

Daniel T. Durham  
Interim CEO



June 22, 2015

The Honorable Orrin Hatch  
Chairman  
Senate Finance Committee  
219 Dirksen Building  
Washington, D.C. 20510

The Honorable Ron Wyden  
Ranking Member  
Senate Finance Committee  
219 Dirksen Building  
Washington, D.C. 20510

The Honorable Johnny Isakson  
131 Russell Building  
Washington, D.C. 20510

The Honorable Mark Warner  
475 Russell Building  
Washington, D.C. 20510

Dear Chairman Hatch, Ranking Member Wyden, and Senators Isakson and Warner:

On behalf of America's Health Insurance Plans (AHIP), I am writing in response to your request of May 22, 2015 for recommendations on legislative options for improving patient care for Medicare beneficiaries with chronic conditions. We appreciate your interest in addressing this important issue through your new Chronic Care Reform Working Group.

Our members have a long track record in advancing new innovations and strategies for meeting the health care needs of patients with chronic conditions, both in public programs and in the private marketplace. A new RAND Corporation study<sup>1</sup>, co-authored by AHIP staff and recently published in the *American Journal of Managed Care*, concludes that chronic care management programs have become a standard component of the overall approach used by health plans to manage the health of their commercial enrollees. The study is based on responses from 25 health plans and an examination of six case studies on health plans' chronic care programs. The authors indicate that all of the plans examined by the study – regardless of size, location, or ownership – offer programs for enrollees with chronic conditions.

In explaining the need for better management of chronic conditions, the RAND study cites data indicating that the number of people in the United States living with one or more chronic conditions is projected to reach 171 million by 2030. The study also notes that 40 percent of the U.S. population is projected to have some form of cardiovascular disease by 2030 and that the related health care costs will triple from the current \$273 billion to an estimated \$818 billion.

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<sup>1</sup> Results From a National Survey on Chronic Care Management by Health Plans, Soeren Mattke, MD, DSc; Aparna Higgins, MA; and Robert Brook, MD, ScD, *American Journal of Managed Care*, May 2015

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The RAND study highlights two similarities in the overall structure of health plan chronic care management programs. First, plans identify all enrollees with chronic conditions, usually based on diagnoses recorded on claims data or through direct referrals from providers or other plan initiatives. Second, health plans perform a risk stratification of those enrollees to match interventions and resources to the specific needs and risks of each patient.

Based on the outcome of this risk stratification, enrollees are assigned to either: (1) health promotion and wellness programs that address unhealthy lifestyles and risk factors through behavioral interventions; (2) disease management programs that focus on improving clinical care of chronic conditions and patient self-management; or (3) case management programs that target the highest-risk enrollees through interventions that are customized to the individual needs of enrollees and include additional services such as coordination with social care services.

As our members work to build upon these successful programs, we offer the following comments and recommendations on the priorities you identified in your letter.

**1. Improvements to Medicare Advantage for patients living with multiple chronic conditions:**

**Value-Based Insurance Design**

Our members have pioneered innovative benefit designs that use research and clinical guidelines to promote better health, manage chronic conditions, and target populations with specific health needs. Health insurance plans and employers use a variety of value-based insurance design (VBID) strategies, including incentives such as premium discounts, and copayment waivers or reductions, to encourage their members to engage in disease management, wellness programs, and other health improvement activities. VBID improves quality of care by encouraging individuals to access critically needed, high-value services and health improvement activities including preventive care. This approach aligns with the national goals of improving patients' health and overall health status and changing financial incentives in a way that drives quality and promotes consistency in health care delivery.

Recommendation: We support legislation that would establish a demonstration program to test and expand VBID methodologies in the Medicare Advantage (MA) program. This bill was introduced as the "Value-Based Insurance Design Seniors Copayment Reduction Act" (S. 1396) in the Senate and as the "Value-Based Insurance Design for Better Care Act" (H.R. 2570) in the House. We also offer the following additional recommendations for the committee's consideration:

- The process through which the Secretary develops participating criteria for the demonstration should include a public comment period to provide an opportunity for input from stakeholders.

