



Working Group of State Legislators for Health Reform

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To: White House Healthcare Reform Office & Congressional Members
Fm: Working Group of State Legislators for Health Reform
Re: Suggestions for strengthening healthcare legislation from State Legislators
Dt: December 11, 2009

The White House Working Group of State Legislators for Health Reform was established in June and is comprised of state legislators from across the nation interested in passing comprehensive federal health reform. Our group has been working with Progressive States Network (PSN) to address issues related to health care reform, and the role of the states. Over 1,000 state legislators from every state (and several territories) in the Nation have signed onto our position papers and statement of principles, and over 80 regularly participate in weekly telephone conference calls. This paper provides background material and our recommendations in conjunction with the third visit by our members to Washington, D.C. to meet with members of Congress and White House staff.

The Working Group has been monitoring the federal legislation for its impact on the states, and we are working to communicate our concerns to the White House and Congress. It is imperative that states are considered in the legislation as it is the states that will be required to take on a major role in implementing its provisions, just as they already administer Medicaid and numerous state-sponsored health care programs. While each state may have unique needs, the fact remains that certain overarching provisions of the legislation will impact all states.

Collectively, the group has identified a list of issues we believe are of immediate concern as the final legislation is voted upon in the Senate and the differences between the House and Senate bills are resolved. The following discussion includes (1) key provisions that need to be included in the legislation to insure that comprehensive health reform succeeds in our states; (2) background material supporting our policy proposals; (3) and specific recommendations.

Although there are many issues of interest and concern, we have focused this paper on the following critical areas:

- Public option and an evaluation of its alternative proposals under consideration;
- The insurance exchange;
- Regulation and enforcement of insurance policies;
- Funding and affordability, including transition funding options;
- Medicaid eligibility and coverage; and
- Cost containment opportunities.

Public Option and Alternative Proposals

We recognize that the public option has become a flashpoint as Congress considers health care reform legislation, and that numerous versions of a public option, and alternatives to a public option, have been drafted and voted upon and are still under consideration. Before evaluating those alternatives, it is instructive to remind ourselves as to why the public option has garnered so much support, especially among state legislators (over 1,000 of whom have signed onto letters endorsing this approach). At bottom, a robust, national public option is a practical way to make health care reform work. Any alternative to it must be carefully crafted to be equally effective. While we are doubtful that an alternative can meet this standard, any proposal should be measured against the following goals which a public option would achieve:

- Injecting true competition in the insurance marketplace, especially in states where one or two companies currently dominate the market.
- Lowering costs.
- Simplifying the complexities of securing health insurance.
- Guaranteeing true portability of insurance so that no one gets dropped through a crack in the system because they change jobs, move, or their health gets worse.
- Covering a sufficient population to be a true insurance plan, not a high-risk pool that simply covers those patients no private insurer wants because they are sick and expensive.
- Setting a baseline for consumer and small business needs.
- Achieving transparency and public accountability.

Several alternatives to a national public option are on the table. These include (1) the state opt-out; (2) the state opt-in; (3) a national plan or plans administered by the Office of Personnel Management (OPM), combined with allowing persons over 55 to buy into Medicare. The opt-out and opt-in both suffer from the same infirmity - they significantly reduce the effectiveness of the public option by shrinking the size of its potential insurance pool, thus reducing choice and competition. They also continue the current interstate competition and “race to the bottom” that pits neighboring states against each other.

To be effective, the OPM/Medicare expansion alternative must address this same problem and several others, because it remains a private plan. We recommend the following:

- **It must be a true national option.** The OPM plan must be available in every state. This will go a long way to assuring significant purchasing power and the benefits of a large insurance pool that includes both the healthy and the sick. It will fail if it functions essentially as last-ditch plan for those uninsurable in the traditional private insurance marketplace.
- **It must be affordable.** Using OPM as a substitute for the public option may be acceptable so long as the subsidies are based on the House version of subsidies (which unlike the Senate version, are relatively affordable).

- **It must be available to all.** All four groups included in the House bill must be permitted to participate (unemployed, self-employed, small business owners, and small business employees), and there should not be any opt-out for states. Since the plan(s) are administered federally not by the states, this makes good policy sense and also assures that the insurance pool is large enough to benefit from economies of scale.
- **The back-up plan must be real and enforceable.** The option to move to a true public plan, as opposed to a private non-profit plan negotiated by the government (OPM), must be real. The possibility that this “hammer” will fall is important in assuring that there is an alternative if the private plans prove inadequate, and will help keep the pressure on all insurers to offer competitive products.
- **Medicare expansion should address reimbursement rates.** Allowing adults 55-64 to opt-in to Medicare is a major step forward. The concern expressed by doctors and hospitals is that Medicare reimbursement rates are too low, which we know is true. This can be addressed as follows: (1) increase Medicare reimbursement by 1-5% for this group of enrollees; (2) create a graduated increase in Medicare reimbursement rates over time for this group; (3) determine if payment to doctors and hospitals will actually be more than they’re getting now (because these people go without care now until they get onto Medicare) . This expansion should definitely be implemented NOW, not in 4 years.
- **Provide bridge funding for state public options and a mechanism to integrate these state plans into the OPM/Medicare/Exchange model.** Many states have some version of a public option, provide an opportunity to buy into a government plan, or other “basic needs” plan. These programs need to be supported financially, particularly as we wait for the health care reform to be fully implemented.

