

**HIGH HEALTH CARE COSTS:
A STATE PERSPECTIVE**

HEARING
BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
ONE HUNDRED TENTH CONGRESS

SECOND SESSION

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(MISSOULA, MT)

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OCTOBER 21, 2008
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Printed for the use of the Committee on Finance

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U.S. GOVERNMENT PRINTING OFFICE

61-687—PDF

WASHINGTON : 2008

For sale by the Superintendent of Documents, U.S. Government Printing Office
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CONTENTS

OPENING STATEMENT

	Page
Baucus, Hon. Max, a U.S. Senator from Montana, chairman, Committee on Finance	1

WITNESSES

Collins, Sara, Ph.D., assistant vice president, Program for the Future of Health Insurance, The Commonwealth Fund, New York, NY	5
Fee, Jeff, M.B.A., president and chief executive officer, St. Patrick Hospital and Health Sciences Center, Missoula, MT	7
Olson, Fred, M.D., chief medical officer, Blue Cross Blue Shield of Montana, Helena, MT	9
Bjelland, Leif, owner, Le Petit Outre, Missoula, MT	11
Foster, Julie, cosmetologist, Missoula, MT	12
Williams, Hon. Pat, former U.S. Congressman, Missoula, MT	20
Fountain, Palm, health care professional, Missoula, MT	22
Bower, Marietta, board member, Montana Comprehensive Health Association, Polson, MT	23
Roberts, Dr. Tom, administrator, Western Montana Clinic, Missoula, MT	24
Orott, Ray, independent contractor, Missoula, MT	25
Newman, Dr. Jan, fellow, American College of Surgeons and American Board of Holistic Medicine, Missoula, MT	25
Olson, Dr. Byron, retired physician, Missoula, MT	26
James, Sheila, Medicare and Medicaid recipient, Missoula, MT	28
Murphy, Dr. Anne, general internist, St. Patrick Hospital and Health Sciences Center, Missoula, MT	28
Lacroy, Bill, organizer, Montana Human Rights Network, Missoula, MT	29

ALPHABETICAL LISTING AND APPENDIX MATERIAL

Baucus, Hon. Max: Opening statement	1
Bjelland, Leif: Testimony	11
Prepared statement	31
Bower, Marietta: Testimony	23
Collins, Sara, Ph.D.: Testimony	5
Prepared statement with attachment	33
Fee, Jeff, M.B.A.: Testimony	7
Prepared statement	66
Foster, Julie: Testimony	12
Prepared statement	70
Fountain, Palm: Testimony	22
James, Sheila: Testimony	28
Lacroy, Bill: Testimony	29
Murphy, Dr. Anne: Testimony	28

IV

	Page
Newman, Dr. Jan:	
Testimony	25
Olson, Dr. Byron:	
Testimony	26
Olson, Fred, M.D.:	
Testimony	9
Prepared statement	72
Orott, Ray:	
Testimony	25
Roberts, Dr. Tom:	
Testimony	24
Williams, Hon. Pat:	
Testimony	20

COMMUNICATIONS

Brothers, David	79
Chadwick, Karen Kelly	80
Copple, Caitlin	81
Grimes, Mark	82
Henry, Hon. Teresa K.	84
Hisel, Matt	85
Kuennen, Anita	86
Moody, Molly	90
Newman, Dr. Jan B.	91
Planned Parenthood of Montana	94
Roy, Michelle	103
Sarnecki, Megan	104
Sobieszczyk, Dr. Teresa	106
Stevick, Ashley	115
Visser, Dirk C.	116

HIGH HEALTH CARE COSTS: A STATE PERSPECTIVE

TUESDAY, OCTOBER 21, 2008

U.S. SENATE,
COMMITTEE ON FINANCE,
Missoula, MT.

The hearing was convened, pursuant to notice, at 11:05 a.m., in conference room #1, St. Patrick Hospital and Health Sciences Center, Missoula, MT, Hon. Max Baucus (chairman of the committee) presiding.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Okay. We are going to come to order. I am very pleased to convene this Senate Finance Committee hearing here in Missoula. We in the Finance Committee have held a series of hearings on health care reform in Washington, DC. This is the first hearing not in Washington, DC, and I am very pleased that the first hearing not in Washington, DC is here in Missoula, MT. It is very important to me that health care reform legislation have a very strong Montana component. Often I think people in Washington, DC tend to forget rural America, partly because they do not spend a lot of time in rural America, and it is very important for us, our parts of the country, to remind Washington how we operate. Sometimes we are the same as people in urban areas, but sometimes not, and it is very important that that difference not be forgotten.

In that vein, I have had a series of what I call listening sessions all across Montana on health care reform. There will be a dozen of them in the month of October. They are not full-fledged Finance Committee hearings, but they are an opportunity for me to have a panel of experts in each different Montana city, whether it is Helena, Billings, or wherever, and then take questions from the audience. So in many respects, they are very similar to the formal Finance Committee hearing that we are having here today, but the main point I want to make is we are going to make sure we have a good strong Montana component in the health care reform.

I am going to begin today with a story of a woman named Terri. Terri is 48 years old and lives in Montana. She started a new job in January. Before she was eligible for health insurance at her job, that is, before she was eligible as an employee, the owners of the company decided to drop their coverage, that is, to drop health insurance. Soon after, Terri was diagnosed with ovarian cancer. She

had emergency surgery, now she must undergo chemotherapy treatments, which she has no idea how she will pay for.

In Montana, like many States, insurance companies can choose not to insure people with certain medical risks. Because of that practice, insurance companies would most likely deny Terri private insurance. In theory, Terri could get insurance through Montana's high-risk pool, but the costs would still be too high for Terri to afford. As her chemotherapy is set to begin, Terri may still have access to care, but she is worried about being able to get treatment in the future, and she is worried about how to pay for it.

Today we will hear the story of another Montanan, Julie Foster. Julie does not have access to the health care that she needs. Sadly, Terri's and Julie's stories are all too common here at home and across the country.

America now spends more than \$2 trillion a year on health care, more than \$2 trillion a year. That is about half private and half public. That averages out to over \$7,000 per person. We in America spend over \$7,000 per person on health care.

In 2006, national health expenditures rose at a rate of nearly 7 percent. That is more than 2 times the rate of growth of the economy; 2 times the rate of growth of the economy. The average annual cost of family coverage in employer-based health plans was \$12,600 in 2008. That is just under the yearly salary of a full-time worker earning the minimum wage. This means that families are spending higher percentages of their earnings on health care costs without getting much in return.

Those hit hardest by rising health care costs are individuals and small businesses. High and rising health care costs have affected the ability of businesses to continue to afford coverage. Small businesses, in particular, report that rising premiums are forcing them to drop health coverage.

According to a Kaiser Family Foundation survey, in the past 8 years, the percentage of employers offering health insurance declined from 69 percent to 60 percent. That is right. Declined. The percentage of employers offering health insurance actually declined from 69 percent to 60 percent. This trend is leaving more and more people uninsured, and it is leaving more and more people worried about where and how they can receive care.

In Montana, only 40 percent of businesses with 10 or fewer employees offers health insurance to their employees. Of the Montana businesses that do not offer health insurance, that is, if you take all Montana businesses that do not offer health insurance, 81 percent cited high premiums as the major reason.

Today we will hear from Leif Bjelland, the owner of Le Petit Outre in Missoula. His testimony provides a firsthand account of how rising health care costs are affecting small businesses here at home. Both employers and employees are feeling the strain of these costs. When businesses begin limiting benefits or cutting them out altogether, Montana families and individuals suffer.

Today you will hear also from Dr. Sara Collins with The Commonwealth Fund about the difficulties that adults face finding affordable health insurance.