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- Rather than limiting the application of VBID to specific chronic diseases, the demonstration should provide plans with opportunities to test VBID models on the full range of conditions that are currently being addressed in the commercial marketplace.
- MA plans should be permitted to target VBID programs to specific individuals, thus allowing benefit packages to be customized for patients with multiple chronic conditions.
- The VBID demonstration should allow a variety of design features including incentives to encourage MA enrollees to participate in disease management, wellness programs, and other health improvement activities. Cost sharing incentives and additional benefits should exist in the form of rewards and not limits to Medicare-covered services.

### **Risk Adjustment**

We strongly believe MA payment policy should promote a continued focus on prevention, early detection, and disease management in alignment with national policy goals and make care coordination available to all Medicare beneficiaries, including the most vulnerable populations. The MA risk adjustment system is a crucial component of this approach. Studies demonstrate that MA plan investments in activities that identify chronic conditions at their earliest stages and implement care management protocols that slow the progression toward more advanced disease states are improving access to preventive care, reducing unnecessary hospital readmissions, and resulting in more appropriate use of services than in traditional Medicare.

However, recent changes to the system announced by the Centers for Medicare & Medicaid Services (CMS) move in the wrong direction. The Agency's decision to fully phase in the 2014 CMS-HCC risk adjustment model in 2016 removes key codes for early stage chronic kidney disease (CKD). A recent Oliver Wyman analysis found a 23 percent reduction in plan payments for individuals with CKD under this approach. This is a significant problem, considering that 56 percent of the population with a CKD risk adjustment code in the 2013 risk adjustment model would no longer have a code for this condition under the 2014 risk adjustment model. As a result, MA plans will have fewer resources for investing in activities that identify chronic diseases at their earliest stages and for implementing care management protocols that slow the progression toward more advanced disease states.

We strongly believe these changes represent a major step backwards by shifting the program's focus away from prevention and toward acute care intervention. Moving forward, we should ensure the MA risk adjustment model reflects national policy goals to identify and treat beneficiaries with multiple chronic conditions – activities which have served as the hallmark of the MA program.

**Recommendation:** The MA payment system, including its risk adjustment model, should support the goal of delivering high quality, coordinated care for Medicare beneficiaries, particularly those with high-cost, high-burden chronic conditions who can benefit the most from early identification and care management services offered by MA plans. Payment policies should ensure that MA plans can continue to innovate and offer services for enrollees with chronic

conditions that are generally unavailable for beneficiaries in the FFS program. Provisions in H.R. 2579, the Securing Care for Seniors Act of 2015, take an important step in recognizing the importance of making changes to the risk adjustment system that appropriately address the needs of beneficiaries with multiple chronic conditions.

### **Star Ratings**

MA plans strongly support rewarding high quality performance and recognize the significant effort CMS has made to develop the quality measurement system. However, we remain concerned that our members focusing on low-income populations, who are more likely to experience multiple chronic conditions, face unique challenges that currently are not accounted for in the Star Ratings System. An AHIP analysis published on the *Health Affairs* website demonstrated Star Ratings performance for low-income focused plans are on average one-half star below plans without this focus and have been so over multiple years. These differences remain despite the considerable efforts our members are putting forward to meet the needs of their beneficiaries.

Recommendation: These findings strongly support the need for changes to the Star Ratings System to account for these characteristics. We support the continued efforts by many in Congress to direct CMS to develop short and long-term solutions addressing this issue. Absent a significant change, there is a risk that the quality-based payments put into place by the Affordable Care Act (ACA) will have the unintended consequence of discouraging organizations from focusing on low-income beneficiaries who have multiple chronic conditions and reducing access to health plans' care coordination, focus on prevention, and emphasis on person-centered care for the vulnerable populations that need it most.

### **Special Needs Plans**

Special needs plans (SNPs) are MA plans permitted to focus enrollment on beneficiaries who are dual eligibles, have chronic diseases, or qualify for institutional-level care to administer intensively targeted programs to meet the distinct needs of these populations. Approximately 2.1 million Medicare beneficiaries are enrolled in these plans. These health plans are demonstrating the value of tailoring innovations in health care practice, quality improvements, and effective strategies to maximize beneficiary care to meet the specific needs of beneficiaries. For example, a study in *Health Affairs* found that beneficiaries with diabetes in a Chronic Care SNP (C-SNP) had “seven percent more primary care physician office visits; nine percent lower hospital admission rates; 19 percent fewer hospital days; and 28 percent fewer hospital readmissions compared to patients in FFS Medicare.”<sup>2</sup> Another study found dually eligible beneficiaries enrolled in these dual eligible SNPs (D-SNPs) in Massachusetts were “less likely to be long-term nursing facility residents... and more likely to have a history of community focused care.”<sup>3</sup>