→ **Recommendation:** The legislation should contain a national public option that each state must participate in, similar to the language passed in the House legislation. In the alternative, the OPM/Medicare expansion could achieve many of the goals of the public option if it is (1) national in scope, (2) subsidies follow those in the House bill; (3) the plan is open to businesses as well as individuals; (4) it is open to all and not only those who have no other options; and (5) the back-up plan is real and operates as a hammer if the private insurer comes up short.

Insurance Exchange

The insurance exchange must be a single national organization or several regional organizations with a sufficient number of participating insurers and covered lives to present multiple options to individuals and small businesses for quality, affordable coverage. We support the Exchange language in the House bill, which would create a national Exchange with the option for states to administer a state Exchange, if they can perform the provisions and requirements of the national exchange.

The Exchange is not a website; it is a hands-on organization that will actively assist consumers and businesses in identifying insurance options. Individuals and small businesses need the exchange as a place to go and shop for a health plan. In contrast to large employers that can select from a choice of plans that spread risk and reduce administrative costs, small businesses and individuals do not have this leverage and pay more for coverage if they can receive it at all. The exchange can make a range of more affordable options, including the public option.

The following conditions must be met by all insurers participating in an Exchange. Moreover, to assure a level playing field and to avoid loopholes that will undermine health care reform, these same conditions should apply to all health insurers and plans:

- **Coverage for pre-existing conditions with no exclusions or denials.** Existing limitations on coverage for people with pre-existing conditions caused by industry underwriting has resulted in inadequate health coverage, higher out of pocket costs, and denials of coverage altogether. These practices lead Americans to forego health care altogether because of the lack of coverage. Furthermore, claims of pre-existing conditions have been used by the industry to delay payment to physicians and hospitals and to challenge payments for claims even where serious pre-existing conditions don't exist. Receiving care on the front end for a pre-existing condition and managing care along the way will be less costly for patients, providers, taxpayers, and insurers than waiting until a catastrophic condition occurs.
- **Limit maximum out-of-pocket payments.** With health care costs on the rise, people are forced to choose between daily living expenses or health care. It is incomprehensible to allow a person to go bankrupt just to stay healthy. By limiting maximum out of pocket costs, a balance can be achieved for persons to afford health care costs and meet living expenses.
- **Gender based rating.** It is unacceptable to base health care rates on gender. Rating women at higher premiums not only discriminates, but puts additional burdens on a gender that historically falls into lower wage jobs and poverty conditions. The final version of reform needs to eliminate this practice.
- **Race and ethnicity-based rating.** There are great disparities in health status and access to insurance and quality care within the African-American and Latino cultures, and insurance policies should be barred from setting rates based on race or ethnicity.
- **No lifetime benefit cap.** Lifetime benefit caps unfairly burden persons with chronic and lifelong conditions. People undergoing treatment for these conditions, such as cancer, diabetes, or heart disease, can too easily meet lifetime caps in just a few years. This leaves people without coverage and possibly without lifesaving care.

- **Transparency.** Consumers, small businesses and providers need greater transparency in health insurance rates, benefit plans, and reimbursements rates to provide for fair competition and the free flow of accurate and factual information in the marketplace. The Exchange must require complete transparency of insurance policies to ensure that consumers and businesses know what they are purchasing and are able to compare policies and determine the best options.
- **Enforcement.** Transparency must be coupled with effective enforcement to ensure that patients' claims are paid, providers receive payment in a timely manner, and premiums are used to pay claims, not inflate profits and administrative costs. We believe that state insurance commissioners should be given expanded authority to regulate national insurance exchange plans within their respective states. Insurance companies must disclose detailed information about their products in a standardized format in the exchange that allows consumers to compare plans in the Exchange.
- **Pre-existing conditions and high risk pool.** Currently in Senate bill provision § 1101 (at Page 44), there is a program of transitional support for "Immediate Access to Insurance for Uninsured Individuals with a Preexisting Condition." Unlike the House bill, this support is only available for state high-risk pools, which freezes out states that have chosen other ways to provide access. The fix is to include, at a minimum, language like the House language that includes public-private partnerships.

→ **Recommendation: We support the House language establishing a national Exchange with the state option. We encourage the Exchanges be open to individuals, families, and small and medium-size businesses. We support extending nondiscrimination and other consumer protections to all insurance plans and providers. We support transitional support to all states, regardless of whether they have a high risk pool, to provide access to uninsured individuals with pre-existing conditions.**

Other Insurance Reforms

Both House and Senate bills include language authorizing "Health Care Choice Compacts." These provisions should be removed in their entirety from the final bill, as they do nothing to encourage real competition but instead they create a "race to the bottom" and undermine the new protections authorized by other provisions of the bill (eg, no preexisting condition exclusion, etc).