In Montana, during the last 7 years, health care premiums for families increased by almost 89 percent. That is a rate that was

5½ times greater than the increase in wages. Premiums increased 5½ times more than increases in wages. Not just health care premiums. That does not include out-of-pocket costs, which means the disparity could be even greater. Such high costs often force individuals to go uninsured for periods of time, and that puts them at risk of unaffordable, out-of-pocket expenses if they get sick.

According to The Commonwealth Fund, in 2007 nearly two-thirds of U.S. adults under 65, two-thirds of U.S. adults under 65 reported putting off getting needed care. Why? Because of problems with medical bills or debt. And sadly, health care spending and medical bills play a role in half of household bankruptcy cases in America; half. Julie Foster will tell you today about her experience.

We can do better. We can increase the number of Americans who have health coverage. We can lower the cost of insurance to help both employers and employees, and we can improve the quality of care to help everyone lead longer and happier and more productive lives. We can make American businesses of all sizes more competitive by helping them to provide health care coverage to their employees.

As a Nation, the U.S. spends almost 50 percent more per person in health care than any other developed country. We spend more than 50 percent per person in America on health care than any other developed country. The other figure is, we spend 16 percent of our GDP—gross domestic product—on health care. Japan spends 8, Germany and France spend about 11 percent. That is, we spend twice as much as a percent of GDP on health care than Japan and 50 percent more than Germany or France. Despite all this, the United States ranks last out of 19 countries in preventable deaths, according to a recent Commonwealth Fund study. We are 19th out of 19 in preventable deaths. That is just one criterion. There are lots of other criteria that measure the United States with other countries in terms of the quality of health care and outcomes of health care, and this is just one. There are many others that have virtually the same results. Namely, we stack up in America about 17th to 19th. Not number 1, even though we spend so much more per person on health care.

Reform must lead to improved quality and decreased costs. We must get better health outcomes for the money we spend. America simply cannot sustain its current rate of growth in health care spending over the long run. We must find ways to cut health insurance costs, because otherwise, health spending will consume, sooner or later, most of our economy.

Our current system leaves too many people without health insurance. Nationwide, 46 million Americans lack health insurance completely and another 25 million are underinsured. We sometimes talk about those who do not have coverage, some 46 million. We sometimes forget to also mention those who have poor coverage, the underinsured, who number 25 million. So that means, if you add the two together, about 71 million Americans either have no health insurance or they have very poor health insurance. In Montana, 160,000 people do not have health insurance and 37,000 of them are uninsured kids.

More than half of Montana's uninsured work full time for small businesses. Let me say that again. More than half of Montana's un-

insured persons work full time for small businesses. This is more proof that our system does not work. Small businesses find it difficult to offer insurance, and workers are left exposed. Our current system is in need of reform.

Today we have a panel well suited to provide both expert and firsthand knowledge of these issues. I must say it is very difficult to choose from so many willing and interested Montanans for today's panel. An awful lot of you wanted to be on the panel today. It was very, very difficult. Basically it was first-come, first-served, but I just thank everybody for their deep interest. I am sorry we could not accommodate everybody. Our witnesses here today, though, will help us understand the effects of high health care costs on employers, employees, health care providers, and families alike. Their diverse perspectives will help us to focus reform so that we reach our goal of having affordable, high-quality health care for all Montanans and Americans.

I would like now to show you my basic goal.

The first is a goal of universal coverage. I believe that we should have—that every American should have health insurance. That is what I mean by universal coverage. Everybody should have health insurance, and I think that there are various ways to get there. I do not advocate a single-payer system. We in America have to have our own unique American solution, probably a combination of public and private coverage so that every American has health insurance.

The second principle is sharing the burden. Neither the employer-based system nor the individual market can fulfill the demand for affordable, portable quality coverage on its own.

The third principle is improving quality and controlling costs, and a little later we will get into why our system is so costly. One thing is, we have such a high percentage of our health care bills attributable to administrative costs. Our pharmaceuticals are expensive, and we have overutilization. There are a lot of reasons why we spend so much in America compared to other countries, and a lot of it is wasteful and inefficient. We have to get to the bottom of it if we are going to solve this thing in any serious way, and clearly address quality.

Quality in America is uneven. We have great quality in some respects—we have great drugs, great doctors, great hospitals—but still the quality of care—partly because of our reimbursement system, other reasons as well—is uneven, and that has to be addressed.

The fourth principle is prevention. American health care tends to focus on sickness. Instead we should devote more time to prevention and focus on care coordination. Not just obesity and tobacco cessation and alcoholism, but it is also care coordination and a little more reimbursement to thinking and a little less reimbursement comparatively to procedures.

The fifth principle is shared responsibility. I think employers, individuals and governments all bear responsibility and all should contribute to reform.

So let us now hear from our panel. I would like to welcome our witnesses. First we will hear from Dr. Sara Collins, who is the assistant vice president with the Program for the Future of Health

Insurance at The Commonwealth Fund. The second witness is—you all know him here in Missoula—Mr. Jeff Fee, the president and CEO of St. Patrick Hospital and Health Sciences Center. The third witness is Dr. Fred Olson, chief medical officer for Blue Cross Blue Shield of Montana. The fourth witness is Leif Bjelland, owner of Le Petit Outre here in town. I worked for Leif 1 day; he is a good employer. Finally we will hear from Ms. Julie Foster, who is a cosmetologist here in town and cannot afford health insurance.

I must remind all the witnesses, the standard rule of these committee hearings is you have 5 minutes to speak. Your full statements will be included in the record. If you feel compelled to speak more than 5 minutes, you know, we will give you a little room there, but whatever works works, and we will just kind of play it by ear here. So we will start first with you, Dr. Collins.

STATEMENT OF SARA COLLINS, Ph.D., ASSISTANT VICE PRESIDENT, PROGRAM FOR THE FUTURE OF HEALTH INSURANCE, THE COMMONWEALTH FUND, NEW YORK, NY

Dr. COLLINS. Thank you. Thank you very much, Mr. Chairman, for this invitation to testify on high health care costs and the implications for U.S. families, and thank you for the invitation to come out to this beautiful part of the country today.

The soaring costs of health care and stagnant incomes are leaving many working families without insurance or with medical expenses that consume a large share of their budgets. An analysis of The Commonwealth Fund Biennial Health Insurance Survey found that nearly two-thirds of working-age adults either were uninsured for a time during 2007, had such high out-of-pocket costs relative to their incomes that they were underinsured, reported a problem paying medical bills, or did not get needed health care because of costs. Over the past 7 years, these problems have spread up the income scale. The Nation now faces a potentially severe economic downturn that could have potent financial implications for lower- and middle-income families, those most at risk of being uninsured or underinsured. There is now an urgent need for a national solution that will provide families with affordable coverage options to ensure access to timely health care and provide protection against catastrophic financial losses.

As Senator Baucus said, in 2006, national health expenditures increased at a rate of nearly 7 percent per year. Again, more than 2 times the rate of growth in the economy. Premiums are growing more than twice the rate of wages and price inflation. Again, the average premium in employer health plans is \$12,700, more than the average yearly earnings of a full-time worker earning the minimum wage.

Employer coverage remains the predominant form of health insurance for U.S. families. Ninety-nine percent of companies with 200 or more employees offer health benefits, but rising premiums, as Senator Baucus said, have weakened the ability of small firms to offer insurance. Just 49 percent of employers with fewer than 10 employees offered health insurance in 2008. This is down from 57 percent in 2000. Employers have also tried to hold down their premiums by increasing employee cost sharing. In-network deductibles

have tripled since 2000, and they have quadrupled for small businesses.

Rising health care costs over the past decade have occurred as family incomes have barely budged. This means that increasing numbers of Americans are spending large shares of their income on health care. It also means that the number of people without health insurance has surged, rising to 46 million in 2007. In addition, as Senator Baucus said, in 2007 an estimated 25 million adults were underinsured. This is up from 16 million in 2003.

