Hospital performance in the value-based purchasing program should be publicly reported and available to consumers. The CMS methodology for determining hospital performance scores and calculating payments for facilities must also be transparent and public.

- **The value-based purchasing program should be subject to ongoing monitoring and evaluation.** The Secretary, GAO, MedPAC, and others should help Congress monitor the value-based purchasing program and provide specific input on any unintended consequences of the program.

These principles would serve as guideposts for efforts to establish a hospital value-based purchasing program in Medicare and are a key component of this plan.

Physician Quality Reporting Initiative. As Congress seeks to reward hospitals that provide high-quality care, steps must also be taken to improve quality and resource efficiency in the Medicare physician payment systems. To further improve patient care,

the Baucus plan would build on the Physician Quality Reporting Initiative (PQRI) and the provider feedback program as a next step in improving patient care.

Despite substantial concerns regarding PQRI, the program is on its way to achieving the goals set by Congress when the program was enacted in 2006: engaging clinicians and other health care stakeholders in developing meaningful quality metrics to evaluate care; putting Federal resources on the table to promote and partially fund quality improvement activities; and expediting the development of data collection processes that will lead to meaningful and actionable information flowing to providers, patients, and payers.

The first round of PQRI was executed in the second half of 2007. More than 100,000 clinicians attempted to participate in the program, and performance results and incentive payments were delivered to participants this summer. At the same time, considerable confusion lingers regarding the reporting mechanism, and reports indicate delays in the delivery of incentive payments and difficulty in accessing feedback reports.

Congress and CMS have recently acted to address these technical challenges and expand provider outreach and education programs so that the foundation of this program remains strong, and physicians are not discouraged from participating. Reforms enacted in MIPPA permit physicians to report on condition-specific groups of measures, such as those addressing diabetes and heart failure, permitting more comprehensive analysis of a physician's ability to care for patients with these chronic illnesses.

In addition, MIPPA requires the establishment of a pathway for physician groups to report quality information on an aggregated basis, reducing administrative burdens and fostering clinician-to-clinician sharing of expertise that will be much more effective in improving quality than purely governmental interventions.

Finally, Congress required CMS to expedite approval of clinical registries to which physicians report performance data. These registries, such as the National Cardiovascular Data Registry spearheaded by the American College of Cardiology, are often operated by clinician groups or medical boards and are capable of collecting richer data sets than can be accessed through claims forms. And physician recognition programs like those sponsored by NCQA are also important conduits for quality reporting. Under MIPPA, registries and recognition programs — once they are approved by CMS — will now be able to submit data to CMS on behalf of participants.

Medical boards in particular are striving to meet the professional needs of physicians while also fostering gains in quality of care. Boards such as the American Board of Internal Medicine (ABIM) are including some quality reporting in their maintenance of certification process. In order to retain ABIM certification every ten years, physicians must not only pass a traditional exam testing their knowledge, judgment, and analytical skills, but they also must participate in at least one quality reporting program. Going forward, PQRI should work in conjunction with medical boards to encourage more frequent and more aggressive recertification processes, including those that go beyond quality reporting to focus on how physicians actually perform.

Before Medicare can transition from pay-for-reporting to pay-for-quality, physicians must be able to successfully participate in PQRI and receive appropriate incentives to do so. The reforms in MIPPA demonstrate a commitment by Congress to keep PQRI a flexible program that responds to provider feedback and capitalizes on developments outside of Medicare (e.g., clinical registries).

Ultimately, Medicare must put physicians on a similar course as the plan described above for hospitals and transition PQRI to a true value-based purchasing program. As a next step, the Baucus plan focuses on improving the clinical importance and validity of the measures that physicians report to PQRI. The program may also require that physicians report the results of patient experience surveys in order to receive a full bonus. Finally, once the recent program improvements are fully implemented, the Baucus plan calls for the current positive financial incentives for physician participation in PQRI to eventually be matched with payment penalties for those who do not report. A report from CMS, required in MIPPA, will give Congress additional guidance on how best to reinvent the Medicare physician payment system from one that rewards quantity to one that focuses financial incentive on high-quality, evidence-based care, and healthy outcomes for patients.

Provider Feedback Program and Episode Groupers. Congress also recently required CMS to begin providing feedback to practitioners regarding their resource use. CMS is authorized to explore different methods, including evaluating resource use on a per capita basis or using episode grouper technology. The per capita method — which essentially examines physician resource use per beneficiary — can be particularly helpful in identifying outliers whose practice patterns fall outside an acceptable "bell curve" of variation.[31] However, this method is less effective in giving providers actionable information by which to change their practice patterns and improve their care for specific patients and particular diagnoses.[32]

An alternative methodology that may hold greater promise, particularly for specialists who tend to perform discreet procedures for a specific illness, is the use of episode grouper software. This technology evaluates the resources used to treat a patient during a specific episode of illness, which may encompass multiple interventions over a period of time and care furnished by multiple providers.[33] While most versions of this technology rely strictly on insurance claims, eventually they could be adapted to include clinical data generated from electronic health records and other sources.

Ultimately, episode groupers could give providers and payers more specific, actionable information that could lead to meaningful reductions in inappropriate care patterns. Medicare should develop its own open-source technology platform that includes information on both episodes of care and per-capita resource use. This will help ensure that episodes of care are both necessary and efficient. Finally, Medicare's physician feedback program should include information regarding quality of care — the health outcomes of patients should not be compromised by efforts to reduce costs in treating specific illnesses.

Quality Improvement for Other Providers and Private Plans. As Congress moves forward on efforts to improve the quality of care provided by hospitals and physicians, efforts to strengthen quality in other care settings must not be left behind.

CMS is currently developing a pay-for-performance demonstration project aimed at home health and nursing home care. For home health care, CMS proposes to test a pay-for-performance model in seven states using quality measures based on the Outcome and Assessment Information Set (OASIS) that agencies have been using to report quality activities since 2000. For nursing homes, CMS is also working to develop a demonstration project that would offer financial incentives to facilities that meet certain conditions for providing high-quality care. This project would be tested in five states. Both of these projects must move forward to help CMS and Congress gain much needed information on how to appropriately increase the focus on quality in the home health and nursing home settings.

Congress should also explore a pay-for-performance requirement for private plans that participate in Medicare. Health plans in the Medicare Advantage program have been reporting a standard set of valid performance measures to CMS for over a decade. CMS should move health plans beyond reporting so that payments reflect plan performance. Additionally, CMS should provide for the development of valid performance measures for prescription drug plans and begin to bring pay-for-performance to these plans, too.

As these efforts to collect, report, and appropriately pay for quality and efficiency move forward, provider concerns regarding the number of methodologies, metrics, and misaligned payment incentives must also be addressed. Clinicians are often subject to several pay-for-performance programs that use different quality measures for similar patients and require different data collection approaches. While significant efforts are underway at the National Quality Forum (NQF) and other quality alliances and industry groups to achieve uniformity, more work needs to be done to standardize measures and administrative approaches and to minimize the burden on providers.

Congress provided substantial funding to NQF in MIPPA to facilitate the endorsement of standardized measure sets and bring stakeholders together to agree on priorities for performance measurement.[34] But Congress can go further by fostering, through the Independent Health Coverage Council, alignment among the insurance plans participating in the Health Insurance Exchange.

Reforming the Sustainable Growth Rate Formula. Moving toward a more value-driven physician payment system in Medicare must start with reform of the current system used to update physician payments. Enacted as part of the Balanced Budget Act of 1997, the Sustainable Growth Rate (SGR) was designed to control spending for physician services provided under Medicare Part B.[35] The statutory formula sets a target amount for spending for certain services including physician services, lab tests, imaging, and physician-administered drugs that are furnished in connection with physician services. If overall spending exceeds the target set by the SGR, payments under the fee schedule are

automatically adjusted downward. If overall spending is less than the target, then payments are adjusted upward.

Since 2002, the formula has called for automatic reductions in the payment update, but Congress has enacted legislation to override the formula each year. These legislative overrides, as CBO has observed, suggest that the current SGR formula is not a viable mechanism to control spending for physician services.[36] However, Congress has struggled to find a viable alternative to the SGR.

The most immediate obstacle to reforming the SGR is budgetary. The flawed formula which is the basis of the SGR, combined with multiple years of Congressional intervention, has left a nearly $300 billion discrepancy over ten years between what physicians are projected to be paid under the formula and what a modest inflationary update over those years would provide.[37]

These projected reductions in physician reimbursement are unrealistic and, if implemented, may have disastrous consequences for the Medicare program. They could likely cause physicians to exit the program and Medicare beneficiaries to lose access to needed care. The now-yearly cycle of Congressional intervention to block these SGR cuts consumes attention and resources that should be directed to other challenges posed by Medicare and other Federal programs. And, because the timing of Congressional action is often unpredictable, it also puts enormous pressure on physician practices across the country as they try to set budgets and meet payroll each month.

As Congress takes steps to resolve the budgetary shortfall posed by the SGR, CMS should use its discretion to define the items and services that are included in the SGR formula's calculations. CMS should use its administrative authority to remove physician-administered drugs, for which payment is based on the average sales price methodology, from the formula in a shared effort to reverse the annual cycle of fixing the SGR.

In addition to the massive budgetary shortfall, there are also substantive obstacles to SGR reform. The fundamental flaw of the SGR is that the behavior of an individual physician, even a large group practice, cannot affect a formula driven by the practice habits of more than 800,000 providers who are paid under the physician fee schedule.

When MedPAC presented its analysis of the substantive options for reforming the SGR in March 2007, it identified two paths: (1) jettison the expenditure target approach and focus on proposals that encourage higher quality care at lower cost; or (2) pursue value-based payment reforms while replacing the SGR with a new expenditure target system for all Medicare providers based, for example, on geographical location or type-of-service.[38]

The first path would explicitly reorient physician payment toward high-value care. It would also avoid further investment of Federal resources in a target-based formula that may not influence individual physician behavior as Congress intends. Applying expenditure targets to other aspects of Medicare — as MedPAC's second path suggests — could create additional administrative burdens without ensuring payment stability.

Eliminating the expenditure target altogether would likely exacerbate the SGR's budgetary shortfall and some in Congress have asserted a strong interest in revising the SGR formula.[39] As we attempt to move beyond the ongoing SGR predicament, it may be necessary to replace it with an alternative expenditure target approach.