Provision § 1333(a) of the Senate bill allows insurance companies to choose which state's laws to use for sale of individual insurance policies to people in all states that are part of a compact. The provision attempts to preserve some state oversight in specified areas, but the scope of that will be determined by regulations developed in consultation with the National Association of Insurance Commissioners (NAIC).

Many states have laws that far exceed NAIC models. The provision also purports to be “voluntary” in that states would need to affirmatively enter into a compact with other states. However, the reality is that industry pressure, coupled with federal endorsement, will likely lead many state legislatures to enter into these compacts. The result will be to destabilize the insurance markets, plunge states into a “race to the bottom,” and severely restrict the ability of Attorneys General and insurance regulators to protect consumers in their states.

The federal floor for consumer protections will become the ceiling:

- Insurers would no longer be subject to rate and policy reviews that protect consumers. In some states, insurance regulators engage in a vigorous process to review and monitor rates and policies and make sure insurance companies aren’t making excessive profits at the expense of consumers. This bill would allow insurers to market plans under laws of other states that do not conduct rate and form review.
- Exempting insurers from rate review prevents Attorneys General from giving consumers a voice in insurance rate hearings and similar regulatory proceedings.

It will encourage litigation and prevent workable oversight:

- Under a “Choice Compact” the state regulator’s hands are tied. One regulator cannot interpret the laws of another state. This leaves litigation as the only alternative, something few states have the resources to pursue. This will result in consumers being unprotected and with less secure insurance than they have now.
- The fragmentation of responsibilities would lead to a litigation nightmare, with constant disputes over which laws of which state fall within the exemptions in the bill. Even when the exemptions seem clear, such as network adequacy standards, the standards must be applied to a contract written under the laws of a different state.
- Many disputes that are now resolved through efficient administrative processes or without any formal action at all will either end up in lengthy and expensive court proceedings or will leave consumers with no meaningful recourse at all. External review of denied claims can literally be a lifesaver, but insurers could now be exempt from any external review law that is stronger than the federal minimum.
- Challenges to regulatory authority as a result of ambiguities and inconsistencies in the hodge-podge of laws will be a serious drain on Attorney General resources, and routine administrative litigation will become more complex because of the choice-of-law questions.

It encourages a “race to the bottom:”

- Insurers will choose the laws of low-regulation States, fragment the risk pool and negate many of the reforms embraced in health reform legislation.
- Insurers could avoid laws requiring the prompt payment of provider claims. This hurts consumers too, because providers would pursue payment from their patients if the insurance company fails to pay its bills on time.

- Insurers will take advantage of their ability to opt out of local laws to cherry-pick through plan design, selling products that attract healthier customers than plans that comply with state law. Any insurers that do comply with the more restrictive standards will face “adverse selection,” in which they are left with less healthy enrollees while the younger and healthier ones would go to plans offering cheaper rates for coverage with less protection.
- Overlapping jurisdiction and conflicting laws will create loopholes for fraudulent actors to exploit.

The Health Care Choice Compact proposal will create an unlevel playing field and could make integrated systems like Geisinger and Kaiser less competitive.

- This proposal, over the long run, will force insurers to “choose” the least regulatory State environment in order to compete.
- But many integrated systems, like Kaiser and Geisinger, would not be able to re-domicile where their networks of hospitals and doctors do not exist. Yet it is the Kaisers and Geisingers of the world who are successfully lowering health care costs through innovative delivery system reforms and care management.

The “new competitors” that would supposedly be brought into the market are an illusion.

- Insurers are already allowed to do business in multiple states. In states where one or two insurers dominate the market, those same insurers would now be given the additional power to pick a different set of laws, more favorable to them, and sell products governed by those laws instead of the laws of their home states.
- The state Health Benefit Exchanges, one of the centerpieces of the reform proposal, would lose their whole purpose. Instead of having a place where it is easy to compare a range of coverage options based on a common set of high standards, consumers would be flooded with a confusing array of plans for which their only meaningful protection is the “buyer beware” warning that their state laws might not apply.

This proposal undermines the insurance reforms critical to the broader health reform effort, and will harm millions of Americans who need meaningful insurance coverage. It is fundamentally flawed and should be removed.

→ **Recommendation: Language in both House and Senate bills authorizing “Health Care Choice Compacts” should be removed in their entirety from the final bill. If it is impossible to delete this section, then an improved version of the House language should be adopted, since it was amended to restore important state enforcement and regulatory functions.**

Funding

In the worst economic downturn in 70 years, states are suffering from plummeting revenues, growing unemployment and growing demands on the safety net. Even with the critical addition of ARRA stimulus funds, most states have implemented draconian cuts and many have also

raised taxes. With a continued weak economy, states are forced to consider further cuts – at the same time that demand for public health insurance programs such as Medicaid is at an all-time high due to unemployment rates. Ironically, even as Congress works to pass legislation expanding health coverage, many states are considering and implementing measures that will erode existing programs that provide health care to low-income Americans. Funding states adequately to cover implementation will be a factor in the success of comprehensive health care reform. Therefore, provisions must be included to address short and long term stabilized funding.