The share of adults under age 65 with problems getting needed health care because of costs rose from 29 percent to 45 percent between 2001 and 2007. Cost-related problems in getting needed care rose across all income groups with adults and low- and moderate-income families reporting the highest rates.

Among adults with chronic health problems, more than 60 percent of those who were uninsured, and nearly half of those who are underinsured reported skimping on their medications for their chronic illness because of cost. Forty-one percent of working-age adults or about 72 million people reported problems paying their medical bills or paying off accrued medical debt over the past year. This is up from 34 percent or 58 million people in 2005.

Three-quarters of adults who reported a problem with medical bills said that they had not pursued needed health care because of costs. This is compared with a quarter of people who did not report problems with their medical bills.

The public is voicing a strong desire for relief from rising health care costs. In a recent Commonwealth Fund survey, 80 percent of adults said that the health care system is in need of a major overhaul or fundamental reform. A strong majority of adults across political parties said that it will be important for the next president to improve the quality of health care, ensure that insurance and health care are affordable, and reduce the number of people who are uninsured.

The Commonwealth Fund Commission on a High Performance Health System has identified key strategies for moving the health care system to a higher level of performance. They include extending affordable health insurance to everyone; aligning incentives to reward high quality and efficient care; organizing the health system to achieve accountable and coordinated care; and investing in public reporting, evidence-based medicine, information technology, and the infrastructure needed to deliver the best care.

In terms of health insurance reform, it will be critical that benefits cover essential services with financial protection, and premiums, deductibles, and out-of-pocket costs are affordable relative to family income. Health risks should be broadly pooled. It should be simple to administer; coverage should be automatic, stable, and seamless; and financing should be adequate, fair, and shared across stakeholders.

Universal coverage must be pursued, along with strategies geared to improving quality and efficiency and reducing the growth in health care costs. A recent report by The Commonwealth Fund, "Bending the Curve," examined the impact on health care costs of several strategies to improve quality and efficiency, including increasing the use of health information technology, comparative ef-

fectiveness evidence, promoting better health and disease prevention, aligning incentives to improve quality and efficiency, and correcting price signals in health care markets. Potential health system savings from these strategies ranged from \$9 billion to \$368 billion over 10 years. Thank you.

The CHAIRMAN. Thank you very much, Dr. Collins. That was very informative. Thank you very, very much.

[The prepared statement of Dr. Collins appears in the appendix.]

The CHAIRMAN. Mr. Fee?

STATEMENT OF JEFF FEE, M.B.A., PRESIDENT AND CHIEF EXECUTIVE OFFICER, ST. PATRICK HOSPITAL AND HEALTH SCIENCES CENTER, MISSOULA, MT

Mr. FEE. Very good. Good morning, Chairman Baucus. Again, I am Jeff Fee, president and CEO of St. Patrick here in western Montana. Founded in 1873, St. Patrick Hospital is the largest community hospital in western Montana and is part of Providence Health and Services, a Catholic not-for-profit health system serving communities across Montana, Washington, Oregon, Alaska, and California. Our system includes hospitals, long-term care facilities, nursing homes, physician groups, and a health plan.

On behalf of St. Patrick and Providence Health and Services, we welcome you here to St. Pat's and appreciate the opportunity to testify this morning on the high cost of health care.

Our perspective this morning is really from a provider's perspective, and I think it is important to note early on that what we see as a primary problem on this particular issue and some of the solutions that we are proposing financially jeopardize hospitals in our current state. It is a risky proposition for us, but we believe it is the right thing. We believe, however, that hospitals should play a different role in ideal future states, and as such, are not suggesting solutions that perpetuate and or protect the hospital and/or health care industry as we know it today.

As you know and as you stated earlier, the high cost of health care is a complex, multi-faceted problem facing Americans today. Pharma, device manufacturers, high-cost technology, litigation, specialty hospitals, malpractice, unfunded mandates, cost shifting, I could go on, all these contribute significantly to the high cost of health care and are in large part symptoms of the larger issue. That issue is horribly dysfunctional structural incentives that have been built into our health care system over the past several decades. Our system is focused not on improving the health of our people in our communities. Rather, it is oriented towards sick care and the notion that problems can simply be solved by doing more medical services and procedures. Physician payment, driven by the Medicare fee schedule and reinforced by the private insurance system, encourages overutilization of high-cost procedures over basic care management. Hospital payment structures encourage increasing the volume of high-cost procedures that are more profitable to offset those services that are not.

Our health care delivery system is highly fragmented. Providers compete for sick patients rather than collaborate to improve health. Simply put, hospitals and health care providers are paid to take care of sick people, not to keep them well. The ugly truth is, the

more we do, the better we do financially. There are built-in economic incentives to overutilize health services. We the providers are rewarded based upon the quantity of service provided, and this fact alone, we believe, drives costs at an unsustainable rate.

As a result of these perverse incentives, the government and commercial payers have put laws, regulations, and burdensome processes in place to counteract this dynamic. Stark Laws, medical necessity criteria, managed care paperwork, documentation standards, Recovery Audit Contractor (RAC) audits, and much more are all regulations aimed at preventing overutilization and do nothing to add to the value of improving the health and wellness of our people in our communities.

To add insult to injury, the cost to hospitals and physicians of overhead related to coding, billing, claims, and compliance with regulation is estimated to be well into the billions. We must develop a health care system that focuses on quality health care rather than quantity sick care; a system that creates incentives to keep our people and communities well; a system that provides all Americans access to quality health care; a system that balances risks with all the key stakeholders, including risks and accountability at the individual level for maintaining health; a system that no longer emphasizes high tech acute care, but, rather, emphasizes wellness and collaborative care management through primary care and integrated health information technology; a system that is patient-centered to provide improved health and wellness for our communities as a whole.

We believe that any measures that truly want to address the foundational problem causing an unsustainable trend in health care costs must address the perverse incentives at their core. While we believe that some of the models and pilots that are currently being explored today, like pay-for performance, for example, are certainly steps in the right direction, we also believe that they are simply tweaks to our existing system and too closely follow the contours of our existing payment and financing structures.

We urge Congress and our next president to consider the following. First, completely overhauling provider payment systems to reorient them towards collaboration aimed at improving the health and wellness of individuals in our communities. Second, shifting the direction of value-based purchasing towards shared provider incentives across the continuum of care. Third, rewarding providers for helping to improve the overall health of their communities.

These are just a few possible ideas for reform of the health care delivery system that we believe would significantly reign in unsustainable increases in our health care costs, but more importantly, significantly improve the health of our people, our communities, and our Nation.

Thank you, Chairman Baucus, and the Finance Committee as a whole for your continued strong leadership on this issue, and I look forward to working with you in the future.

The CHAIRMAN. Thank you very much, Jeff. I appreciate that. I thank you for your testimony. Thank you.

[The prepared statement of Mr. Fee appears in the appendix.]

The CHAIRMAN. Okay, Dr. Olson, you are next.

**STATEMENT OF FRED OLSON, M.D., CHIEF MEDICAL OFFICER,
BLUE CROSS BLUE SHIELD OF MONTANA, HELENA, MT**

Dr. OLSON. Mr. Chairman, thank you for inviting me here today to testify on the important topic of rising health care costs. For the record, my name is Dr. Fred Olson. I am the chief medical officer at Blue Cross Blue Shield of Montana.

Blue Cross Blue Shield of Montana provides services to approximately one-third of the population of Montana and almost 50 percent of the fully insured market. We administer the Children's Health Insurance Program for the State of Montana, and through Tri-West, we handle the health insurance of Montana's military families.