One such approach would be the development of a revised SGR formula that creates multiple expenditure targets based on sub-sets or categories of services. This has the advantage of reallocating resources from high-growth, potentially overpaid aspects of health care to underutilized, potentially more valuable services such as primary care and prevention. Careful attention must be paid to appropriately clustering services so that new prices generated by the SGR do not produce excessive increases or reductions in any particular service. Consideration should also be given to whether GDP growth should remain the short-term basis of SGR expenditure targets as medical inflation is expected to outpace GDP growth at least until the reforms proposed in this paper take full effect.

Finally, in constructing a fee schedule based on multiple targets, careful consideration must be given to ensure that the price outputs of the formula apply to the practitioners responsible for the rate of growth of particular services. For example, in the case of a separate target based on utilization and growth in imaging services, physicians who refer patients for imaging services usually do not receive payment for the performance or interpretation of those services.

Nonetheless, SGR reform should closely examine the growing costs to the Medicare program of advanced imaging utilization and fees. A recent report by GAO found that the significant recent growth in imaging costs is attributable in large part to physicians increasingly providing imaging services in their offices as a means for revenue-generation.[40] MedPAC analysis points to imaging utilization as a factor in the significant regional variation of cost and quality discussed elsewhere in this paper; according to their report, regional use of imaging services can vary by as much as three times.[41] Physician payment reform should pay particular attention to the cost and quality implications of the growing practice of physicians self-referring for diagnostic imaging services. Medicare should also consider establishing a process for the identification and surveillance of high-growth services. If the evidence suggests that prices are distorting physician behavior, then modest reductions in prices that can elicit desirable behavioral changes without impacting beneficiary access could be pursued administratively.

C. PROMOTING COLLABORATION AND ACCOUNTABILITY

While we take steps to improve the quality of care provided to patients, we must also provide new incentives that encourage health care providers to work together to offer patients the best possible care. Today, hospitals, physicians and other health care providers are each paid separately, which creates little incentive for them to work together to effectively manage patient care. Lack of collaboration can have a particularly detrimental impact on patients with chronic or multiple illnesses who can most benefit

from well-coordinated care. Medicare should use payment incentives to drive more collaboration among physicians, hospitals, and other health providers.

The disadvantages of care fragmentation are particularly evident for patients who experience a hospitalization. Discharge from a hospital is a particularly critical and vulnerable time for patients. In many cases, hospital patients are abruptly transitioned to home or post-acute care, and discharges that occur over a weekend mean patients are suddenly expected to assume a self-management role for their recovery with little support or preparation.[42] In addition, the physicians who treat a patient during their hospital stay are often not the same physicians who see the patient once they leave the hospital. Payment systems, including the Medicare program, do not encourage these providers to communicate or work together to ensure patients receive the proper medication and other follow-up that is necessary post-hospitalization.

While lack of care coordination around a hospitalization episode can have a detrimental impact on patients' health and well-being, it also has a significant financial impact, particularly on the Medicare program. According to some estimates, 18 percent of Medicare hospital admissions result in readmissions within 30 days post discharge. These readmissions accounted for $15 billion in spending in 2005, and according to MedPAC, $12 billion of this spending is potentially avoidable.[43] Not only can a reduction in readmissions result in Medicare savings, but it could also reduce geographic variations in health spending. The 30-day readmission rate for Medicare beneficiaries ranges from 14 percent in some states to 22 percent in others.[44] New Medicare payment policies should encourage hospitals and other providers to work together to provide the best possible care to hospital patients both during and immediately following their hospital stay.

As we work to improve patient care around hospitalizations, we must take steps to encourage further collaboration among multi-specialty physicians who treat patients in the community. In the Medicare program, physicians who are paid on a fee-for-service basis have little financial incentive to work together to improve the quality and efficiency of care provided to patients. Any savings they achieve through better care coordination accrue not to their practice but to Medicare. A Medicare demonstration project, called the Physician Group Practice demonstration, is succeeding at slowing cost growth and improving quality by allowing physician groups to share in savings from reduced health spending and should be expanded.

Delivery system reforms should also encourage innovative organizational models that allow for patient care across the treatment spectrum. Health care delivery systems that treat patients throughout the continuum of care — from primary care to hospitalization to post-acute rehabilitation — should be paid in a way that rewards them for improved quality and efficiency. One model that should be tested in this area, and is described in more detail below, is the concept of accountable care organizations (ACOs), which encourage health care providers across the treatment setting to work together to improve patient care.

Reducing Hospital Readmissions. Discouraging unnecessary readmissions by restructuring Medicare payments is good policy. It is better for patients and better for taxpayers. The Baucus plan would take a three-step approach to reduce hospital readmissions and improve care coordination for patients who have experienced a hospitalization.

First, the plan requires CMS to provide confidential feedback to hospitals and physicians regarding resource use for select hospitalization episodes. This data would need to be detailed enough to help providers understand spending and resource consumption, particularly for higher-cost beneficiaries. Once providers better understand how they perform relative to their peers, they could begin to address problem areas. The plan would then require hospital-specific information on readmissions be made available to the public.

Second, the plan would create new financial incentives in Medicare to encourage providers to take greater responsibility for the coordination of care for hospital inpatients. Under current law, Medicare pays the same for hospital stays regardless of whether it is a patient's first inpatient stay or a readmission for the same condition. The plan would adopt MedPAC recommendations as a starting point for creating new financial incentives to reduce hospital readmissions in the Medicare program. These changes would mean reduced payment rates for hospitals with readmission rates above a certain benchmark. This benchmark will need to be defined, but ideas that have been put forward include setting the benchmark as the average readmission rate across similar hospitals or using a higher standard that ties the benchmark to the top performing facilities. In the initial years, this plan would focus on reducing re-hospitalizations for a limited number of conditions that are known to have a high rate of readmissions, such as congestive heart failure, chronic obstructive pulmonary disease (COPD), and coronary artery bypass graft. But over time, the program would be expanded. In circumstances where a readmission is unavoidable, hospitals would not be penalized.

Bundled Payments. The third step will involve testing other models to improve patient care related to hospitalizations. One concept that offers promise for greater efficiency and care coordination is the idea of allowing Medicare to pay bundled or global payments for all services provided to a patient during hospitalization and for some amount of time post discharge.

Using its administrative authority, CMS has taken steps toward bundled payments by establishing the Medicare Acute Care Episode (ACE) demonstration. Currently under development at CMS, this demonstration project would allow hospitals and physicians to receive a global payment for services provided to patients who receive certain cardiac and orthopedic procedures. In the first year, this bundled payment would cover all hospital and physician services provided during a patient's hospital stay. At this point, it does not appear that the demonstration will include services provided post-hospitalization. The project is expected to be implemented early next year and would involve up to 15 demonstration sites. Medicare beneficiaries who receive care as part of the demonstration would receive a partial refund on their Part B premium for agreeing to participate in the project.

A similar project, the Medicare Participating Heart Bypass Center demonstration, was tested in the early 1990s. Under this demonstration, Medicare paid a bundled rate for hospital and physician services around hospitalizations for cardiac bypass graft surgery. In this demonstration, the bundled payment included services provided during the hospital stay as well as services provided immediately following the hospitalization. Results showed increased efficiency and reduced Medicare spending. In particular, CMS found that most participants were able to achieve reduced lab, pharmacy, and intensive care unit spending. Spending on post discharge care also decreased, while quality remained high.[45,46]

More recently, bundled payment initiatives have been tested in the private sector, specifically at the Geisinger Health System. Glenn Steele, Geisinger's President and CEO, discussed the ProvenCare[SM] program at a Finance Committee hearing in September.[47] The program offers a bundled payment for the package of services provided to patients receiving cardiac bypass graft surgery. This bundled payment covers the first physician visit that determined surgery was necessary, all hospital costs for the surgery, and all costs for related care post surgery, including cardiac rehabilitation. As long as all care was provided at Geisinger, the patient pays only one charge for this set of services.

The results of the ProvenCare[SM] initiative have been impressive. Within three months of instituting the program, roughly 86 percent of patients were receiving all recommended best practices related to cardiac surgery care.[48] Based on this success, Geisinger recently expanded this model to other high-volume procedures, such as hip replacement, cataract surgery, obesity surgery, care for babies, and heart catheterization.

Building on these efforts, the Baucus plan would develop and test other models for bundled payments. As part of this effort, the plan would allow the current CMS bundling demonstration to expand to other sites and to focus on other clinical conditions if certain criteria are met. In addition, this plan would encourage CMS to include services that are provided post-hospitalization as part of the bundling payment model.

Moving toward bundled payments is a complex process that would require time and resources. The Baucus plan would seek to limit unintended consequences, such as inappropriate reductions in care to increase profit. In addition, bundling models must also include appropriate risk adjustment to ensure health care providers are not penalized for or discouraged from treating sicker patients. Finally, this plan would work to ensure that efforts to expand payment bundling for hospital and physician services is done in way that is workable for non-integrated and smaller health care providers.

Physician Group Practice Demonstration and Accountable Care Organizations.
A reformed delivery system should also do a better of job of rewarding providers, particularly physicians, who work together to offer high-quality, cost-effective care to patients. The Medicare program is currently testing a project in this area, called the Physician Group Practice (PGP) demonstration. Now in its fourth year, the PGP demonstration includes ten large physician groups that receive enhanced payments for

improving the quality and efficiency of the care delivered to Medicare beneficiaries. Groups that meet quality targets and achieve cost reductions beyond a two percent threshold are permitted to share in the savings that they generate to Medicare. In the second year, all participants demonstrated improvements in quality and achieved below-average growth in costs; four were awarded with incentive payments for reducing costs significantly.[49]

Preliminary results from the demonstration and reports from participants suggest that the program has achieved its goals of better coordination of care for the chronically ill, careful attention to hospital discharge processes, expanded role for non-physician providers, and investments in IT.[50] While some design challenges of this demonstration remain — including the identification of a control group for cost comparison purposes, selection of meaningful quality measures, and timely generation of feedback to participants — the results to date merit expansion. The Baucus plan calls for CMS to establish a framework for reforming and expanding the PGP demonstration after its fifth year, which would end in March 2010. The plan for expansion should give providers a pathway toward accountability and shared savings, but should not restrict beneficiary choice. This effort is consistent with other delivery system reforms proposed in this paper, including expansion of the medical home, greater adoption of health IT, and transparency regarding provider quality and costs.

While the current PGP demonstration focuses on large physician group practices, considerable work has been done to explore the possibility of accelerating broader delivery system integration by expanding the PGP model to encourage provider collaboration and accountability on a larger scale.[51]

Ideal candidates for expansion are organizations that span the continuum of care in a community. Integrated health systems, such as Billings Clinic in Montana, InterMountain in Utah, and Geisinger in Pennsylvania, offer patients access to a range of providers and settings, including hospitals, post-acute, facilities, and the local physician community. Due in large part to their innovative organizational model, these systems are providing high-quality integrated care that is more cost-effective than their competition.