Bridge Funding

To avoid cuts that would increase the rolls of the uninsured, states must find a **bridge** - some way to fund existing programs until health care reform takes effect. Like states, Congress also has an interest in maintaining existing coverage and, if possible, expanding coverage *before* 2013 or 2014. The returned TARP funds provide Congress with a pool of resources to help states weather the current economic storm and strengthen and expand the health care safety net. Following are options that States offer for Congress's consideration:

- **Federal stimulus funding.** The ARRA federal stimulus bill, by significantly increasing the federal Medicaid payments, averted drastic cuts to Medicaid programs across the country. Currently, this additional funding is scheduled to expire in late 2010. Given the continued severity of the recession, extending the higher match rate until state revenues recover would allow states to sustain their Medicaid programs. While a critical step, it would not be sufficient to maintain other state-funded low-income medical programs.
- **Provide temporary federal funding for states' public plans.** Some states have public, state-funded health programs that are being cut and even threatened with elimination during the current budget crisis. These programs serve low-wage workers, most of whom would be eligible for coverage under expanded Medicaid programs in the health reform proposals. It would certainly send the wrong message if states are forced to de-fund and dismantle these popular programs now, while promising to provide health care to these same people in 2013 or 2014. (For example, Senator Maria Cantwell successfully added an amendment in Finance Committee to provide federal funding for the Washington state Basic Health Plan, which provides state subsidized comprehensive health care for the working poor up to 200% of poverty. The state budget problems threaten its continuation.)
- **Allow states that “opt in” to receive early funding to expand coverage. Allow states** that are ready to implement an Exchange, the Medicaid expansion and an individual mandate to do so, by providing additional Medicaid match and the premium subsidies. This will give health care reform a few early successful models to show that health reform can be implemented and *be effective*. *This has the additional advantage of “cementing” health care reforms and reducing the predictable campaign to try and repeal health care reform after the next election cycle.*

High Risk Pool Funds

Not all states have high risk pools, and high risk pools aren't necessarily the only way to address the needs of patients with chronic and expensive conditions who traditionally have not been insured by the private market. The legislation must provide flexibility so that high risk pool funds may be used in alternative ways to accomplish the same goals, recognizing the differences among states. Instead of penalizing states without high risk pools by denying all use of these funds, allowing for alternative uses of this funding stream will serve the same high-risk populations and build on existing models in the states.

- **Enable States to use High Risk Pool Funds for early expansion of Medicaid.** The federal proposals provide 100% match to states for Medicaid expansion populations starting in 2013 (House) or 2014 (Senate). Unfortunately, this means that most uninsured Americans will have to wait 3 to 4 years before seeing the benefits of the legislation. Under this option, the bill would be amended to allow states to use High Risk Pool funds to increase the match rate to 100% for expansion populations *prior* to 2013/2014. Since the vast majority of uninsured are below 133% FPL, early Medicaid expansion would help many Americans get coverage soon after passage of the legislation. Furthermore, this approach uses funds that Congress already intends to appropriate (for the High Risk Pool).
- **Enable states to use High Risk Pool Funds for state-funded, low-income health programs.** The Senate bill currently provides \$5 billion for states to establish High Risk Pools to cover people unable to obtain coverage due to pre-existing conditions. Under this option, the legislation would be modified to: a) permit states to use High Risk Pool funds to sustain "*state-funded low-income insurance programs*"; b) provide more flexibility in the maintenance of effort provision; and c) allow the Secretary to waive the requirement for people to have six months without coverage before qualifying. These changes would help states with state-funded, low-income programs to maintain them in the face of major budget cuts.

Set Rate Funding

Using a set rate for state funding is an optimal way to provide for the state's share of funding reform provisions. The set rate can be calculated based on the average mean of the states with each state below or up to the mean. Each state will pay at a preset level. No state will lose money and 25 states will see an increase in reimbursements.

→ **Recommendations:** The legislation must fund states adequately to cover implementation and to address short and long term funding challenges with the expansion of Medicaid and maintenance of effort requirements. Bridge financing during the transition to the new system will help assure its success and avoid financially penalizing states that have already moved ahead to insure low income persons, and is particularly needed during the current economic downturn. Recommended policies include continuing additional Medicaid match with stimulus or TARP funds, providing temporary funding for state public plans, using high

risk pool funds for low income subsidies and early Medicaid expansions, and using a set rate for state funding.