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<sup>2</sup> Cohen, Robb, Lemieux, Jeff. Mulligan, Teresa. Schoenborn, Jeff. *Medicare Advantage Chronic Special Needs Plan Boosted Primary Care Reduced Hospital Use Among Diabetes Patients*. Health Affairs 31, NO.1: 110-119. January 2012. (content.healthaffairs.org)

<sup>3</sup> JEN Associates, Incorporated, “MassHealth Senior Care Options Program Evaluation: Pre-SCO Enrollment Period CY 2004 and Post-SCO Enrollment Period CY 2005 Nursing Home Entry Rate and Frailty Level Comparisons.”

Recommendation: Without further Congressional action, federal authority for SNPs will expire on December 31, 2018. We strongly support permanent SNP reauthorization. These plans are demonstrating their value for individuals with chronic conditions and are an important component of a national strategy to effectively address the needs of this population.

### **Telehealth**

Health plans have embraced telehealth through the widespread use of nurse hotlines, remote monitoring services, electronic office visits, and other innovative ways of providing value to enrollees. Expanding the use of telehealth technologies is crucial to improving beneficiary access and value under the MA program. Telehealth improves beneficiary access to primary care, facilitates care coordination, and supports efforts to increase compliance with disease management programs.

Recommendation: MA plans should be allowed to include a broader scope of telehealth services in the basic benefit package. The current limitations require MA plans to use supplemental benefits funded by rebates or premiums to offer expanded coverage of remote access technologies. This has increased premiums and limited the availability of other additional benefits or buy-downs of Medicare cost sharing. In the Medicare Shared Savings Program (MSSP) final rule that was just issued earlier this month, CMS indicated that it intended to test waivers of the billing and payment requirements for telehealth services under the Innovation Center, with the goal of making a waiver option available to ACOs in 2017. In the interest of regulatory parity and alignment across programs available to beneficiaries, we recommend that available waivers under the MA program be modified, if necessary, to reflect any additional flexibility that CMS may choose to provide under the MSSP.

## **2. Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternative payment models (APMs) currently underway at CMS, or by proposing new APM structures:**

### **Medigap Cost-Sharing Plan Flexibility**

As the FFS payment model changes, cost-sharing structures will likely change with it and Medicare enrollees will want to continue to manage their cost-sharing exposure through Medigap coverage which is popular among seniors (with a better than 90% satisfaction rate<sup>4</sup>), especially seniors with chronic conditions<sup>5</sup> and those on lower incomes.<sup>6</sup> Prohibitions or limits on Medigap's protections can cause seniors to forego needed care that can result in poor health outcomes and increased costs to the Medicare program. This is of particular concern to those with chronic conditions. We believe that if allowed to do so, Medigap carriers will be interested

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<sup>4</sup> 2014 Medigap Enrollee Survey AHIP, Purple Strategies, March 2014

<sup>5</sup> Lemieux, Jeff, et. al., Medigap Coverage And Medicare Spending: A Second Look, *Health Affairs*, March 2008 vol. 27 no. 2 469-477

<sup>6</sup> *Beneficiaries with Medigap Coverage*, AHIP Center for Policy and Research, April 2015.

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in delivering innovative supplemental products that are built around changes to FFS payment models geared toward improving care for the chronically ill and all Medicare enrollees.

Recommendation: Congress should ask the National Association of Insurance Commissioners (NAIC), as the primary regulators of Medigap insurance, to advise on whether Medigap standard plans should be created that reflect the changing payment structures of traditional Medicare, or are geared toward enrollees that participate in alternative payment models. This Congressional request to the NAIC could include an assessment of the Medicare Select program to see if modifications in that program might enhance collaboration between Medigap insurers and providers that are using cost-sharing in their care management structures. Congress should also require that any changes in cost-sharing requirements or Medigap standardized plans do not interfere with access to needed services.