The term accountable care organizations (ACOs) has been used to describe these and other provider groups that are optimal candidates for payment based on improvements in quality and savings achieved through improved care processes.[52] Based on the results from the current PGP demonstration, the Baucus plan would create a new Medicare pilot program to test the cost and quality opportunities of value-based payments to ACOs.

Organizations eligible to participate in this new project should include integrated delivery systems, hospitals that employ their own physician staff, academic medical centers and their affiliated faculty practices, multispecialty group practices, physician hospital networks or independent practice associations, and primary care physician groups able to identify the other providers from whom their beneficiaries receive their care. The new ACO pilot should be implemented in part in communities and regions where meaningful integration does not yet exist — such as in rural areas and small group practices.

As part of this project, ACOs would be subject to group level reporting on a list of quality measures endorsed by the National Quality Forum (NQF). CMS would establish a timeline to phase in reporting on these measures, so that within five years, participating ACOs would be reporting on at least the following classes of measures: (a) risk-adjusted health outcomes and improvement on specified ambulatory chronic conditions as well as common inpatient chronic conditions, and (b) patient experience measures for both ambulatory and inpatient care. CMS would establish benchmarks for achievement and improvement that ACOs would have to meet in order to qualify for incentive payments. ACOs that successfully report on measures in a manner consistent with the Physician Quality Reporting Initiative (PQRI) would qualify for the incentive payment under that program as well, as is the case for existing PGP demonstration participants.

To determine whether ACOs are successfully controlling costs, CMS would establish a formula that would allow current and future years' per beneficiary spending at the ACO to be estimated as accurately as possible using Medicare Part A and Part B claims for the beneficiaries it treats. Using multiple prior years of data would allow more accurate and stable estimates of current year spending.

An issue to be resolved with input from stakeholders and other experts would be how to establish cost trend targets for participating ACOs.[53] Several approaches to developing the targets should be considered, balancing the following interests: encouraging providers in both high- and low-cost regions to participate and receive shared savings payments; reducing unwarranted geographic variations in per-beneficiary spending; and promoting regional and ACO-level equity in the amount of increases in per-beneficiary spending permitted under the shared savings program. Perhaps a middle ground would be to begin with a formula using regional trends that would slowly phase in a national element to more aggressively reduce cost growth over time.

Incentive payments would be awarded to ACOs that reduce spending significantly below the target rate set by the formula. A threshold savings amount should be set — such as the two percent mark used in the PGP demonstration — to avoid incentive payments being made to ACOs based on natural variations in their year-to-year spending. Savings should be based on real system improvements and not accidents.

The plan also calls on CMS to develop a formula for distributing shared savings payments that would give providers a strong incentive to participate in the program, while ensuring that a substantial share of the savings would accrue to the Medicare Trust Fund as the magnitude of savings increases. The PGP demonstration allows participating provider groups to recoup 80 percent of the cost reductions that they achieve beyond the two percent threshold, with a cap on incentive payments of five percent of total Medicare spending. An alternative approach would distribute 100 percent of first three percent of additional savings beyond the threshold to the ACO, with the share of savings diminishing above the five percent mark and continuing to decline up to a maximum threshold set by CMS.

The development of a shared savings program building on the success of the PGP demonstration should proceed as rapidly as possible. To achieve this goal, CMS should implement ACO pilots on as broad a scale as is feasible, which could permit testing variations of the model. As is the case with other areas, CMS could also use existing authority to align payment models in specific regions or states to support similar initiatives led by private payers and state Medicaid programs.

Gainsharing. As part of delivery system reforms, the Baucus plan would also take steps to break down existing barriers that keep health care providers from improving patient care through increased collaboration. Successful implementation of new payment and delivery models to promote coordination and value-based purchasing may require changes to the regulatory structure governing provider collaboration. For example, the Stark and anti-kickback laws — which appropriately protect against financial conflicts-of-interest between hospitals and physicians — have come to broadly prevent hospitals from offering financial incentives to physicians who appropriately use imaging services or prevent readmissions through disease management protocols.

Allowing providers to share among themselves savings from improved efficiency and quality — also known as gainsharing — is one potential strategy to encourage provider collaboration.[54] CMS conducted demonstration projects in the 1990s that allowed participating hospitals to experiment with gainsharing arrangements. While these projects proved successful at reducing costs and improving patient outcomes, subsequent decisions by the HHS Office of the Inspector General (OIG) have significantly dampened gainsharing efforts by allowing only limited projects to move forward.[55]

More recently, Congress directed CMS to conduct two demonstration projects that would examine whether physician-hospital collaboration is an effective method for promoting quality and constraining costs. CMS is conducting a pair of multi-year programs that will allow up to 24 hospitals to share with their physician partners a portion of any savings to the Medicare program that are generated from improved quality and efficiency of care delivered to Medicare beneficiaries. In particular, one demonstration will focus on tracking patients beyond their hospital stay, to determine whether provider collaboration can save money and generate efficiencies across multiple clinical episodes and settings.[56]

While promising, neither demonstration has officially launched to date. Once underway, these projects should provide valuable information on which modern gainsharing strategies work and which do not, as well as any unintended consequences associated with provider collaboration.

Concerns about unfettered gainsharing that does not ensure patient safety are warranted. Therefore, the Baucus plan would strive to work with CMS, the HHS OIG, and interested stakeholders to develop gainsharing proposals that strike the appropriate balance between thoughtful incentives for coordination of care and careful protections against financial conflicts-of-interest that could harm quality of care.

D. HEALTH CARE INFRASTRUCTURE

A health system that performs to its potential — providing high value care for every dollar invested — requires adequate infrastructure to support it. The reforms outlined in this plan would require new investments in our health care infrastructure. Priorities for infrastructure investment include: comparative effectiveness research, health information technology (IT), and the health care workforce.

Comparative Effectiveness Research. The U.S. produces some of the most technologically advanced medical care in the world. Yet patients and their physicians can face a daunting task choosing among treatment options. This plan envisions a national approach to conduct and promote comparative effectiveness research, which would ultimately improve the ability of providers to deliver the right care at the right time for each and every patient. Such an effort would likely lower costs too, as the Congressional Budget Office has signaled that national health spending could be significantly reduced if more unbiased data were available and used widely by providers and patients.[57]

The rapid development of medical technology and medical treatments in the U.S. poses a challenge for our health system: can it produce evidence regarding what treatments work best in a timely fashion? Experts agree that the U.S. lacks sufficient capacity to produce unbiased information to compare existing treatments to determine which ones are more effective and for which patients.[58,59,60,61,62] Providers have more diagnostic tests and treatment options to choose from than ever before, but too often they lack knowledge as to whether one works better, or if several lead to similar outcomes.

On a limited scale, organizations like the Technology Evaluation Center funded by the Blue Cross and Blue Shield Association and the Veteran Administration's Center for Health Care Evaluation conduct research that compares the effectiveness of different medical treatments. The National Institutes of Health (NIH) as well as the Agency for Healthcare Research and Quality (AHRQ) have also conducted seminal research comparing one or more medical interventions.

Despite these efforts, current funding for effectiveness research in the U.S. is inadequate to keep pace with medical innovation. Public and private research efforts are also highly fragmented and poorly coordinated.

Several well-respected panels—including the Institute of Medicine (IOM), the Medicare Payment Advisory Commission (MedPAC), and the Congressional Budget Office (CBO)—have called on Congress to create a national entity charged with conducting this type of research.

The Baucus plan answers these calls. As first suggested in the Comparative Effectiveness Research Act of 2008,[63] introduced earlier this year, this plan would create a new institute charged with identifying the most pressing gaps in clinical knowledge that prevent the health system from delivering the best outcomes for patients.

The Health Care Comparative Effectiveness Research Institute envisioned in the Comparative Effectiveness Research Act of 2008 would be a private, nonprofit corporation with a Board of Governors appointed from the public and private sectors by the U.S. Comptroller General. The Institute would be created as an independent entity to remove the potential for political influence on the development of national research priorities. Comparative effectiveness research would be more credible, and more useful, if it remained free from political influence and reflected broad stakeholder input.

In addition to setting national priorities, a new institute should provide for the conduct of the studies that would meet its priorities. The Institute should not just recommend areas of inquiry; it should produce the vital information needed. It should be able to contract with experienced Federal agencies, like NIH, and AHRQ, that have robust research networks in place and that can be put to good use here. The Institute must also have flexibility to meet its priorities by contracting directly with private researchers as appropriate.

The comparative effectiveness Institute would need to assess the full spectrum of clinical interventions, including pharmaceuticals, medical devices, procedures, services, and other therapies, which have the greatest gaps in evidence and variations in practice patterns. A broad scope would provide better evidence for existing diagnostics, treatment, prevention, and management of health conditions. Importantly, the research should meet the goal of helping patients, providers, and payers of health care to make more informed clinical decisions.

In addition, the Institute would also need to disseminate its research findings to the public. It could work in concert with government agencies (such as the Centers for Disease Control and Prevention and AHRQ), medical societies, and patient networks. Its reports should serve both clinical and general audiences.

Activities of the Institute should be open to public input and transparent in order to maintain integrity of the research. For example, the Institute should publish its charter, rules, proceedings, and reports and make them available on a public Internet site. Its meetings should be open to the public. It should also provide for public comment periods at key stages—including the development of research priorities and study designs—in addition to holding public forums on controversial or complex topics.

Most importantly, the Institute should be subject to rigorous oversight of its finances and mission in order to maintain the public trust. The Comptroller General should perform regular audits of its activities to ensure that the Institute meets its statutory mission in a fair, open, and credible manner.

These new endeavors would need an adequate and stable source of funding. Public funds would be the best option to get the Institute up and running. But the information produced by such an Institute would benefit all Americans—those who receive health care through public *and* private sources—so it makes sense for a small assessment on private health insurers to be included. A mix of public and private resources is the best long-term

framework for funding, and more reflective of the composition of the Institute and its broad reach.

America must make a greater investment to generate information about what works in health care. In the absence of sound evidence, clinical guidelines and protocols can vary widely. Knowing more about the effect of different health interventions would help to reduce the variability in treating disease, help to better manage and prevent illnesses, and help to lower health costs for everyone.

Health Information Technology. Most providers in the health care system collect and transmit information on paper, over the phone, and via fax machines. More advanced health information technology (IT) offers tools to streamline and support the process of collecting and analyzing the data needed to provide the best and most efficient care possible. Clinical IT comprises multiple applications that can support different functions in health care, such as:

- Tracking patient care;
- Allowing physicians to order medications, lab work, and other tests electronically, and then access test results;
- Reporting to chronic disease registries; and
- Providing evidence-based decision support to physicians.