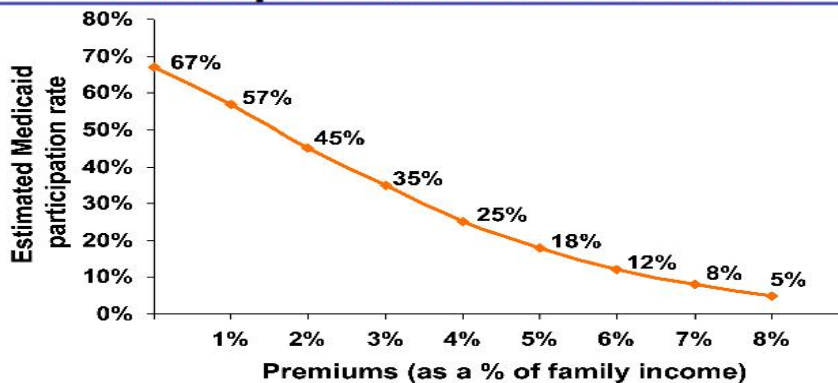
Affordability

We have significant concerns about the affordability provisions in the Senate bill. The bill made some improvements to the proposed health care reform legislation that passed in the Senate Finance Committee, but it still falls short in helping people with lower income to afford access to health coverage, particularly compared to the House bill. *While we do support mandating the purchase of insurance by individuals, this mandate is only feasible if the subsidies are pegged at a level that recognizes fiscal reality, with exceptions if there is significant hardship.*

Premium subsidies and out of pocket costs. The bill that passed the House sets premiums and out-of-pocket costs at levels that are closer to amounts that lower-income families (families with incomes under 250% FPL) can afford. These families are the least able to bear the brunt of a federal mandate to purchase insurance, and they could end up paying several thousand dollars more in health care costs under the Senate approach. However, we recognize that it is unlikely that final legislation will include subsidies that are deeper than those proposed in the House bill. We do think that it should be made clear that the subsidy levels in the House bill are a compromise and don't really reflect what households with low income can truly afford.

The chart below shows the results of a study by Leighton Ku and Theresa Coughlin, examining the impact of increasing premiums as a percentage of income on participation in health insurance among low-income households. *The chart clearly shows that as premiums for low income households increase as a percentage of income participation in health plans drop dramatically, and that even the House levels are too high for people with low income to truly afford coverage.*

Figure 1
Fewer Low-Income Uninsured Families Participate as Premiums Rise



Sources: Based on data from L. Ku & T. Coughlin, "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences," *Inquiry*, 36: 471-480 (Winter 1999-2000); see also L. Ku, "Charging the Poor More for Health Care: Cost-Sharing in Medicaid," Center on Budget and Policy Priorities (May 7, 2003).

There is a significant difference in the cap on annual out of pocket costs in the two bills. The House bill would provide an annual cap of \$1000 for families with income at 150% FPL and \$2000 for families with income at 200% FPL. The Senate bill sets an out-of-pocket cap at \$3,867 for households at both income levels. This is 14.1% of the annual salary of a family of three living at 150% FPL and 10.6% of the annual salary for the same size family at 200% FPL. *Health care costs could be as high as 19% of a family's income under the Senate provisions. Clearly the Senate levels are unrealistic.*

The following chart from a report by Community Catalyst and PICO outlines what a family at 150% FPL would be expected to pay under the current Senate proposal versus the House bill:

Health care costs for a family of three earning 150 percent FPL (\$27,465) under both the House and the Senate bill

For a family of three earning \$27,465	House	Senate
Premium	\$824	\$1,263
Out-of-pocket cap	\$1,000	\$3,867
Maximum total health care costs	\$1,824	\$5,130
Maximum total health care costs (as a percent of income)	7%	19%

(http://www.communitycatalyst.org/doc_store/publications/affordability_basics.pdf)

Actuarial Values.

The insurance plans available in the exchanges would have lower actuarial values under the Senate bill than the House bill, particularly for households with low incomes. The actuarial value measures overall how much a household will be expected to pay for health care costs versus the insurance provider. The actuarial value is extremely important and has not received as much attention as other pieces of the legislation.

→ **Recommendations.** We recommend that final legislation adopt most of the cost sharing protections in the House bill, including the subsidy structure and out of pocket caps for people with income below 250% and the actuarial values for all populations with incomes below 400% FPL. The subsidies and out of pocket limits for families with incomes at 300% and 400% FPL are stronger in the Senate bill than the House bill.

Medicaid Payment & Coverage

The House bill extends Medicaid eligibility for people under 65 to 150% FPL. The House bill includes a strong maintenance of effort requirement that will require states to maintain existing levels of eligibility in their Medicaid programs, even after the implementation of the new eligibility level for Medicaid and the health care exchange goes into effect.

The Senate bill extends Medicaid eligibility for people under 65 to 133% FPL. Newly eligible adults, i.e. childless adults and some parents, will receive a slimmed down “benchmark package”. This means that in most states, childless adults and parents, who were not eligible for Medicaid prior to the passage of health care reform, would have access to fewer benefits than all other Medicaid recipients.

The Senate bill also includes a maintenance of effort requirement for Medicaid eligibility until the time at which the health care exchange is fully operational. States facing budget deficits will be allowed to cut back eligibility levels above 133% FPL. This means that states with higher eligibility limits could choose to cut eligibility for parents to 133% FPL.