### MSSP / ACOs

Earlier this year, we submitted comments to CMS addressing changes to the Medicare Shared Savings Program (MSSP) and the payment of Accountable Care Organizations (ACOs). Our comments addressed regulatory issues and focused on three broad areas:

- We encouraged CMS to engage with the private sector to reduce fragmentation across payers, reduce administrative burdens on providers, and promote consistent signals to stakeholders across the health care system to maximize quality and efficiency improvement efforts.
- We encouraged CMS to build upon the improvements demonstrated by the Pioneer ACO program with respect to financial savings, quality of care, and patient experience – and apply these lessons to the design and implementation of the MSSP.
- We encouraged CMS to promote a level playing field between ACOs and other marketplace products, and ensure regulatory parity among the choices available to Medicare beneficiaries. We further recommended that: (1) CMS should leverage the lessons learned from the extensive regulatory framework and oversight infrastructure that is already in place under the MA program; and (2) available waivers under the MA program should be modified, if necessary, to reflect any additional flexibility CMS provides under the MSSP.

### **3. Reforms to Medicare’s current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions:**

#### Medigap Enrollee Health Support Pilots

Medigap products are designed primarily to protect Medicare beneficiaries from high or unexpected out-of-pocket medical costs, which is critically important since Medigap enrollees are shown to be at low income levels (49 percent of rural Medigap policyholders and 40 percent

of all Medigap policyholders have incomes of \$30,000 or less).<sup>7</sup> According to research published in *Health Affairs*,<sup>8</sup> Medigap beneficiaries are, on average, more likely to have multiple chronic conditions that are complex and expensive to manage compared to Medicare beneficiaries as a whole. Therefore, the fact that Medigap enrollees have more complex and chronic conditions than the general Medicare population may present unique opportunities to interact with these Medicare enrollees in new ways to help them improve their own health status.

Decisions about what is and is not medically appropriate for each patient are made by the treating physicians and the Medicare Administrative Contractors (MACs) adjudicating FFS claims. Medigap carriers must by law pay the supplemental portion of each claim that is paid by the MACs, and cannot control what services are or are not paid for. This distinction is important because it explains why Medigap carriers cannot directly manage or coordinate care. However, Congress can support those Medigap carriers that are exploring other ways they can interact with their members to assist them in interfacing more efficiently with the Medicare system.

Recommendation: AHIP requests that Congress support the current efforts of a number of Medigap insurers to develop voluntary model demonstrations that show how traditional Medicare and private Medigap insurers can work together. For example, “Medigap enrollee health support” pilots currently under development have the potential to generate significant savings for the Medicare program. These pilots are designed to allow Medigap carriers to give support to their chronically ill enrollees such as health counselors that help them navigate their chronic conditions, assistance in getting needed services and care, and incentives for healthier lifestyles. These value-added services are delivered separate and apart from their standardized Medigap benefits. Congress can also support such innovation by requiring that CMS make specific types of Medicare data available to those Medigap carriers participating in enrollee support pilots.

### **Medicare Physician Fee Schedule**

We have submitted comments to CMS addressing issues raised by the agency’s proposed rules for the Medicare physician fee schedule. Broadly speaking, we believe policymakers should focus on reforms that transition the Medicare FFS program to alternative payment models that promote quality and value, rather than perpetuate the inefficiencies and flaws of the outdated FFS system. Additionally, below are two significant issues we highlighted in our comment letters on the proposed rules for 2014 and 2015:

- We recommended regulatory improvements to the new CMS code (GXXX1) for managing the care of Medicare patients with two or more chronic conditions outside of a face-to-face visit. Specifically, we recommended that CMS develop an audit mechanism to determine if a physician’s office has provided all of the service elements required for use of this new code. We also expressed support for a requirement that practices offering chronic care management

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<sup>7</sup>*Beneficiaries with Medigap Coverage*, AHIP Center for Policy and Research, April 2015.

<sup>8</sup> Lemieux, Jeff, et. al., *Medigap Coverage And Medicare Spending: A Second Look*, *Health Affairs*, March 2008 vol. 27 no. 2 469-477.

services be required to utilize certified electronic health record (EHR) technology that includes an electronic care plan that is accessible to all providers within the practice and is available to be shared with care team members outside of the practice. Furthermore, we emphasized our view that extra payments for chronic care management services should be viewed in the context of more substantial efforts to transition to value- and outcomes-based payment models and, additionally, that the Medicare physician fee schedule should evolve to reflect more value-based payment and delivery models that include a strong emphasis on care coordination activities.