Encouraging more rapid adoption and use of health IT systems will improve health care quality and make our health care system more efficient.[64,65] Automating the collection of clinical data will also be a vital component of better quality performance measurement and reporting.[66] Technology can facilitate richer data sets for comparative effectiveness research,[67] and help providers use comparative effectiveness findings in their own clinical practices. The Baucus plan provides Federal-level leadership to spur the modernization necessary to support a truly patient-centered delivery system.

Health IT adoption by providers has been low to date, especially for physicians in small-group practices.[68] Providers, particularly physicians, cite as obstacles the cost of purchasing and implementing systems, a fear of investing in systems that may soon be obsolete, as well as a lack of a clear return on investment.[69,70] Some providers, especially in smaller settings, lack the resources or expertise to navigate the large and complex market of health IT products or to maintain such a system over time. Implementing health IT also requires changes in office organization, processes, and culture that clinicians and office staff may resist. Safeguards must be put in place to ensure that patient privacy is protected. And existing payment incentives discourage health IT adoption. Reductions in office visits, hospital admissions, and other services that could be achieved through the use of health IT would accrue to the benefit of payers and patients but not to providers themselves.

Despite these challenges, there is a growing consensus among patient advocates, providers, and payers that a path forward that drives adoption and protects patient privacy must be found.

Consistent with recommendations made by MedPAC and others, the Baucus plan proposes three strategies to encourage the adoption and use of health IT: (1) financial incentives, (2) assistance to providers in navigating the health IT market and implementing systems, and (3) promotion of information sharing among providers.

Direct grants, loans, and financial incentives provided through Medicare pay-for-performance initiatives could promote adoption of health IT. Congress recently established bonus payments in Medicare for physicians using qualified e-prescribing systems. These bonus payments phase down over five years and become a requirement (enforced through payment reductions). A similar model could be employed to encourage the use of electronic health records if other obstacles are addressed.

Helping providers navigate the health IT market and implement qualified systems could also aid widespread adoption. The Baucus plan will accelerate efforts to certify software products by setting a deadline for the establishment of harmonized interoperability standards; if the private sector does not find timely consensus, then the Office of the National Coordinator for Health IT would immediately promulgate standards. The plan also calls for additional technical assistance to help providers assess products, understand their needs, and manage implementation and ongoing maintenance.

Promoting the sharing of information among providers also would improve coordination of care and efficiency, getting more out of health IT. Efforts at the community level to increase this exchange have seen limited success in some areas, but stronger leadership at the Federal level will be necessary to initiate nationwide adoption of advanced, interoperable health IT systems.

Health Care Workforce. Today, health care workers represent roughly 12 percent of the American labor force.[71] While these workers strive to provide high-quality care and make important contributions, there are growing concerns that the U.S. does not have a sufficient supply of health care professionals to meet the demands of a changing and aging population.

Various studies suggest that the country is facing a health professional shortage. According to the American Association of Medical Colleges (AAMC), there have been at least 35 studies published since 2002 demonstrating current or future physician workforce needs.[72] Among these is a report by the Health Resources and Services Administration (HRSA), which predicts that demand for physician services will exceed supply by 2020.[73] Other studies by HRSA warn of a nursing shortage in the coming years.[74]

As the population continues to age, a shortage of health care workers will become increasingly problematic. Between 2005 and 2020, the number of Americans over age 65 is projected to increase by 50 percent.[75] During the same period, the number of physicians is projected to grow only 16 percent.[76] An inadequate physician supply will not only affect the elderly, but also the 20 percent of Americans who live in underserved communities and already struggle to obtain access to medical care.

The Federal government plays a key role in training future health care professionals through the Medicare Graduate Medical Education (GME) program. Included in the 1965 legislation that created Medicare, the GME program provides subsidies to help teaching hospitals and other entities cover the direct costs associated with medical training in accredited teaching programs. The program has served as a major funding source for medical training for most teaching hospitals. In 2007, Medicare spent roughly $8.8 billion on GME activities.

While the Medicare GME program has provided essential resources for training America's physicians, it needs to be reexamined. In recent years, the AAMC and other stakeholders have raised concerns about rules in the current Medicare program that place a cap on the number of medical residency slots that can be supported by the GME program. The residency cap was established as part of the Balanced Budget Act of 1997 in response to what many considered an oversupply of physicians in the pipeline.[77] Since this rule took effect, the landscape of physician supply relative to demand has shifted, and roughly 6,500 medical training positions have been created that do not receive support from Medicare.[78]

Also of concern has been the question of whether the Medicare GME program should place a greater emphasis on providing training in critical focus areas, such as primary care, geriatrics, and preventive services. There is also discussion about allocating GME funds toward nurse practitioners and physician assistants who also play a role in managing patients' primary care needs. In addition, others have recommended that training programs place a greater emphasis on preparing providers to practice in an organized delivery system or team-based environment.[79] Similarly, GME funding should be used to train residents outside traditional hospital settings, such as in community-based primary care offices.[80] These policies represent a shift in the structure and focus of the GME program, but are worth serious Congressional consideration.

In addition to direct payments for GME, Medicare also subsidizes the indirect costs of patient care associated with graduate medical training. Indirect medical education (IME) payments under Medicare are based on the ratio of residents to beds — the higher the ratio, the higher the payment. These payments are not well targeted and are set at a level that is twice as high as what can be justified empirically. According to MedPAC, more than $3 billion in extra payments are made to teaching hospitals with no accountability for how these funds are used.[81] Congress should increase accountability around how these and other GME funds are spent.

As we work to strengthen graduate medical education programs, we must also take steps to increase the number of racial and ethnic minorities who enter our health workforce. Minorities are underrepresented among our nation's health care workers. Among physicians, African-American and Latino physicians comprise only three and a half and five percent, respectively, of the physician workforce compared to 11 and 13 percent, respectively, of the general population. Native Americans/Alaska Natives comprise only two percent of the physician workforce. The same degree of disparity is also evident in the

area of nursing care. Racial or ethnic minorities represent only 14 percent of the nursing workforce while they represent 34 percent[82] of the general population.

Strategies to improve the racial and ethnic diversification of our health workforce include increasing the number of pipeline education programs at the high school and college level and providing funding for scholarship and loan programs that support racial diversification among health workers and medical faculty. Many of these programs, such as Title VII and Title VIII of the Public Health Service Act, merit re-examination as we work to improve our health care infrastructure. Loan assistance and forgiveness programs for caregivers who choose to practice in underserved areas should also be expanded to make sure that patient needs are met, especially as we expand access to insurance for millions of Americans.

Significant work must be done in these areas, and Congress must dedicate the time and attention to graduate medical education that it deserves. Policy solutions in this area should be considered as part of health care reform. Next steps could include:

- Evaluating whether changes are needed to the number of allowable GME training slots;
- Exploring options to increasing the residency cap for certain specialty areas;
- Determining ways to modernize the GME benefit through policies to allow training in other treatment settings and encouraging a focus on care coordination;
- Increasing accountability of indirect medical education (IME) funding; and
- Working with the Senate Health, Education, Labor and Pensions (HELP) Committee to address workforce shortages and support increased racial and ethnic diversity within the health care workforce by strengthening public health programs in these areas.

These efforts are critical if we are to place our nation's workforce on sound footing to address the health care needs of current and future generations.

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CHAPTER IV BAUCUS PLAN: FINANCING A MORE EFFICIENT HEALTH CARE SYSTEM

The U.S. spends $2.3 trillion a year — more than 16 percent of the U.S. economy — on health care, and economists warn that rising health care costs represent a serious threat to our long-term fiscal security.[1,2] We spend more than any other country on health care — both per capita and as a percentage of gross domestic product — yet the Congressional Budget Office (CBO) estimates that up to one-third of that spending does not improve Americans' health outcomes.[3] *That means we spend over $700 billion more than we need to get the outcomes that we receive today*. Clearly, excess spending must be eliminated and dollars put to better use — not only to correct the imbalances of the current health care system, but to offset the high costs of much-needed comprehensive reform.

Americans deserve a health care system in which everyone has affordable coverage, no matter their age, income, employment, or health status. This will require an investment. Some experts predict that a health system covering all Americans would necessitate $100 billion to $150 billion in new Federal spending per year.[4,5] But savings from the reforms proposed earlier in this Call to Action and the financing mechanisms in this section can make the net cost of reform much smaller.

National spending on health care can be lowered, and quality improved, by realigning the health care system toward prevention and primary care, rewarding providers that deliver quality, evidence-based care, and investing in critical research and health information technology that can lead to higher-value care. Beyond these measures, the Baucus plan endorses even further, more direct steps in these five areas to curb excess health care spending.

- **Fraud, Waste, and Abuse.** New initiatives should be implemented immediately to better detect and eliminate financial fraud and abuse in our public programs. Taxpayer dollars should cover needed benefits and not fraudulent medical claims.

- **Increased Transparency.** Public reporting of the costs and quality of care — as well as the relationships between providers and drug or device makers that may lead to biased decision-making — can encourage providers to pursue better outcomes and help patients choose better, more efficient providers and treatments when they are able to do so. Information about the full value of employer-sponsored health care could help employees make better coverage decisions for themselves and their families. Greater transparency in these areas can help eliminate waste and drive better value throughout the health system.

- **Medical Malpractice.** Careful reforms of medical malpractice laws can lower administrative costs and health spending throughout the system, while ensuring that injured patients are compensated fairly for their losses.

- **Private Insurance Plans in Medicare.** If private insurers participate in Medicare, they must bring value to the program and beneficiaries. Overpayments to private

insurers in the Medicare Advantage program must be eliminated so that spending is put on a level playing field with traditional Medicare. Payments should also be modified to promote the best of what plans have to offer beneficiaries, without financial giveaways to insurers. Price discounts for prescription drugs of the dual-eligibles in Medicare's prescription drug plans should reflect discounts in Medicaid.

- **Long-Term Care Services and Supports.** The current long-term care system is expensive, fragmented, and does not encourage the delivery of high-quality care. Further expanding home and community-based care, testing new models of care delivery and coordination, and better supporting family caregivers are essential to improving the quality and efficiency of the system. These ends cannot be accomplished without a stronger investment in a more robust workforce.