The cost of health care, which is rising at unsustainable rates, is of paramount importance to Blue Cross Blue Shield of Montana. We are pleased to be able to provide our thoughts on what we consider to be some of the top drivers of health care costs.

The U.S. consumes approximately twice as much health care as other industrialized nations. Many factors have been identified as contributing to this overutilization of health care services. Insurance has tended to insulate patients from true health care costs by covering the majority of services. Studies have shown that patients choose to receive 40 percent more health care services when the cost is born by someone else.

We support publication of cost and quality information that will allow patients to become more cost-effective consumers, and insurance products that reward cost-effective behavior. Many feel that more health care results in superior outcomes, in spite of numerous studies that have shown excessive consumption of health care to be counterproductive. In the U.S., we approve therapies without consideration of cost in contrast to other nations which consider benefits as well as costs in their approval processes. As we learned at the Senate Finance Committee's health care summit in June, 30 percent of health care spending goes towards ineffective, inappropriate, or redundant care. I applaud Senator Baucus for introducing the Comparative Effectiveness Research Act, which will help support evidence-based medicine. We need more information on what works best in medicine, and we need to support use of electronic medical records that can help prevent redundant care.

Patients today are increasingly frustrated at being unable to locate a primary care physician who is accepting new patients. The United States has the highest ratio of specialist physicians to primary care physicians found among industrialized nations. Comparing nations, there is a clear correlation between an increasing percentage of primary care physicians and more cost-effective health care. Comparing States within the United States, analysis of Medicare costs and quality metrics shows the same relationship. States with higher percentages of primary care physicians as compared with specialist physicians have shown lower health care costs and higher quality metrics.

U.S.-trained physicians are increasingly less likely to become primary care physicians. A 2007 survey of 1,177 4th-year medical students at 11 U.S. medical schools showed that only 24 students, 2 percent, were planning to become internal medicine generalists. The U.S. needs to address the growing shortage of primary care

physicians by actively managing its physician training programs and by enacting changes in the physician compensation system that pays specialists 2 to 3 times more than primary care physicians.

Unhealthy lifestyle choices, including smoking, lack of exercise, and eating habits that lead to obesity add significantly to health care costs. According to the Centers for Disease Control and Prevention, 33 percent of adults and 14 to 18 percent of children are obese. The CDC also found 24 percent of men and 18 percent of women still smoke. More often than not, these personal choices lead to chronic diseases such as diabetes, hypertension, and heart disease. As a result, 6 out of 10 adults in the U.S. have at least one chronic condition. To contain health care costs, we must add additional support to programs that promote wellness through improved lifestyle choices and reduce the prevalence of chronic conditions.

Medical malpractice suits increasingly target bad outcomes rather than true malpractice. Malpractice insurance varies by specialty, with direct costs varying between \$5,000 and \$200,000 per physician per year. In addition, physicians learn to practice defensive medicine, ordering services that protect them from litigation rather than help to define or treat a patient's medical condition. The true costs of malpractice litigation are difficult to quantify, but continue to substantially contribute to rising health care costs.

We often see facilities duplicating very expensive services such as cancer treatment as they compete within the health care market. Competition in health care in contrast to competition in other economic sectors does not seem to lower costs. U.S. consumers pay the cost of these duplications. We need a mechanism to constrain deployment of these duplicative medical services in some areas while assuring the provision of necessary services in others.

While cost shifting does not increase the overall cost of health care, it does lead to higher health care costs and higher insurance costs for individuals insured through the private sector. Cost shifting occurs when the uninsured cannot afford to pay their health care costs and when Medicare and Medicaid pay less for health care services than providers find acceptable. Health care providers in Montana tell us that the cost shifting from Medicare and Medicaid to the commercially insured is approximately 35 percent. That 35 percent cost shift translates into an approximate increase in paid claims of \$700 per year for each Blue Cross Blue Shield Montana insured member.

Cost shifting will become more problematic as our population continues to age. By 2030, it is estimated one-fourth of the population in Montana will be over age 65, resulting in additional cost shifting to the commercially insured.

Blue Cross Blue Shield of Montana believes that the reimbursement rates for Medicare and Medicaid must be adjusted to reduce cost shifting. We also support universal coverage which will eliminate cost shifting for care of the uninsured.

Thank you for your time today. Blue Cross Blue Shield of Montana appreciates the focus the Senate Finance Committee is putting toward health care reform. We believe your efforts will bring about substantive reform from which all Americans will benefit.

The CHAIRMAN. Thank you very much, Dr. Olson.
 [The prepared statement of Dr. Olson appears in the appendix.]
 The CHAIRMAN. Mr. Bjelland?

**STATEMENT OF LEIF BJELLAND, OWNER,
 LE PETIT OUTRE, MISSOULA, MT**

Mr. BJELLAND. Thanks for having me. My name is Leif Bjelland. I am the owner of Le Petit Outre here in town. I feel that I can speak on behalf of myself and many small businesses, and share my experience with you in terms of health insurance.

I started a business about 10 years ago. I was the only employee; currently we have 31 employees. Of those, 22 are full-time employees and are qualified for health care insurance.

Five years ago we started shopping around to actually get a policy, and I felt pretty proud about the policy that we came up with. The decision was to kind of strip down and custom create a policy for our group specifically. My full-time employees are a fairly young group, a fairly healthy group, very active and in outstanding health. The policy that we created, actually, took away prescription drugs, and I had my employees pay 25 percent of the policy pretax out of their pocket or out of their paycheck, and we turned that around and gave them a medical flex account so they could actually use that money directly 100 percent towards whatever health care kind of instances came up, COBRA or doctor office visits and such.

In the last 5 years, we have seen our rates increase above and beyond what we were told initially. What we were told was the standard increase was 18 percent per year, 1½ percent per month. You know, the increases have been anywhere from 25 to 50 percent per year, and over those years we have actually changed our policy, and our deductibles have become higher, and the quality of the policy has decreased.

At this point in time, you know, I am kind of looking at our policy and what we are doing and trying to make a choice as to whether this is something that we continue or if I would be better off turning this money around directly to our employees and giving them the choice of finding their own policies or using that money for preventative measures directly.

For us, I mean, being a small business in Missoula, we bake le petit outre—we bake bread, so a lot of baguettes. And I guess, if I were to compare, our baguettes go for about \$2.50 a piece and, over the last 5 years, if we were to compare the amount of increase in my policy and the price of my bread, we would be looking at a \$5 loaf of bread, and I do not think anybody would be buying that.

So I really kind of have an unsustainable trend. It is something that I feel that I might not be able to afford to be doing in the future, and I definitely feel that reform is necessary. Thanks.

The CHAIRMAN. Thanks, Leif, very much. I appreciate it.

[The prepared statement of Mr. Bjelland appears in the appendix.]

The CHAIRMAN. Okay, Julie.

Ms. FOSTER. My turn.

The CHAIRMAN. Let 'er rip.

**STATEMENT OF JULIE FOSTER, COSMETOLOGIST,
MISSOULA, MT**

Ms. FOSTER. Thank you for letting me speak today.

I am a cosmetologist here in Missoula, MT, and I am here to share my story about my accessing health care and how it has impacted me and my family.

I have been a hard worker my entire life, and, after graduating from high school, I worked my way through cosmetology school and have never been unemployed. As a single mother, I have always worked to pay medical bills for my daughter and myself. I have never been able to afford health insurance and have made too much money to qualify for assistance programs. To pay for the birth of my daughter, I made arrangements for monthly payments, and I worked for several years to pay off the debt.

When my daughter was 1 year old, she had spinal meningitis and was in the hospital for 9 days, 5 of which were in intensive care. As a result of a huge medical bill, I was forced to file bankruptcy, basically. It was either you make a \$100-a-month payment or, you know, we will sue you, so I filed for bankruptcy.