- We recommended a verification mechanism and additional requirements for physicians who receive payments under the Medicare physician fee schedule for complex chronic care management services. We suggested that the verification mechanism should include an attestation by the patient or caregiver to verify that the chronic care management services were actually delivered. We further recommended that the practitioner, before billing for these services, should be required to demonstrate that: (1) a coordinated care plan was received from all other primary providers (e.g., cardiologist, pulmonologist, etc.); (2) an active effort was made to resolve any discrepancies among the care plans from different providers in order to develop a single unified plan of care; and (3) follow-up was conducted with the patient to ensure adherence to the care plan.

Recommendation: On the legislative front, we recommend for consideration a pilot program to highlight MA plans' efforts to coordinate and improve care by transferring Medicare FFS beneficiaries with the most complex and costly conditions into MA. The highest cost FFS beneficiaries are often in and out of facilities, seeing multiple providers and taking dozens of medications that do not necessarily translate into higher quality of care. Therefore, we ask Congress to test innovative models of care focused on the costliest 10 percent of Medicare FFS beneficiaries and how their care would change in MA program. The goal would be to focus on integrated approaches that improve quality, patient outcomes and experience, as well as lower costs.

#### **4. The effective use, coordination, and cost of prescription drugs:**

Prescription drugs play an important role in the overall treatment of patients who have chronic conditions. This is particularly true for high-priced specialty drugs that have demonstrated great promise in the treatment of cancer, rheumatoid arthritis, multiple sclerosis, and other chronic conditions. The exorbitant prices charged for these drugs, however, are placing a heavy strain on our nation's health care system. The cost of treating a single patient with specialty drugs can exceed tens of thousands of dollars a year.

Health plans, employers, and other stakeholders are searching for new ways to restrain cost growth while simultaneously maintaining access to safe and effective drugs for patients. The following are several steps that should be taken to address this challenge.

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Recommendation: The exclusivity period for biologics should be shortened to promote greater price competition and earlier access to lower-cost specialty drugs or generic biologics. The Federal Trade Commission (FTC) has concluded that the current 12-year exclusivity period is “unnecessary to promote innovation by pioneer biologic drug manufacturers” and may harm consumers by “directing scarce research and development dollars toward developing low-risk clinical and safety data for drug products with proven mechanisms of action rather than toward new medical inventions to address unmet medical needs.”

Recommendation: Congress should prohibit patent infringement claims from being settled through “pay-for-delay” settlements that prevent generics from entering the market in a timely manner. By removing these barriers to competition, this step would expand the availability of low-cost, effective generic drugs.

Recommendation: We oppose efforts, in the current debate on patent reform, to provide an exemption for pharmaceutical or biological product patents from the inter partes review (IPR) process. The IPR process plays an important role in invalidating patents that do not represent true innovation. Weakening this process would effectively extend the original patent monopoly for pharmaceutical and biological products and result in significantly higher prices for consumers. House Judiciary Committee Chairman Bob Goodlatte has commented about the proposed exemption: “According to the CBO, this may even draw a fairly significant budget score because it would increase the prices that Medicare and Medicaid pay for prescription drugs.”

Recommendation: Congress should provide new authorizing language for the Patient-Centered Outcomes Research Institute (PCORI) that explicitly allows it to consider research on cost-effectiveness as a valid component of patient outcomes research. PCORI and the Agency for Healthcare Research and Quality (AHRQ), in their funding of research on the effectiveness of treatments and technologies and their dissemination of the results of that research, should prioritize the establishment of a multi-stakeholder, deliberative process that can use such research to provide trustworthy recommendations on high-value and low-value care options to providers, payers, and patients. These steps would provide information to consumers and providers about which treatments and drug regimens work best and which are less effective.