- **Tax Incentives for Health Coverage.** Congress should also explore targeted reforms of the tax code to make incentives work better within the current system. Since the mid-1950s, tax incentives for employer-sponsored health benefits have made employer coverage more affordable for millions of workers. Similar but smaller tax incentives increase access to coverage for the self-employed and ease the burden of health expenses for people with no employer coverage. Such tax provisions have been and will continue to be the main tool used to foster employer-based health insurance coverage in the U.S. But it is time to explore ways in which tax incentives can be modified to distribute benefits more fairly and effectively. At the same time, targeted reforms can promote smarter, more efficient spending of health care dollars by consumers themselves.

In the short term, health care reform will likely cost taxpayers more than the government can achieve in savings from all reforms and financing changes. Much of the savings from reforms, such as comparative effectiveness research and malpractice reform, would not accrue until policies have been in place for several years.

Congress and the public must be realistic about the timeframe in which the fiscal success of reform is measured. If we fail to act, however, the current national expenditure on health care will double from over $2 trillion to $4 trillion, tens of millions will continue to be uninsured, poor quality will continue to contribute to nearly 100,000 deaths each year, and the nation's entitlement programs will consume a greater portion of the Federal budget. In short, the costs of inaction, both in human and financial terms, would eventually be far greater than any initial outlays. America must choose to invest now in a health care system that will richly repay the nation with greater health and economic stability in the long term.

A. FRAUD, WASTE, AND ABUSE

Fraud, waste, and abuse cheat the taxpayer, can harm beneficiaries, and threaten the financial integrity of essential Federal health care programs. Many payment errors are the result of honest mistakes unrelated to providers or suppliers trying to take advantage of

Medicare, Medicaid, and CHIP. However, some providers and suppliers purposefully manipulate these programs for financial gain.

There are clear differences between fraud, waste, and abuse. Fraud and abuse connote some level of culpability in that they involve billing practices or behaviors that include misrepresentation of or overcharging for services delivered. Fraud is willful or intentional, and abuse is a deviation from acceptable business and medical standards. Both lead to unnecessary costs to the payer.[6]

In 1994, the Health and Human Services Inspector General, June Gibbs Brown, said in testimony before the Senate Appropriations Committee that, "Fraud is the obtaining of something of value through intentional misrepresentation or concealment of material facts. Abuse is any practice that is not consistent with the goals of providing patients with services which (1) are medically necessary, (2) meet professionally recognized standards, and (3) are fairly priced. Waste is the incurring of unnecessary costs as a result of deficient practices, systems, or controls."[7]

The full magnitude of health care fraud, waste, and abuse cannot be determined with precision, but evidence of the problem is everywhere. For instance, the U.S. spends more than $2 trillion on health care every year. Of that amount, the National Health Care Anti-Fraud Association estimates conservatively that at least three percent — or more than $60 billion each year — is lost to fraud. The Secretary of Health and Human Services (HHS), acting through the Department's Office of Inspector General (OIG), and the Attorney General, run the Health Care Fraud and Abuse Control (HCFAC) program, which coordinates Federal, state, and local law enforcement activities to prevent health care fraud and abuse. In the ten years since its inception, HCFAC has returned over $10.4 billion to the Medicare Trust Fund alone.[8]

The amount of money wasted on billing errors and other mistakes is also staggering. Last year, the Medicare program reported a fee-for-service payment error rate of 3.9 percent, which means that Medicare paid over $10.8 billion incorrectly.[9] Many of the improvements to the delivery system discussed in the preceding chapter would help reduce wasteful spending. Better alignment of incentives and value-based purchasing in particular would reduce waste because they will cut down on instances in which Medicare pays for something beneficiaries do not need.

While the efforts to fight fraud, waste, and abuse have been commendable, we need to do more. Outlays for Medicare and Medicaid almost doubled between 2000 and 2008, but the outlays for fighting fraud and abuse in these programs have not kept pace. We can provide more and better care for our beneficiaries if we do more to reduce fraud, waste, and abuse.

Medicare, Medicaid, and CHIP must have flexibility to quickly deliver high-quality, low-cost services while minimizing providers' administrative burdens. More can be done to combat unnecessary spending. The Baucus plan, which includes ideas articulated by HHS OIG,[10] would focus on preventing fraud, waste, and abuse before they happen, and aggressively detecting them when prevention fails. A five-part strategy will effectively

fight fraud, waste, and abuse, while allowing the programs to effectively serve beneficiaries.

First, the government must do a better job of screening those allowed to become providers and suppliers in Medicare, Medicaid, and CHIP. Ensuring that only well-intentioned and law-abiding people and companies have the privilege of providing health care items and services to beneficiaries is an important initial step. For example, in January of 2005, an individual arrived in Miami-Dade County from Cuba and soon thereafter enrolled as a Medicare provider. From April until June, his new company billed over $4.1 million in fraudulent claims and was paid $1.65 million. He has since disappeared. This person should never have been allowed to become a supplier.

Second, government payment methodologies should discourage, rather than encourage, providers or suppliers from engaging in fraud, waste, or abuse. For example, in 2006, Medicare allowed an average $7,215 for rental of a piece of durable medical equipment that costs about $600 to purchase new.[11] As a result of these excessive fees, beneficiaries also incurred $1,443 in coinsurance charges for this equipment. The competitive bidding program for durable medical equipment, prosthetics, and orthotics has been temporarily delayed. Competitive bidding is a proven method for saving money and reducing fraud in this area, however, and the program should move forward.[12]

Third, working with providers and suppliers to promote compliance with program requirements and quality and safety standards could actually increase it. Most health care providers and suppliers intend to act in accordance with program requirements, but need help doing so. The same is true for quality and safety standards applicable in Medicare, Medicaid, and CHIP.

Fourth, the Federal government has an absolute duty to conduct vigilant oversight of Medicare, Medicaid, and CHIP and continuously monitor for evidence of fraud, waste, and abuse. Improvements and enhancements in the collection and review of data, establishment of internal controls, investigation of providers and suppliers, mandated reporting of violations, and penalties and sanctions would enable better detection and punishment of inappropriate or unlawful behavior.

Finally, responses to detected fraud must be swift and strong. Punishments must be sufficient to deter others from considering the same behavior. Program vulnerabilities that are revealed by the fraudulent conduct must be remedied to prevent repeated abuse. For example, Florida's Miami-Dade County is home to many companies that claim to be durable medical equipment suppliers, infusion clinics, and other Medicare providers and suppliers. In May 2007, the Department of Justice and HHS OIG created a strike force whose primary goal was to attack the fraud problem by decreasing the amount of time between the government's detection of a fraud scheme and the arrest and prosecution of the offenders. That effort has lead to over 76 convictions and criminal fines and civil recoveries in excess of $140 million.

Success demands that the resources devoted to fighting fraud, waste, and abuse be sufficient to respond to this growing problem. The Baucus plan would invest much needed resources to carry out this fight because it takes time, manpower, and money to effectively monitor and detect fraudulent, wasteful, or abusive practices. Effective elimination of fraud provides a significant return on investment. According to the Office of Management and Budget, the HHS OIG demonstrated a return on investment of 16:1 for these efforts.[13]

Watchdog and advisory agencies like the HHS OIG, Government Accountability Office, state Medicaid Fraud Control Units, the Medicare Payment Advisory Commission, and law enforcement agencies must be provided with the resources that they need to combat fraud, waste, and abuse. We also need to work with the HHS and CMS program managers responsible for protecting and effectively managing these programs.

B. INCREASED TRANSPARENCY

Making more information available to health care providers and consumers would remove much of the mystery that currently shrouds our health care system. It is often too difficult for Americans to understand what services they receive or why they receive them, what they pay for relative to their insurer, or what their insurer is charged — not to mention what a service actually costs. Providers suffer from some of this same confusion. This lack of understanding leads to frustration.

Increasing transparency — providing more and better information — would improve the level of understanding. With better information, consumers, providers and payers would gain a better understanding of how the system works and would be able to see how health care dollars are spent. Providing meaningful and useful information would alleviate much of the frustration and suspicion.

The Baucus plan focuses on three areas that would benefit from greater transparency: physician-industry relationships, physician self-referral, and cost and quality information.

Physician-Industry Relationships. Harvard's Eric Campbell told the Finance Committee: "A physician-industry relationship exits whenever a physician accepts anything from a pharmaceutical or device company such as dinners at fancy restaurants, pens, drug samples, lunches, trips and paid consultancies."[14] Though these relationships may lead to advancements in medical technology and a better understanding of medical procedures, "this practice likely results in substantial increases in the costs of health care."[15] These higher costs occur because industry gifts, "may also result in physicians prescribing higher priced, brand-name drugs instead of cheaper, equally effective alternatives."[16] These types of relationships are common throughout the physician community.

According to a Harvard Medical School study, "most physicians (94 percent) reported some type of relationship with the pharmaceutical industry, and most of these relationships involved receiving food in the workplace (83 percent) or receiving drug samples (78 percent). Thirty-five percent received reimbursement for costs associated with professional meetings or continuing medical education, and more than one quarter (28

percent) received payments for consulting, giving lectures, or enrolling patients in trials."[17] In 2005, pharmaceutical companies spent $7 billion on sales representative visits to physicians and provided $18 billion worth of free samples.[18]

To dissuade inappropriate relationships, both the American Medical Association (AMA) and the Pharmaceutical Research and Manufacturers of America (PhRMA) adopted or revised their codes of conduct involving industry relationships. The AMA "allows physicians to accept gifts as long as the gifts primarily benefit patients and are not of substantial value."[19] The PhRMA code states such relationships "are intended to benefit patients and to enhance the practice of medicine," and should be used, "solely on each patient's medical needs."[20] Though these updated guidelines are a step in the right direction, "there is also evidence that interactions prohibited by voluntary codes continue to occur."[21]

Four states (Minnesota, Vermont, Maine, and West Virginia) and the District of Columbia have enacted laws that require drug manufacturers to report any cash and in-kind payments made to physicians.[22] Many advocate more detailed reporting of gifts between industry and physicians on a national level. National legislation has been introduced that would require drug and device companies to disclose all gifts of $25 or more to physicians and other medical providers.[23]

A recent MedPAC report to Congress outlined several advantages of such a requirement. It may discourage inappropriate arrangements between physician and industry, allow the media to explore potential conflicts of interest, enable payers to examine physician practices that may be influenced by particular relationships, and highlight those physicians who have decided not to take part in inappropriate relationships.[24]

Unfortunately, data collection alone may not prevent inappropriate relationships. However, once national, system-wide data is available, the extent of industry influence and the wasteful spending that it leads to can be better determined. With this information, stronger enforcement can be put into place, so that regardless of provider relationships, we can be sure physicians are recommending and performing medical care based on sound medical science rather than heavy-handed industry influence.