There were two other medical situations that have caused extreme financial hardship during my life. I sustained a broken arm and leg when I was walking across the street and I was hit by an uninsured motorist. Luckily I had tremendous family support during that time, and my daughter and I were able to live with my parents. I have been a patient at Partnership Health Care Center for many years. Partnership Health Care Center is the local community health center that offers services at a sliding scale fee. The health center was able to help me when I had a broken ankle after slipping and falling off my steps on my way to work.

I continued to seek services at Partnership, although I have tough times making ends meet with my current salary. I make too much to qualify for the sliding scale fees. As a result, I only seek medical advice when it is—excuse me, sorry, I am not a public speaker. But I seek medical advice when it is an absolute emergency, and rarely do I go to the doctor for annual exams.

Additionally I am too young to qualify for the State of Montana Breast and Cervical Health Program. I am 47 years old and have never had a mammogram due to the cost of it. I know that preventive care is essential to assure a healthy future, but I simply cannot afford it.

My employer does not provide insurance coverage for me, nor do I have an option to purchase it. If I go out and find my own policy, they will take it out of my check pretax, but to find my own policy, that is going to cost me \$300, \$400 with, you know, preexisting conditions and everything like that, so—oh. I am able to afford dental and eye care coverage through a private company, which I pay for myself. However, there is no way that I can afford medical insurance. I take great pride in myself and my work. I also take great pride and instill my work ethics in my daughter. I have worked hard to be a homeowner and have lived in the same place for over 20 years. I do not spend my money on frivolous things and make sure that I am able to cover the basics on my salary. I hesitate to think what would happen if a major medical event or chronic disease were to happen to me.

I would like to take this time to thank you for listening to my story. Unfortunately, my story is so common, and I work with people and know many people in the same situation I am in. Addressing the lack of coverage for people in our country is very important, and I appreciate you taking the time to work on this problem.

The CHAIRMAN. Well, thank you, Julie, very much.

[The prepared statement of Ms. Foster appears in the appendix.]

The CHAIRMAN. Thank you for taking the time to share that with us, and you are right: your story is all too common. These listening sessions I have had across the State, it comes up all the time, your story, or something very similar to yours. It is a huge problem. Okay. I am going to ask our panel just a question here. A couple—three, actually. I would like each of you to respond. The first is, do you think—and you have already indicated your answer to my question in your statements, but I will ask it again. Do you think we should set up a system in America where every American has health insurance? I will ask that question first. Should every American have health insurance under some system, whatever it is, that we set up? Let us start with you, Dr. Collins.

Dr. COLLINS. Absolutely. I think universal coverage is critical to improving our performance. I also think it is critical to getting our health care cost growth under control as well.

The CHAIRMAN. Okay. Mr. Fee?

Mr. FEE. Absolutely.

The CHAIRMAN. Okay. Dr. Olson?

Dr. OLSON. Absolutely.

The CHAIRMAN. Good. And Leif?

Mr. BJELLAND. Yes, I do, as long as it does not come down on the lap of small businesses.

The CHAIRMAN. That is the next question—how do you do it? And Julie?

Ms. FOSTER. Absolutely.

The CHAIRMAN. Okay. All right, I will get to that. How do we do this? Your thoughts. You know, different countries do this differently. And Canada has its single-payer system. Other countries have their systems, so forth. As you work toward universal coverage, that is, working toward everybody having health insurance, how do you suggest we do this? What should some of the components be to allow that to happen? I will start again with you, Dr. Collins.

Dr. COLLINS. I think an option for us right now is to move forward by building on the existing system. So, building on the strongest risk pools, the large employer-based pools that we have. Also building on public insurance programs: Medicaid and the State Children's Health Insurance Program. So, looking at what part of the system is working really well, particularly in terms of risk pooling, and then fixing the part of the system that works so poorly. The individual and small group markets are the weakest part of the system. If you lose coverage through an employer or you are a small business, it is difficult to find affordable coverage because of the underwriting issues in those markets. I think we will need to make sure that there are standard benefits so that people, when they buy coverage through any reorganized individual insurance market such as an exchange or connector, will know what

they are getting. That their deductibles are not so high that, for example, people do not get mammograms when they need them, do not get cancer screenings when they need them, and also ensuring that premiums are affordable. So also, providing premiums subsidies for people.

The CHAIRMAN. Now, some people suggest something called an individual mandate or, to get at it a different way, employer pay-or-play. Your thoughts in all that, because I am told the Massachusetts system, for example, has a mandate.

Dr. COLLINS. Yes.

The CHAIRMAN. And coverage there is quite high.

Dr. COLLINS. That is right.

The CHAIRMAN. About 98 percent in Massachusetts. Other people think, oh, no, do not do that. Senator Obama's plan has an individual mandate for kids but not for all the rest of Americans. Senator Clinton's plan, when she was running, had an individual mandate.

Dr. COLLINS. Yes.

The CHAIRMAN. But I do not think Senator McCain has one in his plan.

Dr. COLLINS. That is right.

The CHAIRMAN. He wants to repeal the employer-provided coverage and put in place a tax credit for individuals to buy insurance, but what about a mandate?

Dr. COLLINS. Well, if you look at the estimates that have been done of Senator Obama's plan, you know, making some assumptions about the details of the plan, you get about halfway to universal coverage without the individual mandate. He has a mandate for children as you said, but not an individual mandate for everyone. So, if we want everyone covered in a mixed, private/public system like that employer-based public program, and in this new exchange or connector, we will need to require everyone to have coverage. It needs to be affordable coverage, it needs to be a benefit package that everyone is comfortable with.

The CHAIRMAN. Okay. Jeff, your thoughts.

Mr. FEE. Yes, I think it goes back to some of my talking points. I think that if we realign the incentives away from quantity sick care towards quality health care, I think the savings along that line will be absolutely massive. If you just think about—

The CHAIRMAN. You are talking about care coordination.

Mr. FEE. Care coordination and the whole concept. I mean, it really is a perverse incentive when hospital administrators are rewarded by having full beds, their beds full in the hospital.

The CHAIRMAN. Okay.

Mr. FEE. Because I can tell you, just from a business perspective, when our beds are empty, we are sweating, and it should be the exact opposite. I believe that, if you go look at all the laws and regulations that go into trying to prevent an appropriate utilization, with the appropriate alignment and incentives, if we really are working together in a collaborative model, a lot of the utilization issues, they go away and so do a lot of the regulations that really do not do anything to add to health care.

The CHAIRMAN. Those are all good points, but how does that get us toward universal coverage? How does that move toward all of us having health insurance?

Mr. FEE. Well, first, I believe that, if you align the incentives appropriately and you allow those savings to actually be realized, I think the financing piece of it becomes much more easy, because I really do believe—I mean, if you just look—

The CHAIRMAN. That is less expensive for what you get.

Mr. FEE. Significantly less expensive.

The CHAIRMAN. Yes.

Mr. FEE. I mean, again, if you look at the realities of us as providers, the better, the more we do—and this is the ugly truth—the more we do, the better we do financially.

The CHAIRMAN. Right.

Mr. FEE. So there are incentives. However, if you get out ahead of the curve and you are managing health—and there does need to be shared risk. There needs to be risk at the individual level as well as the institutional level. We believe that more rational care, as Dr. Olson alluded to, saves significant dollars and also keeps people from getting into situations where they come into the organization much sicker than they would be if they were managing their health.

The CHAIRMAN. So, Dr. Olson, how do we get universal coverage?

Dr. OLSON. I think the gap is primarily determined by individuals who can—

The CHAIRMAN. We have—do we still have the figure up there? Forty-six million uninsured, 25 million underinsured. That is 71 million Americans either with no insurance or underinsured.

Dr. OLSON. Yes.