Recommendation: CMS should be provided the flexibility to set a single payment rate under Medicare Part B for groups of clinically similar drugs based on the lowest cost item. Adopting such a “least costly alternative” (LCA) standard would encourage cost-effective drug coverage and provide savings to consumers by setting a price ceiling for drugs within a category of drugs considered clinically equivalent and interchangeable. Consumers and patients selecting a higher-cost drug would be responsible for any cost-differential between the drug selected and the lowest cost, clinically equivalent drug within a class. These policies work best in drug categories where there is sufficient competition and alternative drugs and treatments available to patients. In addition to reducing costs, this policy also would reduce incentives for physicians to prescribe more costly drugs when comparable lower cost alternatives are available.

**5. Ideas to effectively use or improve the use of telehealth and remote monitoring technology:**

New developments in information technology, coupled with advances in telehealth and medical science, have the potential to transform the delivery of care for consumers who otherwise must travel long distances to see a physician or, in some cases, forego needed health care services. Below we highlight two proposals that, by removing obstacles to telehealth, open the door to improved health outcomes and a higher quality of life for individuals who face challenges in accessing health care services.

Recommendation: We support legislation that would provide guidance to the states in establishing common standards for the delivery of health care services through telehealth. This bill was introduced as the “Telehealth Modernization Act” in February 2015.

Recommendation: We support legislation that would permit licensed Medicare providers to treat patients across state lines through telehealth. This bill was introduced as the “TELE-MED Act” in the 113th Congress.

**6. Strategies to increase chronic care coordination in rural and frontier areas:**

We support an expanded role for non-physician providers, particularly in rural and frontier areas where patients have limited access to care due to physician shortages. Nurse practitioners and other providers with advanced degrees should be granted the autonomy to provide services allowed by their state licenses – such as writing prescriptions for medications, administering treatments, and ordering and interpreting diagnostic tests – without the oversight of a physician. This is an important step, along with the telemedicine initiatives we discussed in the previous section, toward improving access to primary care services in remote and medically underserved parts of the nation.

**7. Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers:**

Patient engagement and consumer transparency tools are important strategies for improving the health and well-being of individuals with chronic conditions. Health plans are working closely with patients on an array of programs that help increase medication compliance, promote rewards for seeking health appraisals and meeting personal goals, and provide low-cost or no-cost coverage for certain preventive and other high-value benefits. Health plans also are making information about premiums, cost-sharing, and deductibles available in readily understood, web-based formats. This approach to patient engagement helps patients make informed decisions, better manage their own care, and adhere to treatment plans and wellness programs designed to their specific conditions.

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Through our participation in the Partnership for Sustainable Health Care<sup>9</sup>, we have joined other stakeholders in the hospital, physician, business, and consumer sectors in recommending steps to decelerate health care costs and improving quality. One of our recommendations is to provide incentives for greater consumer engagement in care. This includes encouraging the use of high-value services and providers through tiered cost-sharing and related financial incentives. The goal of such tiered cost-sharing is to create financial incentives for consumers to make better use of their discretionary care choices, leading to savings from improved adherence to preventive measures and evidence-based care, lower utilization of unnecessary services, and the use of more efficient, higher-quality providers.

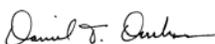
These incentives for engaging patients in making informed decisions about their health are supported by the VBID strategies we discussed earlier for promoting participation in disease management, wellness programs, and other health improvement activities.

**8. Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions:**

Health plans have played a leadership role in implementing delivery system reforms and new payment models. By partnering with hospitals and physicians, health plans are promoting team-based care through a variety of initiatives, including patient-centered medical homes, accountable care arrangements, bundled or episode of care payment models, and comprehensive global payment models. Through these initiatives, health plans are offering their provider partners data and decision-support tools to help physicians recognize gaps in care, such as which patients need comprehensive case management, which patients are most at risk of developing serious conditions, and which are in need of immunizations and preventive care. These reform efforts are showing significant promise in reducing preventable hospital admissions/readmissions and emergency room visits, improving patient outcomes and patient satisfaction, and providing greater value to consumers.

Thank you for considering our comments and recommendations on these important issues. We appreciate your commitment to advancing chronic care reform on behalf of our nation's Medicare beneficiaries, and we look forward to continuing to work with you to address this priority.

Sincerely,



Dan Durham  
Interim CEO

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<sup>9</sup> Partnership for Sustainable Health Care, Strengthening Affordability and Quality in America's Health Care System, April 2013