Medicaid Eligibility at 150% FPL. Medicaid is designed to meet the needs of people with lower incomes. Medicaid offers access to comprehensive services, some of which are not always covered through private insurance. Medicaid also provides important protections against excessive cost sharing. Because Medicaid is the most appropriate program to provide critical health coverage to people with lower incomes, we recommend that any final health care legislation extend Medicaid eligibility for people under 65 to 150% FPL as the House bill does.

Strong Maintenance of Effort Provision. The maintenance of effort requirements for Medicaid in any final bill will be important to ensure that low income parents in states remain covered up to a higher FPL currently used by some states. Maintenance of effort language is very important to ensure that states don’t lose ground in providing critical health coverage. Such language must, however, be accompanied by financial help from the federal government to states to ensure that they can maintain existing eligibility levels in their programs.

Comprehensive Coverage for Medicaid Members. It is essential that Medicaid members have access to a “full” benefit package. This ensures that people have access to coverage that they need and do not end up costing the Medicaid system more in the long run. Experience in states with these “slimmed down” plans has found Medicaid members struggling to make ends meet and doing without health care. They simply do not have the financial wherewithal to access health care services that are not offered in a slimmed down package, resulting in worse health outcomes and more acute need.

→ **Recommendations:** We support the provisions of the House bill extending Medicaid eligibility for people under 65 to 150% FPL, and maintenance of effort language that will require states to maintain existing levels of eligibility in their Medicaid programs, combined with bridge funding for those states so they are not penalized for moving ahead with state programs to cover the uninsured. Medicaid members should have access to a “full” benefit package, not a “slimmed down” plan which will result in worse health outcomes and more acute need.

Cost Containment

Most states have a keen interest in the passage of a Health Care Reform bill that expands coverage to millions. But, states are also clear that any reform must be sustainable. Failure to implement aggressive measures to contain costs now will merely postpone the day when health care will be unaffordable for most Americans.

The following is a list of cost-containment measures that many states recommend for inclusion in Health Care Reform legislation. Some of these will be unpalatable to different stakeholders; but, without such changes, our efforts to reform the system may be in vain.

Payment reform:

The single most important step we can take is to transition from a fee-for service (FFS) system to a capitation approach. This would neutralize the perverse incentives under FFS to provide too much care; and encourage movement toward coordinated systems of care¹. It's critical to start now, as it will take many years to move practitioners toward this very different way of practicing medicine. Some suggestions to get there:

- **Primary care:** Research indicates that simply increasing the availability of primary care can reduce excessive utilization². States support current proposals to increase payments for primary care while holding payments for most specialty practices constant. States also support efforts to immediately increase the pipeline of primary care providers by providing incentives, such as conditional scholarship and loan forgiveness programs, for students entering primary care.
- **Use data to promote evidence-based medicine.** Reform legislation should require payers, including Medicare, to promote evidence-based medicine. Best practice measures that could be used to shift actual practice should be determined by an independent, inclusive process that has strict conflict of interest standards. This must not be allowed to be confused with "rationing care". Rather, we need to be clear that a reformed system will only pay for care that is safe and effective. Medicare and other payers should share data with providers and provider groups on how well they follow evidence-based (i.e., safe and effective) medicine. Such reports could offer an "educable moment" on evidence-based best practices. As providers become aware of how their practices depart from safe and effective care, most will modify them accordingly.
- **Pay-for-Performance:** Pay for performance is very difficult to implement as it can lead to unintended (and undesirable) consequences. Instead, incentivize the shift to coordinated systems of care including the highly successful medical home model. Groups of providers

¹ The 1990s' backlash against managed care was due, in part, to systems that pitted insurers against doctors. This can be addressed by making doctors partners in the managing of care, as proposed in the Accountable Care Organization model.

² For example, see [studies](#) authored by Dr. Barbara Starfield.

that achieve certain outcomes (e.g., adoption of best practices, high client satisfaction, achieving outcome measures such as reduced hospital and ER episodes, appropriate screenings, etc.) should receive bonus payments. Receipt of bonus payments could be conditioned on using them to improve quality and coordination of care.

- **Bundled payment:** There is much discussion of bundling payment, but this approach is unlikely to address the underlying problem: i.e., paying for unnecessary procedures. Bundled payment can still promote unnecessary procedures. For example, if a region provides unneeded cardiac stents, bundling payments for the procedure may reduce re-hospitalizations but will do little to eliminate instances where the surgery was simply unnecessary.
1. **Comparative Effectiveness Research (CER):** Many states recommend strengthening the proposed CER Commission. States' experience with CER have shown that, to be effective, a commission must:
 - (1) Be comprised of independent, respected experts;
 - (2) Exclude individuals with any financial conflict of interest; and
 - (3) Be insulated from the political process.