The CHAIRMAN. And Julie talked about it; she cannot afford health insurance. How do we get universal coverage?

Dr. OLSON. I agree that I think the issue is that health care is too expensive in this country and that people cannot afford insurance, and the help has to be for those people who are between making so little money that they are on Medicaid and being able to afford private insurance, and I think the government needs to help in that area in support.

The CHAIRMAN. So you are saying what—expand Medicaid?

Dr. OLSON. I think—

The CHAIRMAN. Children's Health Insurance?

Dr. OLSON. Some expansion of—

The CHAIRMAN. Partially?

Dr. OLSON [continuing]. Government support for individuals who are caught in that window—

The CHAIRMAN. What about a mandate?

Dr. OLSON. You know, I am not—

The CHAIRMAN. In our country, you know, you have to have auto insurance before you can drive a car.

Dr. OLSON. Yes.

The CHAIRMAN. And some suggest, man, if we require a health care system, you have to have health insurance. Now, that gets a little bit to Leif's question and also Julie's: but what if I cannot afford it? So we have to have some way to deal with that, and some further suggest you have to have a mandate for the pool to be large

enough. So we have a huge, big pool, more easily accommodate pre-existing conditions, et cetera. So, just asking the question, is that something that is out of question, a mandate—what do you think?

Dr. OLSON. You know, I do not think we are opposed to it, but I think there are probably some people who are.

The CHAIRMAN. Well, I am asking you.

Dr. OLSON. I am not opposed to it.

The CHAIRMAN. Okay.

Dr. OLSON. No, I think it is entirely reasonable to mandate that people have health insurance because the uncovered do confer costs to the people who are covered.

The CHAIRMAN. Yes.

Dr. OLSON. And that is the logic.

The CHAIRMAN. Well, I think you are right. It is a big bugaboo for a lot of people, and there is no doubt about that. The question I am trying to drive toward is, how in the world are we going to get in this position where every American has health insurance and that it would be—you talk about cost, that is clearly part of it, but the question is, does a requirement help solve the problem or not so long as, you know, the affordability part is addressed? What do you think, Leif? What about a mandate?

Mr. BJELLAND. I think a mandate would work for youth, and I think that a lot of times when we look at this, we are looking for immediate solutions to a problem that is really complex and affects a lot of different people differently. You know, in my conversations with some of your staff, we were looking at—like I said, I have a young group, a pretty healthy group. My needs are way different—

The CHAIRMAN. Right.

Mr. BJELLAND [continuing]. Than people who are approaching Medicare age or, you know, upper 50s, early 60s, and that has to be—we are not going to hit everybody, we are not going to solve this, but I think it is more of a generational thing.

Maybe we should shift from mandated youth and then a preventative perspective.

The CHAIRMAN. Yes. A lot of youth will think, why mandate me? I am invincible, you know, I do not get sick, why me? That is just for older people.

Mr. BJELLAND. Well, preventative mind-set, though, right?

The CHAIRMAN. Right.

Mr. BJELLAND. I mean, a shift. I mean, we are talking about obesity and then this is long-term. I mean, these are long-term problems. So, I mean, there is a long-term solution there.

The CHAIRMAN. Okay.

Mr. BJELLAND. We need to start somewhere.

The CHAIRMAN. Sure. Julie, your thoughts?

Ms. FOSTER. But then again, I had a 17-year-old niece who passed away from leukemia, you know. It could happen to anyone. Mandating would be wonderful if you can make it affordable.

The CHAIRMAN. All right. Which raises the next question. Affordable cost. You have touched on this already. What are the big drivers, the cost drivers in the American system? What makes America's system so expensive compared to other countries? Two or

three basics, what are they, and once you have identified them, what do we do about them, how do we control them? Sara?

Dr. COLLINS. I think there are a couple differences. If you look at how we differ from other countries, one of the key differences is what we pay for health care, so what we pay physicians. We pay 70 percent more for prescription drugs than other industrialized countries.

The CHAIRMAN. So we pay physicians more?

Dr. COLLINS. We pay physicians more.

The CHAIRMAN. We pay more for drugs?

Dr. COLLINS. We pay more for drugs, and we pay more for devices.

The CHAIRMAN. Yes.

Dr. COLLINS. And that also leads to overcapacity, and that has been mentioned a little bit this morning. So outpatient clinics, for example, can make a lot of money without providing very many procedures. The other key difference between us and other countries is administrative costs.

The CHAIRMAN. Why are those so high in America compared to other countries?

Dr. COLLINS. Part of it is insurance administration. The individual market is a particular culprit, but there are other culprits in our system. We, as you know, spend 7 percent of our national health expenditures on administration relative to about 2 percent in Japan, Finland, France. So, very big differences. About 25 to 40 percent of the premium dollar in individual plans—market plans—goes to the costs of administration. In terms of other cost drivers, technology is a huge driver of our costs, and also obesity is a huge contributor to cost growth in the system.

The CHAIRMAN. Sometimes I hear doctors say, you know, this hospital has the latest and greatest PET scan or MRI, the latest version, and it costs 30 percent more, but it only helps me in my diagnosis and treatment about 2 percent more.

Dr. COLLINS. Yes.

The CHAIRMAN. I mean, it just—we all have to have the latest and greatest to keep up with the Joneses, because patients demand it, even though we really do not need it. It does help in a lot of areas, but it does not help as many areas as physicians ideally would prescribe. Is there anything to that, do you think? Let me ask Mr. Fee that question.

Mr. FEE. Can you rephrase the question? I want to make sure—

The CHAIRMAN. Yes. It is just that it is overutilization, for one, between hospitals, to keep up with the Joneses and compete, whether it is St. Pat's, Community—

Mr. FEE. Sure.

The CHAIRMAN. You have to have the latest and greatest and all that kind of stuff.

Mr. FEE. No, it is definitely a driver, and I think that it again speaks to the nature of the competition in health care versus other sectors, because sometimes you can engage in competitive practices that really do not do anything to necessarily enhance quality; it really just is aimed at pursuing market share, trying to move busi-

ness into your organization, again because we are incentivized to do more. That is how we ultimately get paid.

The CHAIRMAN. Okay. Dr. Olson, you know, some say our system is more expensive unnecessarily because we have such high administrative costs compared to other countries. That is your business, right?

Dr. OLSON. It is.

The CHAIRMAN. So what do we do about that?

Dr. OLSON. I hope I get this number right. As I recall, Medicare's administrative overhead is about 6½ to 7 percent when we add up central and contractors. Blue Cross Blue Shield of Montana is running 10.2 percent of administrative overhead. I trust your numbers for other industrialized nations. They are too high. In part, we are spending money processing claims under our current claims processing system, CPT coding, hospital coding, to pass costs, to pay providers and pass costs back to employer groups, et cetera, et cetera. It is something of a complicated system, and I think, if you look at some of the most efficient, in terms of administrators, in the country, which are probably in Medicare, no one gets below 6½ or 7 percent, so I think it is—there is probably a plateau there. The way we codify and pay for health care, it is going to cost that much money.

The CHAIRMAN. All right. Let us just cut to the quick here and just ask the provocative question. Is there a need for private commercial coverage when it adds additional administrative costs. Other countries generally do not—

Dr. OLSON. No, they have a single payer.

The CHAIRMAN. That is right.

Dr. OLSON. Yes.

The CHAIRMAN. So what is—and I am sorry it is such a provocative question.

Dr. OLSON. No, it is a loaded question for me, you know it is, but, you know, my personal feeling—

The CHAIRMAN. I get asked tough questions like this all the time. This is my opportunity.

Dr. OLSON. You know, I mean, I am an American citizen, and my insurance is \$14,500 for a family of four through Blue Cross.

The CHAIRMAN. Yes.