For these reasons, the Baucus plan would require disclosure of gifts and other transfers of value made by drug and device companies to physicians and other health care professionals. Only with this information can potential bias be known. And the requirement to disclose may deter inappropriate behavior. Disclosure is the only way to know if there are inappropriate influences on the delivery of care and use of taxpayer dollars.

Physician Self-Referral. Physicians, like most professionals, expect to get paid for the work that they perform. Some physicians, however, have found a way to game the system so that, in addition to getting paid, they reap additional financial benefits from the provision of certain health care services. Physicians can accomplish this by having ownership or other financial interests in equipment or facilities — such as an MRI machine

or a hospital — that provide health services. When those physicians refer their patients for services from which the physician reaps the additional financial benefits — a practice known as self-referral — there is reason to be concerned about the physician's motives.

Physician self-referral is generally prohibited by Federal law when the patient is covered by Medicare or Medicaid.[25] Self-referral creates conflicting incentives for physicians, because the financial incentive to increase utilization of the financially-rewarding services may conflict with otherwise sound medical and professional judgment. Ultimately, this practice often results in an "increased use of services and higher payments from third party payers."[26]

Congress has enacted several laws to confront this problem. In 1972, Congress enacted the Anti-Kickback Statute, which "broadly prohibits the purposeful offer, payment, or receipt of anything of value to induce the referral of patients from services reimbursable by a federal health care program."[27] Few prosecutions occurred, however, and referrals to imaging facilities or medical laboratories were not deterred.[28]

In 1989, Congress enacted the Ethics in Patient Referrals Act (known as Stark I), which prohibits physicians from "referring Medicare or Medicaid patients for clinical laboratory services to labs with which the physician has a financial relationship…unless the relationship fits within a specified exception."[29] In 1993, Congress enacted amendments (known as Stark II) expanding the prohibited services to "physical and laboratory therapy, radiology, radiation, home health care, hospital, outpatient prescription drugs, and many types of medical equipment and supplies."[30]

The Baucus plan would scrutinize physician self-referral to ensure that physicians are not engaged in financial arrangements that place financial interests ahead of the needs of patients and the American taxpayer. Physicians deserve fair pay for providing services, but they should not be able to game the system unfairly. Increased transparency to both patients and payers in the form of disclosure of physicians' financial interests is first step.

One example is physician ownership of hospitals. There is concern that physician ownership of hospitals leads to cherry-picking the patients who are healthiest and most able to pay, while leaving the patients who are sickest and least able to pay for community hospitals to treat, often without much compensation, if any. This cherry-picking only exacerbates the cost shifting to those Americans with insurance. This concern is heightened by the fact that the patient often is unaware of a physician's financial interest in providing services at a hospital in which he or she has an ownership interest.

Physician-owned hospitals are often smaller and more specialized than community hospitals. They tend to focus on lucrative lines of service. Community hospitals, on the other hand, tend to provide all service lines, including emergency departments. Community hospitals find it difficult to compete with their more cash-rich physician-owned counterparts. Over time, the trend of increasing physician ownership of hospitals jeopardizes the continued viability of community hospitals.

The issue of self-referral must be reviewed in light of how health care is and will be delivered. No serious effort at reform can ignore the potential gaming that financial conflicts may create.

Cost and Quality Transparency. Rising health care costs have fueled an interest in greater public availability of price and quality information. Public reporting and transparency can aid patients in making more informed decisions about their treatment options. Such information could also spur providers to make improvements by benchmarking their performance against their peers. And health care price and quality information can be used by private health plans and public programs to reward quality and efficiency.

The demand for more transparent price and quality information has been driven primarily by employers and health plans.[31] But consumers believe they have much to gain from greater transparency, too. A recent survey, for example, found that 84 percent of Americans want hospitals, physicians, and pharmacies to publish their prices.[32] Additionally, 90 percent of health care consumers want to partner with their physician in making health care decisions, and more than 60 percent claim to have searched for information to help make health care decisions.[33]

Public programs have also embraced greater transparency. An August 2006 Executive Order directed Federal health programs — including the Federal Employees Health Benefit Program, Medicare, programs operated by the Indian Health Service, and TRICARE — to make quality and pricing information available to beneficiaries and enrollees by January 1, 2007.[34]

Pursuant to this order, and building on existing programs, Medicare currently posts hospital quality measures online at the Hospital Compare website. Hospital-specific process measures include those related to heart failure and heart attack care, pneumonia care, and surgical care improvement. Information is also available for risk-adjusted mortality rates and patient satisfaction. The Centers for Medicare and Medicaid Services (CMS) has also started making available comparative price information for common outpatient procedures, such as wrist fracture pinning, colonoscopy, and hernia repair.

While public availability of Medicare price information is novel and has been hailed as a first step, the information is based on an average, and it is not current or hospital-specific. In addition, the price and quality information is not linked, which undermines the value of any comparison by patients and beneficiaries.

At the state level, recent legislation has required public reporting of hospital retail charges. Most experts agree, however, that this information is too detailed and not meaningful, because it contains unit prices rather than episodes of care.[35] Trying to estimate a hospital stay based on charge data is "like shopping for a car by adding up the prices suppliers charge for all the nuts and bolts that go into one."[36]

The value and usefulness of cost and quality information may be limited by practical factors. Decisions about health care are often involuntary — made under emergency

conditions or emotional distress. Patients also may not have the opportunity to choose among hospitals if a referring physician is not on staff at the preferred hospital. Even for non-urgent elective procedures like LASIK vision-correction surgery, variation in quality, misleading advertising, and inconsistent bundling of services that makes apples-to-apples price comparisons difficult, all contribute to imperfect market conditions.[37]

Medicare's recent experience with making cost and quality information available online, combined with real-life examples from the private sector, provide valuable lessons for making information meaningful. Some of these lessons, also described in recent congressional testimony by the Commonwealth Fund,[38] include:

- **Information currently available is inadequate.** Although progress has been made even in the past two years, cost and quality information is rarely available to patients, and physicians lack comparative information on the quality of the care they provide or the care provided by physicians to whom they refer their patients.

- **Price and quality information should be provided together.** Information on the price of a specific health care service provides little value. Knowing the total cost of caring for a condition is more meaningful, particularly if combined with information on the quality or outcomes of the care.

- **Transparency alone is not likely to transform health care.** Shopping for the best physician or hospital is impractical for very sick patients and patients with chronic conditions, particularly when care is sought under emergency conditions. Yet, these patients incur most health care costs. Moreover, purchasers, payers, and providers — not patients — are in a better position to demand greater quality and efficiency. And providing price information without a clear use could lead to collusion instead of competition.

To promote greater transparency in ways that would be meaningful and reliable to consumers and providers, the Baucus plan would leverage Medicare's ability to play a leading role. Medicare can and should release more information about the price and quality of covered services. For example, the current price information available for outpatient procedures should be paired with information on quality measures and expanded to other sites of care.

Medicare should also make its data more widely available, with significant regulation of its use, so that it can be combined with similar data from other payers (such as health plans that serve employers and Medicaid) to build more robust profiles of clinicians' care that are based on a broad spectrum of their patients. The Department of Health and Human Services has started down this path by initiating Charter Value Exchanges in select communities. These initiatives allow stakeholders in a community to combine their data with Medicare data with the goal of releasing a single set of cost and quality measures for the entire community. To access the Medicare data, stakeholders must agree on a common set of performance measures.

With appropriate privacy protections, Medicare data can be instrumental in promoting greater cost and quality transparency within the health system. This data must be used in ways that build consistency around cost and quality measures, however, as done through the Charter Value Exchanges.[39] While the prospect of data sharing generates concern among clinicians, Medicare data can be used to generate more meaningful, accurate and consistent information across the health system so that, ultimately, reporting is acceptable and less burdensome for the provider community.

This plan also would require health plans offered through the Health Insurance Exchange to provide uniform cost and quality metrics. The Independent Health Coverage Council would work with health plans and purchasers to develop consistent definitions and principles. Plans would also be encouraged to incorporate this information into pay-for-performance systems.

As a further step in greater transparency of health care costs, information about the full cost of employer-provided health care should be transparent to employees. Currently, employers must inform employees of the amount of wages paid by the employer, along with the taxes withheld from such wages during the calendar year. The information, provided on the Form W-2, must be given to each employee by January 31 of the succeeding year. But no such requirement exists for the amount an employer pays for health insurance coverage. Some employers voluntarily report the value of the health benefits they provide, either in an annual statement to their employees or in box 14 of the Form W-2. This plan would require employer health costs to be fully disclosed to all employees. Better educating workers about the full cost of their health care coverage could encourage them to seek or demand lower premiums, which in turn could help contain growth in spending.

The push for increased transparency highlights the need for greater adoption of health information technology (IT) and evidence-based medicine. This plan proposes to invest in health IT and comparative clinical effectiveness research. Taken together, these tools can help drive the U.S. health system toward greater efficiency and increased engagement in health care decision making among consumers.

C. MEDICAL MALPRACTICE REFORM

Medical malpractice insurance premiums have risen steadily over recent decades, at times increasing an average of 15 percent a year.[40] Some states have seen even more dramatic increases. Pennsylvania, for example, experienced increases ranging from 26 to 73 percent in 2003.[41] While the Government Accountability Office has found that access to medical care is not "widely affected" by large premium increases,[42] and malpractice costs account for less than two percent of health costs,[43] physicians and other health care providers contend that the current legal environment leads to the practice of defensive medicine. Ordering more tests, procedures, or visits primarily to avoid liability rather than to benefit patients may contribute to unnecessary health care spending.

A serious effort at comprehensive health care reform, then, should address medical malpractice.

Reducing malpractice premiums alone would not have a substantial effect on overall health spending. CBO estimates that a 25 to 30 percent reduction in malpractice costs "would lower health care costs by only about 0.4 to 0.5 percent, and the likely effect on health insurance premiums would be comparably small."[44] But helping patients and providers to cooperate rather than participate in time-consuming and expensive legal battles may help to shift America's health care system away from the costly practice of defensive medicine and toward the best quality care and adherence to standards of care.

The current litigation system does not do a good job of compensating victims of malpractice or of reducing the occurrence of medical malpractice. In fact, "research typically shows Americans rarely take their disputes to court. Of every one hundred Americans injured in an accident, only ten make a liability claim, and only two file a lawsuit."[45] Yet, the large number of malpractice claims filed still overwhelms the legal system, and only 30 percent of claims filed result in payments to victims of medical malpractice.[46] Alternatives to civil litigation need to be utilized so that administrative costs associated with litigation, which account for 60 percent of malpractice premiums,[47] can be reduced, while simultaneously allowing credible claims to be compensated fairly and quickly.