Industry representatives should be able to share relevant research; but cannot participate in making recommendations. Including industry representatives would make the body ineffective, as well as much less credible. Concern has been raised that CER will lead to rationing care. Again, we need to be clear that taxpayers should only pay for care that is safe and effective. Government should certainly not pay for care that doesn't work, or - worse - actually hurts people.

2. **Administrative simplification and electronic records:** the current fragmented payer system generates excessive administrative waste. Studies estimate that 30-40% of health care premiums in small group and individual markets are spent on administrative activities and that every primary care provider has 4 or more office staff simply to handle the complexities of billing, prior authorizations, formularies³. States recommend strengthening the requirements for uniform billing codes, credentialing, medical management and authorization, and continuing support for providers to move to electronic records initially provided through ARRA.
3. **Drug and Medical Equipment:** the promotion of unnecessary and sometimes dangerous medicines and medical equipment is a significant driver of health care costs. For example, McKinsey Global Institute found that the U.S. spends twice as much for drugs as the average for other industrialized (OECD) nations⁴. In the U.S., brand-name drugs cost 77% more; biologics cost 35% more; and marketing rules add \$30 - \$40 billion in annual costs.

³ For example, see <http://oic.wa.gov/legislative/reports/SimplificationRpt.pdf>.

⁴ See// http://www.mckinsey.com/mqi/rp/healthcare/accounting_cost_healthcare.asp

→ **Recommendations:**

- Use the purchasing power of the federal government to leverage savings. Specifically, extend the federal governments purchasing rates to state Medicaid programs;
- Aggressive application of evidence-based medicine, as described above, should help reduce the trend;
- Re-establishing the historical ban on marketing to the public would reduce the practice of patients demanding the newest drug;
- Banning prescription drug and medical equipment manufacturers from providing gifts of any kind to providers. In addition drug samples should not be used to market prescriptions. If that is not achievable, require complete public disclosure of all payments to providers and make these readily available to the public. We support the Physician Sunshine provisions in the House legislation which is more effective than the Senate language which includes numerous loopholes.

Ambulatory surgery and diagnostic imaging:

Ambulatory surgical centers (ASC's) and diagnostic imaging centers (DIC's) have gross margins ranging from 28 – 38% and their per capita use is very high compared with other industrialized nations. McKinsey Group estimates that physicians in the U.S. make about 46% more than other OECD nations, in part due to ASC and DIC referrals where the physician has a financial stake⁵. Existing statute is ineffective in preventing self-referrals. The legislation should address this by discouraging financial relationships that drive unnecessary care, and establishing stronger disincentives for self-referrals.

Inpatient Services:

Hospitals are not immune from providing unnecessary care: U.S. hospitals do more of certain procedures on a per capita basis than other industrialized countries⁵:

Procedure	Ratio of US to OECD procedures
Knee replacements	2 : 1
PCIs	2 : 1
Bypass surgery	1.7 : 1
Cardiac catheterization	1.4 : 1

Capitated payment may reduce these ratios; but, in the interim, Health Care Reform should require that Medicare reduce payments for procedures that appear to be occurring excessively.

→ **Recommendations:** We recommend a series of cost containment measures including payment reform with an emphasis on primary care, coordinated care including medical home models; using data to promote evidence-based medicine with strict conflict of interest

standards; administrative simplification; restricting the promotion of unnecessary and sometimes dangerous medicines and medical equipment by re-establishing the historical ban on marketing to the public would reduce the practice of patients demanding the newest drug and banning prescription drug and medical equipment manufacturers from providing gifts of any kind to providers.

Prescription Drug Pricing as a Cost-Containment Strategy:

1. Medicare Part D Pricing

The current Medicare Part D program is wasteful, expensive, and confusing -- and it doesn't even accomplish the goal of providing a comprehensive prescription drug benefit under Medicare. The formularies change on a regular basis, enrollees hit the infamous "donut hole" and lose coverage, and there are bait-and-switch tactics causing seniors to sign up with plans that subsequently fail to cover their medications, payment denials are routine and the route to appeal those denials not well understood or fully utilized.

Passage of health care reform provides the opportunity to fix Medicare Part D, while recouping wasted taxpayer and consumer dollars spent on overpriced drugs. Failure to do so will continue a fiscally unsustainable program and continue to deny affordable prescription drug coverage to our seniors. While the Senate provisions that standardize the appeal process and limit somewhat the impact of the donut hole are a step in the right direction, they fall far short of what is needed.

- **The "Donut Hole":** A recent study found that about 25% of Medicare beneficiaries reached the coverage gap and about 4% reached the \$5,100 threshold, making them eligible for catastrophic coverage. According to the study, those reaching the donut hole were typically people with chronic illnesses who filled an average of five prescriptions each month. Along with cutting back on medications, these beneficiaries also stopped using an average of one in five prescriptions during the coverage gap. According to the study, Medicare drug benefit beneficiaries decrease their use of medications by 14% upon reaching the coverage gap.
- **Overcharging by Design:** A July 2008 report by the House Committee on Oversight and Government Reform found that the prices paid for the drugs used by the dual eligible beneficiaries under Medicare Part D are significantly higher than the prices paid by Medicaid for the same drugs. The higher prices for the top 100 drugs produced a windfall of \$1.7 billion for drug manufacturers in 2006, the first year of Medicare Part D. The higher prices produced an even larger windfall of \$2 billion for the drug manufacturers in 2007. An earlier staff report in October 2007 found that Medicare Part D pays on average 30% more for drugs than does Medicaid and that this discrepancy in pricing produced a windfall worth over \$3.7 billion for drug manufacturers in the first two years of the Medicare Part D program.