Dr. OLSON. I have been a primary care doctor before I worked for an insurance company.

The CHAIRMAN. Yes.

Dr. OLSON. So, you know, I have seen this issue from a number of sides, and my personal feeling is that it is the will of the American people. If the American people want a single payer, so be it.

The CHAIRMAN. Yes. What about pharmaceuticals? You know, I have been told many times that each of us in this room subsidizes a European consumer who consumes the same drugs manufactured by the same company because those countries negotiate price with pharmaceuticals. Medicare does not negotiate a price with pharmaceuticals. We pay more; it is an unnegotiated price. Is that part of our problem, too? Should the United States negotiate—should Medicare negotiate with pharmaceuticals, negotiate price? Is that a problem with the health insurance industry? I am asking that question because you as an insurer must run into that.

Dr. OLSON. Yes. Well, we have a pharmacy benefit, and so we are able to negotiate prices for prescription drugs, obtain mail-order retail, but not so for physician office use. That is based on average sale price plus, and the prices are set by the pharmaceutical industry, so I think that the prices are inflated compared to what other countries pay. They look at cost and benefit, and they are willing to say “no” to a pharmaceutical company to keep a drug off a formulary if the price is not reduced so that they feel it is cost-effective.

The CHAIRMAN. I appreciate this. There have been tons of questions asked, but I am going to open it up for everybody in the audience here, too. I just think this is a huge issue, and it is a huge opportunity for us as a country to address. Our health care hodgepodge system, whatever it is, I think it is in a real crisis, because costs are going up so much, and it hurts individuals like Julie and small businessmen like Leif; it hurts all of us as taxpayers because Medicare is going up as a component of the Federal budget. I mean, it has to be addressed from the cost side, in addition to coverage. It just makes no sense to me that we allow in America a system where so many people do not have health insurance. That is just wrong, and people should have health insurance, and also the quality issues, and they are very, very real, a little bit more difficult to get at. Aligning reimbursement with quality clearly is the goal, and how you do it is very, very important. But I just think we have to address this, and I am going to make this one of my top priorities next year in the Congress, and I will work with whomever is president, either John McCain or Barack Obama and introduce a bill the first of the year just to try to get at this and have a lot of hearings like this, talking to a lot of people. I think we can no longer just nickel and dime this, we cannot just work around the edges. We have to come up with a more systemic, more comprehensive health care reform, and now is the time to do it with a new president, new Congress, and, if we do not, we may not have this opportunity for another decade. So we have to strike while the iron is hot, and I think it is—the iron is getting pretty hot right now, so it is time to strike, but I want to thank you very, very much.

Okay, let us open it up to everybody in the audience here.

One thing I ask, though, is this. It is very tempting for persons to say, make changes for me, you know, for my industry, my special interest group and so forth, and I am trying to avoid that. What I would like everyone to do as much as possible is, not promote your own agendas but, rather, share some basic thoughts about health care reform. What do we have to do so we are sharing and finding a good solid health care reform result, and I just appreciate your deep involvement here. But let us just not be too much for ourselves individually, let us be a little more for ourselves together as a country and a team.

Okay. Number 1. Would you please say your name, sir, and—it is a real honor for us to have our first speaker be Pat Williams, former member of Congress, who is not known to be reticent or bashful or shy, and is very smart, very intelligent, and very perceptive. Pat, we are honored to have you here.

**STATEMENT OF HON. PAT WILLIAMS,
FORMER U.S. CONGRESSMAN, MISSOULA, MT**

Mr. WILLIAMS. Senator, it is nice to see the chairman of the Finance Committee here, and it is always good to be with you, Max. Thanks for doing this in Montana. I assume, but let us not take it for granted, that Montanans understand this State's role in trying, again and again, to pass national health care through the U.S. Congress.

The first effort was under Harry Truman by Montana Senator Jim Murray in the late '40s and the early '50s. Murray found that he had a very difficult reelection effort after trying it because some scored him, frankly, as a socialist or a communist, and it was almost 50 years following that that any president or any Congress dared try again, and that was under Bill Clinton in 1994.

As you know, Max, Montanans had sent me to Congress some years earlier, and I happened, by circumstance, to be in the enviable position of being the second Montanan to try to lead on passing health care reform. I chaired a committee called Labor Management and then was senior member on the full Committee on Education and Labor. We became the first committee in American history to pass out health care legislation. My committee passed out a bill somewhat similar to what President Clinton had drafted, and on top of it, for competitive and consideration purposes, passed out with it second legislation for single-payer. Now, those bills passed both the subcommittee and the full committee but did not come to the floor of the House, and the Senate, likewise, did not act. And now, 14 years later, our senior Senator Max Baucus has the honor of chairing the Finance Committee, and Montana finds itself once again in the driver's seat, so to speak, with regard to health care.

Perhaps it is right that Montanans should, in some small measure, lead the way, because our State is almost dragging bottom when it comes to appropriate health care for its citizens, and this region of the Rocky Mountain West is dragging bottom.

When it comes to the coverage, health care insurance coverage of the children of working families, the Rocky Mountain West, these eight States, are the worst. It is the worst region in the country for insuring moderate-income children. Of the worst eight States in the Nation in that coverage, the Rocky Mountain West has five of them. No other region of America has even two of the worst States.

It is a crime that a region this generous, this open is the worst region in America for covering children, which means, as you know, we are the worst in the world unless one wants to count the poverty-ridden, war-depressed, basket-case nations around the world.

In Montana we are not doing, unfortunately, much better. The last statistic I saw showed that Montana had one of the poorest ratings in America for health care coverage of its people. Only slightly over 40 percent, as you heard, of our employers provide health care coverage to their employees.

I want to make some recommendations, Max, based on my 4 years of experience with just this issue in front of the House of Representatives, and I do this on behalf of not only myself, but an

8-State public policy western group called Western Progress, as well as Montanans for Health Care.

First, of course—and I will be very quick because a couple of them have been covered—first is portability. We must have health care insurance that will follow us around the country because we are a mobile lot these days.

Second, we do have to prevent insurance companies from cherry-picking. They have to cover the sick as well as the well.

Third, we have to encourage preventive care. Americans are not very good at it. We have to have access for every single American, bar none.

We have to stop cost shifting, Max. We have to correct the shortages of health care personnel, for example, primary care physicians. We have to allow Americans the choice of coverage, hospitals, and doctors. In our view, we have to have tax fairness. That is, we ought to collect the revenue from health care on a graduated scale. Those Americans able to pay more, should. We have to have catastrophic coverage. We have to have cost management, and the partners in determining that have to include all the stakeholders. If the Congress does not do that, if we do not include the hospitals and we do not include the insurance companies, then I think it will be less than a quarter of a century until hospitals and insurance companies start to go broke and the Congress of the United States will have another major bailout on their hands. So, if we are going to do this through the insurance companies and the private sector, then we had better protect them, or we are going to end up bailing them out in relatively short order. And finally, as we have heard, Max, we have to have reduced administrative costs.

Now, on my own, I would like Max to make this suggestion. I understand your concern, I guess, is about single-payer, and I assume it is based on the fact that it is highly unlikely that the Congress of the United States will pass single-payer. But for myself, Max, I would encourage you not to take it off the table even though it cannot pass, because the mere consideration, we found out in my committee in the House in 1994, the mere consideration and hearings of health care single-payer inform the members of Congress and inform the debate because it gives you comparative bills. I doubt that it can pass, but I do not think it ought to be taken off the table, and I do not think it ought to be denigrated for this reason. Seniors have single-payer; it is called Medicare. Our returning veterans have single-payer; it is called veteran's care. And those single-payer systems around the world were adopted off of Social Security single-payer retirement, Medicare single-payer health care, and GI health care insurance single-payer veteran's care. That is where a lot of the world got their ideas for their single-payer packages, and it is one of the reasons the rest of the world is now ahead of the United States.