Malpractice reform could address money and time spent on litigation, as well as improve patient and provider satisfaction with the resolution of complaints or grievances. Additionally, changes made as part of reforming the health care system would affect medical malpractice. For example, damages awarded for care necessary as a result of malpractice would be reduced because the cost of care would decrease across the board. Also, improvements in preventive care and care coordination would reduce the likelihood of risky procedures that are a source of malpractice claims.

The Fair and Reliable Medical Justice Act, introduced in the 109th Congress and again in the current Congress, includes ideas for ensuring safe and effective medical care, while working to limit malpractice insurance premiums.[48] This legislation would provide grants to states to create alternatives to current tort litigation in an effort to increase access to recovery for patients with low-dollar value claims and improve satisfaction with claims resolution for patients and provides. States would have flexibility in developing alternatives to civil litigation, with three specific models outlined in the bill: (1) the early disclosure and compensation model, (2) the administrative determination of compensation model, and (3) the health court model.

The early disclosure model offers health care providers tort liability immunity after an offer, in good faith, to pay compensation to any patient injured or harmed as a result of care. The compensation would have to include any economic loss to the patient, non-economic damages (as determined by the state) and reasonable attorney fees. The University of Michigan Health System (UMHS) implemented this system in 2002 with astounding results. Three years after the program was established, UMHS had reduced its

annual litigation costs by $2 million and reduced the number of lawsuits, as well as the time it took to resolve the suits, by more than half.[49] That is one of the goals of the early disclosure model. Fostering communication about medical errors and awarding appropriate compensation in a non-adversarial setting are the hallmarks of this approach.

By increasing communication about medical errors, and doing so in a non-adversarial setting, the collection of medical error data will increase, leading to improved patient safety. Data collection is essential to preventing errors by enabling providers to better understand how errors occur. "Accurate information also provides a baseline measurement for further assessment of the effectiveness of the changes made."[50] Unfortunately, under the current system, data collection remains limited because of the lack of incentives. Alternatives to litigation, such as early disclosure, provide incentives to disclose medical errors, while continuing to protect the provider and improve patient safety.

The second approach, the administrative determination of compensation model, calls for the establishment of an administrative board to designate classes of avoidable injuries. Based on these classes, the board would determine the level of compensation awarded to the patient. An appeals process would also be established to review decisions made by the board.

Under the third alternative, a specialized health court would be established. The court would be presided over by judges with expertise in health care with the ability to hire outside experts. The judges' decisions regarding compensation would be binding but subject to an appeals process.

The Fair and Reliable Medical Justice Act serves as a foundation for an important element of this health reform plan. Like the legislation, the Baucus plan would call on states to take the opportunity to develop alternatives for resolving conflicts and compensating patients who are the victims of medical errors. In addition to receiving Federal assistance to establish an alternative model, states would also receive assistance to collect data about medical errors, which would help keep patients better informed and create an opportunity for providers to learn from each other. In fact, the systems developed by the Department of Defense and the Veterans Health Administration that successfully track such data could serve as models. Patients and providers should have the chance to cooperate, rather than participate in a time-consuming and expensive legal battle. This plan would help achieve that important objective.

D. PRIVATE INSURANCE PLANS IN MEDICARE

Medicare beneficiaries can obtain benefits through the traditional fee-for-service program or by enrolling in private insurance plans that are approved to offer Medicare benefits. Private insurance plans are paid a monthly amount by the government for each beneficiary whom they enroll. In return, insurers agree to provide coverage for the range of Medicare benefits that their enrollees need. The program allowing private insurers to serve Medicare beneficiaries is called Medicare Advantage (MA).

The Medicare Payment Advisory Commission (MedPAC) estimates that Medicare Advantage (MA) insurers are currently paid 13 percent more than the amount Medicare would pay if the same beneficiaries remained in the traditional fee-for-service program.[51] Current estimates indicate that these excess payments will total $62 billion over the next five years, and $169 billion over the next ten years.

MedPAC has called for Medicare Advantage payments to be set equal to traditional Medicare.[52] The health insurance industry defends these payments by pointing to extra benefits that low-income MA enrollees receive relative to traditional Medicare, like eyeglasses, dental coverage, and lower copayments. But delivering these extra benefits through Medicare Advantage is not as efficient as delivering them directly through traditional Medicare. Moreover, MedPAC reports that MA plans are less efficient at delivering Medicare Part A and B benefits than the traditional fee-for-service program.[53] Private insurers' higher overhead and added administrative costs — including profits — mean that fewer benefits are passed along to beneficiaries. CBO and the U.S. Comptroller General estimate the administrative costs of private plans serving Medicare beneficiaries are in the range of 11 to 13 percent, compared to estimates of 2 to 5 percent for the traditional Medicare program. [54,55,56,57]

The majority of Medicare beneficiaries have multiple chronic conditions that could be treated more effectively through interdisciplinary care teams, and the insurance industry contends that private plans better coordinate care and improve quality oversight in the Medicare program. There is no solid evidence that supports this assertion. Not all Medicare Advantage plans are designed to integrate or coordinate care across the spectrum of providers, and not all use electronic medical records to better manage care. Even so, all Medicare Advantage payments are based on the same rates — whether or not the plan uses advanced methods of coordinating and delivering care.

Congress must act to level the playing field between traditional Medicare and Medicare Advantage payments and the Baucus plan would do so. Enacted in July 2008, MIPPA took modest steps to reduce overpayments to private plans beginning in 2010. There are a number of ways to complete this. One is to set MA payments on par with traditional Medicare in every county in the country. However, Medicare costs can be low in some areas of the country and extraordinarily high in others. Simply setting MA payments equal to traditional Medicare could maintain overpayments in some areas and create severe underpayments in other areas relative to insurers' costs.

The Baucus plan would seek to better understand how insurers' costs differ by region of the country in designing new policies to eliminate the remaining excess spending in the Medicare Advantage program. MIPPA has already directed MedPAC to compare Medicare and private insurance costs and develop alternative ways of setting MA payments. MA payments should be reformed to achieve neutrality with traditional Medicare at the national level. But the benchmarks against which MA plans are paid should have more to do with plans' own costs.[58] One option is to base MA payments on a blend of local and national Medicare costs, reducing MA payments in high-use areas and increasing payments in low-use areas.

Alternatively, insurers' payments could be based on a blend of their own costs per enrollee with Medicare's costs per beneficiary at the local or national level. Competitive bidding is another option that could be considered or tested for MA plans. At a minimum, Congress should repeal the "premium support" demonstration included in the MMA of 2003 because it unfairly ties Part B premiums to how much insurers' costs differ from traditional Medicare. Finally, Congress must seek ways to eliminate excess spending that results from differences in the ways MA plans and traditional Medicare code diagnoses in patients' medical records.

In addition to determining and adopting mechanisms to reduce overpayments, Congress should consider paying Medicare Advantage plans for delivering coordinated, cost-effective care to beneficiaries with the highest risk of complications and spending. One option is to pay MA plans more if they meet medical home criteria defined by NCQA and specific performance measures. If MA plans do not meet these criteria, their payments would be reduced over a defined period of time. As with proposals involving traditional fee-for-service Medicare, paying MA plans for such care could increase the quality of care provided to beneficiaries in MA plans and could possibly lower Medicare spending by reducing complications from chronic illnesses.

Private insurance plans also deliver Medicare's prescription drug benefit and are paid by the government for each beneficiary they enroll. Insurers in the program contract with pharmacies to dispense drugs, and they negotiate with drug manufacturers for discounted prices. Current law allows insurers to use their own formularies to negotiate prices with manufacturers and to manage the quality of the drug benefit. Recent studies suggest that the price breaks negotiated by Medicare prescription drug plans are not as high as those legislated through the Medicaid drug rebate program.[59] This means Medicare pays more than Medicaid for the prescriptions of the dual-eligible population, which was switched from Medicaid to the Medicare drug benefit in 2006.

Congress should consider extending the Medicaid price discounts to the drugs consumed by the dual-eligible population in the Medicare program in order to maintain the previous price breaks. Insurers would continue to negotiate prices on behalf of the other beneficiaries who enroll in their plans. Congress should also be apprised of Medicare's price breaks in the aggregate, relative to Medicaid and other sectors, in order to gauge the performance of the prescription drug program.

E. LONG-TERM CARE SERVICES AND SUPPORTS

Long-term care differs from other types of health care in that the goal is not to cure an illness, but to provide patients with the highest level of functioning possible and improve quality of life. The need for long-term care affects individuals of all ages: children born with disabling conditions, working-age adults with inherited or acquired conditions — many of whom are able to work — and the elderly with chronic illnesses. Care for these individuals is most often provided by informal caregivers — family or friends — who provide care with little or no compensation. More than 50 million informal caregivers currently tend to the needs of individuals and family members of all ages.[60]

Today, about 9.4 million adults, five percent of the adult population, receive long-term care services in the community or in institutions;[61] and about 1.1 million children living in the community have long-term care needs.[62,63] An estimated 69 percent of people turning 65 years old will need some form of long-term care assistance before they die.[64]

The current system for delivering long-term care is expensive, inefficient, and does not encourage the delivery of high-quality care. In 2005, national spending on long-term care was estimated to be nearly $207 billon.[65] States and the Federal government are the largest payers of these services. Medicaid alone accounts for as much as 49 percent of long-term care spending — most of which was provided in an institutional setting.[66]

Medicare covers a limited amount of post-acute care in skilled nursing facilities and in the home for certain beneficiaries. And Medicare benefits are not coordinated with Medicaid — even though the Federal government bears much of the cost for these programs. Likewise, conflicting incentives may increase costs and diminish the quality of care.[67] Divergent characteristics, program goals, eligibility requirements, and covered services for Medicare and Medicaid programs often lead to uncoordinated care and a fractured delivery system for individuals needing long-term care and assistance.

The cost for nursing home care is extremely expensive, about $70,000 per year on average. Without financial assistance from Medicaid or private insurance, most people simply cannot afford extended nursing home care.[68] Home or community-based care is more cost-effective,[69] and most patients would prefer care in these settings to institutional care.[70,71]

In recent years, Congress has taken some steps to reform the long-term care system. The Deficit Reduction Act of 2005 provided new flexibility for states to offer home and community-based long-term care services in Medicaid.[72] Despite this progress, the program maintains a strong bias toward institutional care due to payment and access rules. Congress has considered innovative, alternative approaches to institutional care,[73] but reform has remained elusive due to a lack of consensus on both policy and financing.