Who benefits? A study by the Center for Economic and Policy Research (CEPR) analyzes the extent to which various groups of seniors benefited from this legislation. The report, "The Impact of the Medicare Drug Benefit on Health Care Spending by Older Households," found that *most seniors experienced no reductions in their health care spending as a result of the Medicare Drug benefit*. In fact, the study found there is only limited evidence that the Medicare drug benefit provided relief for older households, and for many seniors, the burden of health care costs actually increased.

2. Generic pathway for biologics:

We have serious concerns about the section in the Act that establishes an FDA approval process for generic versions of expensive biologic drugs. Biologics, which include important treatments for cancer, arthritis and diabetes, cost 22 times more on average than conventional drugs and are predicted to make up half of all new drug approvals within a few years.

Already government programs are straining to cover their cost. By 2006, 43% of the Medicare Part B budget was spent on the top six biologic drugs. Yet the provisions in the bill would give brand-name biologics 12 years of data exclusivity, *more than double the five years conventional drugs receive*, even though the pharmaceutical industry's own numbers show development costs are equivalent. Sticking with the 12-year exclusivity provision is fiscally foolish and jeopardizes the long term sustainability of health care reform. Let's look at the numbers:

- The Congressional Budget Office estimated significant savings from S. 1695 - Biologics Price Competition and Innovation Act of 2007, which would have established an abbreviated regulatory procedure for licensing biological drugs that met certain requirements. The CBO said enacting S.1695 would reduce total expenditures on biologics in the United States by about \$25 billion between 2009 and 2018 (over that 10-year period, such savings would equal roughly 0.5 percent of national spending on prescription drugs, valued at wholesale prices). Direct spending by the federal government would decrease by \$46 million from 2009 to 2013, and by \$5.9 billion from 2009-2018.
- Another report, by economist Robert J. Shapiro, former undersecretary of commerce in the Clinton administration, found that "generic versions of the top 12 categories of biologic treatments with patent protections that have expired or that are due to expire in the near future could save Americans \$67 billion to \$108 billion over 10 years and \$236 billion to \$378 billion over 20 years."

3. Evergreening:

We are even more concerned that the provisions include a loophole that will allow pharmaceutical companies to make minor modifications to the drugs and receive a brand new

12-year marketing monopoly. Rather than promote innovation, research and development, which is the purported rationale, these provisions will actually remove incentives for meaningful future innovation and block price-lowering generic competition indefinitely in many cases.

4. **Pay-for-Delay:**

The legislation should ban a current practice that costs taxpayers and consumers millions annually - the 'pay-for-delay' sweetheart settlements between brand name and generic drug companies. While the House bill includes such a ban, the Senate bill currently does not. If the health reform bill bans "pay-for-delay" settlements, it would help patients get the medicines they need while saving \$12 billion dollars in public spending and \$35 billion overall in the next decade.

Since 2005, brand-name drug companies have stifled competition by paying generic drug makers millions of dollars in exchange for agreements not to bring generic drugs to the market. These settlements are very costly to government programs, consumers, and insurers because they can delay the availability of certain generic drugs for several years. For example, Bayer Corporation paid three generic drug manufacturers nearly \$400 million to delay bringing a generic version of the drug Cipro to the market. Because generic drugs cost 60 to 90 percent less than brand name drugs, generics are one of the most important tools to reduce cost and increase access to needed medicines. Generic drugs also yield significant savings. For example, the FTC estimates that the early availability of generic versions of just four drugs – Zantac, Prozac, Taxol, and Platinol – saved more than \$9 billion in drug costs. A June 2009 study by the FTC concluded that a ban on such 'pay-for-delay' settlements could save \$35 billion or more in future prescription drug costs over the next decade.

→ **Recommendations:** We strongly support the following recommendations which will reduce the cost of health care generally and the reform legislation specifically, including Medicare Part D, while at the same time expanding access to life-preserving medicines: (1) the federal government should negotiate Medicare drug prices as is already done through Medicaid and the Veteran's Administration; (2) the donut hole should be closed now, through industry price roll-backs; (3) the provisions for an FDA-approved pathway for generic biologic drugs should be amended to reduce the 12 years of data exclusivity offered to new products to a maximum of five years; (4) the evergreening loophole that will allow brand-name companies to make minor modifications to existing biologics and obtain a brand new 12-year market monopoly should be removed; and (5) collusion and sweetheart deals that prevent conventional generic drugs from being brought to market should be banned.

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