Home and Community Based Services (HCBS) have become a popular way to support individuals who want to remain in their own homes and communities. HCBS options are generally provided through Medicaid waivers, but beneficiaries must have a significant level of disability to qualify.[74] And even those who qualify often have difficulty accessing care; by 2005 there was a waiting list of more than 207,000 Medicaid beneficiaries for HCBS waiver services.[75]

The Baucus plan would consider options to further expand access to HCBS in Medicaid. These options include providing states with new tools and incentives to make them more available to more beneficiaries and exploring options to better coordinate care for dual-eligible individuals under Medicare and Medicaid.

The plan would also encourage states to explore new options that improve access to long-term care services and supports to prevent the progression of disability and to help

individuals remain in their own homes. By intervening earlier with targeted assistance, states can help prevent or delay costly institutionalizations and provide a more patient-centered benefit. In addition, exploring inefficiencies and conflicting incentives within Medicare and Medicaid could improve the quality of care and decrease costs.

Providing support for family caregivers should also be an important part of any reform plan. The plan would provide assistance to individuals, families and caregivers in navigating the complex and fractured long-term care services and supports system. With this help, individuals in need of care and their families would be better able to make the most appropriate care choice.

Family caregivers cannot be expected to fill all the gaps in our current system. Long-term care reform should include options to recruit, train, and retain a robust workforce that can ensure high-quality care. One concept that has been put forward to address these shortages is providing educational and training opportunities to adults who are participating in the Temporary Assistance for Needy Families (TANF) program, who represent a pool of more than 900,000 individuals who could provide an important resource in meeting our nation's workforce needs.

Institutional or residential care is appropriate in some cases; however, it should be a choice for individuals and families. This plan would pilot new models of institutional care, such as the Green House model,[76] that has shown promise for both improving the quality of life and care in these settings. In addition, this plan incorporates several options to reform the delivery system to provide better care coordination and chronic disease management. Others may include investment in aging and disability resource centers (ADRCs) and programs that limit secondary disabilities by promoting nutrition, exercise and fall prevention. Because almost 25 percent of deaths occur in long-term care settings, ways to provide the best quality care at the end of life should be considered.[77]

In the long run, fundamental reform of the long-term care system will be necessary. Achieving ultimate success will require both public and private solutions. While we consider options to improve the care in our public programs, we should also explore policies that make quality long-term care insurance products more affordable and accessible.

F. TAX INCENTIVES FOR HEALTH COVERAGE

Tax breaks for health insurance premiums and other health expenses are among the largest tax expenditures in the Federal budget. In 2007, the total value in foregone revenue for health tax benefits was more than $300 billion.[78] Congress should explore ways to restructure the current tax incentives to encourage more efficient spending on health and to target our tax dollars more effectively and fairly.

Current tax law favors individuals who receive health insurance through their employer. The employer's contribution to health care and premiums is excluded from an individual's income for both income and payroll tax purposes. In addition, an employee's share of the

premium cost can be excluded if it is made through what is called a cafeteria benefit plan. This means workers are not taxed on the value of their health premiums, even though the premiums are part of the worker's total compensation package. There is no limit on the amount of premiums that can be excluded from wages. The tax exclusion fosters employment-based health coverage, because it lowers the cost of buying insurance through an employer.

In addition to the employee exclusion, other incentives to purchase health care and health coverage are available through the tax code. An employee's pre-tax contributions for health insurance or medical expenses through a Flexible Spending Account (FSA) are excluded from income and therefore not subject to tax. There are no limits on the amount of wages an employee can contribute on a pre-tax basis to an FSA. For individuals who qualify to contribute to a Health Savings Account (HSA) by enrolling in a high-deductible health plan, up to $2,900 of those contributions for individuals and $5,800 for families are deductible in tax year 2008.

Self-employed individuals can deduct the cost of health insurance premiums for themselves, their spouse, and their dependents for income tax purposes, but they must pay self-employment tax on these amounts. This is less favorable treatment than employer-provided health insurance. And finally, those who purchase health insurance through the individual market, and those who have out-of-pocket medical expenses, may deduct their spending to the extent that it exceeds 7.5 percent of their adjusted gross income and they itemize their deductions.

Most economists argue there are problems with the current set of tax incentives for heath care. [79,80,81,82] First, they argue that the incentives are inequitable because the amount of tax benefit received differs based on how health coverage is received: those covered through their employers are rewarded with the largest tax breaks, while those who must obtain coverage on the individual market receive a much smaller tax break, or none at all. Current incentives are also regressive because they are, for the most part, more valuable to taxpayers who are subject to higher marginal rates. As such, they give larger subsidies to higher-income workers, instead of to the lower-income Americans who need more help buying insurance.

Second, many economists argue that the unlimited employee tax exclusion leads to increased health spending. The unlimited tax benefit for the exclusion encourages workers to purchase more expensive coverage to avoid co-payments and deductibles. This lower cost sharing can lead to higher use of services that are considered non-urgent and discretionary. Additionally, employees who have different health insurance options from which to choose may spend health care dollars unnecessarily to simply buy the most expensive plan they can afford, instead of looking at the amount of coverage that they actually need.

Some have proposed eliminating the current tax exclusion for employer-based health insurance premiums and converting the benefit to a tax deduction or tax credit.[83,84] This approach goes too far because it could cause widespread disruption in employer-based

health benefits. Reform should not endanger coverage for the more than half of all Americans who now have health insurance through an employer.

More targeted reforms of the exclusion might make the incentive more equitable and reduce spending in the health care system. One option for reform is to cap the amount of health care premiums that can be excluded from employee wages for income and payroll tax purposes. This could be done by limiting or capping the tax exclusion based on the value of health benefits or, as an alternative, based on a person's income — or both. Employees could be allowed to exclude, for example, up to a specific dollar amount in health benefits from their wages each year. If they purchase health plans with greater benefits, the difference between a more generous plan and the cap could be subject to Federal and state income taxes. Alternatively, the exclusion could be available on a sliding scale based on income: people with low wages could be allowed to exclude 100 percent of the premiums offered through their employers, with the percent allowed phasing down or out with income.[85]

Tax incentives can be an effective way of subsidizing the cost of health insurance. New tax incentives for small businesses and low-income individuals were discussed earlier in this plan. Current tax policies for health coverage must promote efficient uses of care and distribute subsidies fairly. We must also balance any tax reforms in this area with the desire of Americans to maintain employer-based health coverage.

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[85] Certain data collection issues would need to be addressed in order to implement an income cap.

CONCLUSION

The case for health reform is undeniable. Improving the U.S. health system is one of the most important challenges we face as a nation, and the inability to achieve comprehensive health reform will undermine any efforts to secure economic recovery. Health reform is an essential part of restoring America's overall economy and maintaining our competitiveness at home and around the world.

Health care reform is also necessary to protect the finances of our working families. Nearly 46 million Americans lack health coverage and another 25 million are underinsured. Rising health care costs and mounting medical bills have become a pocketbook issue for too many families, becoming one of the biggest factors in personal bankruptcy filings.

Each of the key challenges facing our health care system — lack of access to care, the cost of care, and the need for better-quality care — must be addressed in concert. Covering millions of uninsured through a broken health system will be fiscally unsustainable. Attempting to address the inefficiencies plaguing our system and the perverse incentives in the delivery system without covering the uninsured will fail to alleviate the burden of uncompensated care and cost shifting. The time for incremental improvements has passed; health care reform must be comprehensive in scope.

This Call to Action provides a starting point for the upcoming health care reform debate. It is a vision and not a legislative proposal. It is comprehensive but not an exhaustive exploration of every health care issue that can or should be considered.

As a first step toward consideration of health care reform, Congressional leaders and the public must understand that reform will likely require an initial investment. In the short term, health care reform will cost more than can be achieved in savings from all the quality improvement initiatives and financing changes. But these changes will improve the quality of the health care that Americans receive and reduce the cost of that health care, ultimately putting our system on a more sustainable path. More importantly, the costs of inaction, both in human and financial terms, are greater than any initial outlays.

The next crucial step is a constructive dialog on policy priorities among policymakers, stakeholders, health policy thought leaders and the public. Consensus will be difficult to achieve, but common ground from which to build can and must be found.

APPENDIX
LIST OF ABBREVIATIONS

AAMC – American Association of Medical Colleges

ABIM – American Board of Internal Medicine

ACE – Acute Care Episode

ACO – Accountable Care Organizations

AFDC – Aid to Families with Dependent Children

AHRQ – Agency for Health Care Research and Quality

AMA – American Medical Association

ARDC – Aging and Disability Resource Center

BBA – Balanced Budget Act of 1997

CBO – Congressional Budget Office

CDC – Centers for Disease Control and Prevention

CHIP – State Children's Health Insurance Program

CMS – Centers for Medicare and Medicaid Services

COPD – Chronic Obstructive Pulmonary Disease

EHR – Electronic Health Record

FEHBP – Federal Employees Health Benefit Program

FMAP – Federal Medical Assistance Percentage

FPL – Federal Poverty Level

FQHC – Federally Qualified Health Center

FSA – Flexible Spending Account

GAO – Government Accountability Office

GDP – Gross Domestic Product

GME – Graduate Medical Education

HCBS – Home and Community Based Services

HCFAC – Health Care Fraud and Abuse Control

HELP – Senate Committee on Health, Education, Labor, and Pensions

HHS – Department of Health and Human Services

HIT – Health Information Technology

HQID – Hospital Quality Incentive Demonstration

HRSA – Health Resources and Services Administration

HSA – Health Savings Account

IHS – Indian Health Services

IME – Indirect Medical Education

IOM – Institute of Medicine

IRS – Internal Revenue Service

MA – Medicare Advantage

MedPAC – Medicare Payment Advisory Commission

MIPPA – Medicare Improvements for Patients and Providers Act of 2008

MRI – Magnetic Resonance Imaging

NCQA – National Committee for Quality Assurance

NHCS – National Health Care Survey

NHIS – National Health Interview Survey

NIH – National Institutes of Health

NQF – National Quality Forum

OASIS – Outcome and Assessment Information Set

OIG – Office of the Inspector General

OMB – Office of Management and Budget

PGP – Physician Group Practice

PhRMA – Pharmaceutical Research and Manufacturers of America

PHSA – Public Health Service Act

PQRI – Physician Quality Reporting Initiative

RHC – Rural Health Center

RUC – Relative Value Update Committee

SGR – Sustainable Growth Rate

SSDI – Social Security Disability Insurance

SSI – Social Security Income

TANF – Temporary Assistance for Needy Families

UMHS – University of Michigan Health System

VBP – Value Based Purchasing