So, Max, I commend your good efforts here, and I am glad that another Montana is again in charge, so to speak. Thanks a lot for having me.

The CHAIRMAN. Thank you Pat, very, very much. I do appreciate it. Your basic point is a good one, namely, we are all in this together, and, well, we have to find solutions that are, again, systemic and comprehensive. We are all in this together, and I do be-

lieve everything should be on the table; nothing is off the table. Someone said, if I am not on the table, I will be on the menu, and we want to make sure that nobody is on the menu here. We are all on the table as we find a common solution.

Yes, sir?

**STATEMENT OF PALM FOUNTAIN, HEALTH CARE
PROFESSIONAL, MISSOULA, MT**

Mr. FOUNTAIN. Hi, I am Palm Fountain. I started working in health care around 1962 or '63. I happened to watch this whole fiasco take place, from where people started worrying about the health care system to where they started putting in place measures that they thought might turn things around, and it only made things worse.

I have done everything from being a CNA working in people's homes to doing research at the grad school in public health and at the med school at the University of Pittsburgh, so I have seen a lot of health care. I have worked in large met centers and worked in very small hospitals and worked in people's private homes, and I have seen a wide range of things go on.

One of the things I hear said here, and almost everybody in health care and the average person knows, is that one of the biggest priorities absolutely has to be preventative medicine. One of the things when we talk about other countries that comes up—one of the major points of why they do so much better is preventative medicine. We would like to think that our health care is really great. We are 36th in quality of health care in the world. That means a lot of third-world countries are way ahead of us. We need to get very real about our health care. We need to come down a peg. We really need to—in a real way, in a functional way—admit that we suck and then start to work up from there. A lot of what I hear being proposed is like having a festering sore that is bloody and pussy and we just want to put a bandage on top of it. We really do need to look closely at the cause, and like a doctor, a good physician, take out the bad tissue until we get to healthy tissue, and a lot of that is going to do with how we think about health care, how we think about insurance companies. I have dealt with insurance companies. They have been my biggest problem in trying to deliver good health care to clients.

I have also been a registered nurse. When I was an RN and trying to give good care to my clients, the one big thing that was a stumbling block was health care and the insurance companies. They are not health care companies, they are sick care. They have clerks making decisions over doctors, and trying to get to a doctor and an insurance company to help make a decision for the client is very difficult, and very often you talk to a doctor who is not a specialist in the area that they are making a decision on and maybe has very, very little information or almost none. So that was one of my biggest things, and then the other thing is trying to get that preventative care for a client once they leave the sick care part of it. We do not support it, we do not have a philosophy or a way of thinking that allows us to see preventative medicine as important. The high tech is important. We think of that as real health, and it is not. By the time a person gets that far, we are

a failure in 90 percent of the cases. If we had preventative care, that is where the success is. So, if we want to be successful in health care, we have to go for the preventative.

And so far as doctors, doctors retrain all the time, and we have large numbers of doctors who are specialists. If we start to turn things around, doctors can retrain just like everybody else. They retrain to do a new specialty or to extend their specialty, so they could just as easily retrain to do the higher job of family practitioner, family care.

The CHAIRMAN. Okay, thanks, I really appreciate that. Thank you. I would like to say—just out of respect for everybody else—there is a long line here of people who want to speak, so I would just urge everyone be very brief, and I am going to frankly after 2 to 3 minutes, I am just going to have to ask you to wrap up in the interest of time for everybody else, otherwise we are not going to be able to get through everything.

Okay.

STATEMENT OF MARIETTA BOWER, BOARD MEMBER, MONTANA COMPREHENSIVE HEALTH ASSOCIATION, POLSON, MT

Ms. BOWER. Hi, Senator Baucus, I am Marietta Bower.

The CHAIRMAN. Hi, Marietta.

Ms. BOWER. I live in Polson, drove myself here this morning. My biggest challenge was finding a place to park so I could get out of my car. As I was thinking about your hearing, I feel that the public and private sector need to work together. The hat I am wearing today is not primarily as a patient. I serve on the board of the Montana Comprehensive Health Association, which was created in 1985 by the Montana legislature to provide access to health insurance to people who are denied because of preexisting conditions. Mostly it is heart disease, cancer, things like that.

After I was injured in a horse accident in 1983, in a couple of years I needed insurance. I had insurance, but when things expire, you do not have it anymore, you cannot afford it, and, so, the MCHA came along just in time for me.

The MCHA has two purposes. It insures people who cannot get insurance, but it also is the portability avenue for Montanans on the HIPAA requirement which guarantees portability of insurance for people who leave group coverage. The two pools serve over 3,000 Montanans, and their average premiums are \$800 a month. That is a lot. Persons who enroll in the MCHA make considerable sacrifices so they can take care of themselves so that they do not need to use the services as much as possible.

Insurance companies that do business in Montana pay 1 percent of their premiums into the MCHA to help cover our costs because the premiums for these high-risk individuals do not cover the claims, and we are facing a huge deficit in the next few years unless something major happens, like the rising costs of medical care being stabilized, but that is not too likely in the near future. For those in the high-risk pool, we—

The CHAIRMAN. I am going to have to ask you to summarize, Marietta.

Ms. BOWER. One of our avenues has been taken away from us, and that is Medicare. We are not able to access Medicare premium

payers anymore, and the people who are self-funded, or TPAs, we are not able to access them as well to help share the cost—you know, even it off like you are talking about. If everybody pitches in, we can cover it.

The CHAIRMAN. Okay, thank you, thank you very much. Thank you, Marietta.

Okay. Next?

**STATEMENT OF DR. TOM ROBERTS, ADMINISTRATOR,
WESTERN MONTANA CLINIC, MISSOULA, MT**

Dr. ROBERTS. Senator Baucus, thanks very much for holding the hearing here. My name is Tom Roberts. I am a retired internist, actually practicing as an administrator right now for the Western Montana Clinic. It is interesting that health care expenditures cross-country vary so much, maybe by as much as a factor of 2-fold. That difference in what we spend as a country to a large extent is related directly to how many hospital beds we have in the different sections of the country and how many specialists we have in the different sections of the country.

Health care costs are inversely related, as you know, to the number of primary care doctors that we are able to field into the State and into the country. Despite that, as we all know, the primary care docs are dying. I mean, they are really not out there practicing anymore. Fred Olson and myself are pretty good examples of that, and a lot of that problem is that we are just not paying those guys to practice medicine. The students understand that, the residents understand that; they are not going into primary care medicine, they are not making that choice, and I think a lot of that comes down to the bottom line.

Fred and I talk about this periodically and, you know, maybe he can chip in, but when I left practice 3 years ago, I had a 75-percent Medicare practice. That was after 25 years of practicing internal medicine. At that point, after I subtracted expenses from what I earned, there was \$25,000 left over, so that is not enough to support primary care docs. We are just not doing that, and I am curious as to what you think we can do in the future to beef that up.

The CHAIRMAN. Thank you very much, Dr. Roberts. In answer to your question, first of all, I totally agree with the main point.

Dr. ROBERTS. Yes.

The CHAIRMAN. And many, many people are starting to understand that, and the figure I heard today is what I have heard a couple, 3 times, namely only 2 percent of medical school graduates now go into primary care because that is not where the money is, and they have the big loans to pay off, so they are going to—

Dr. ROBERTS. That is right.

The CHAIRMAN [continuing]. Choose specialties where the money is in many respects. What do we do about it? One thought I have is, as you know better than I, that our major teaching hospitals get a lot of money from the graduate medical education portion on Medicare and something else called IME (Indirect Medical Payments) on Medicare, and my thought is, well, if Medicare is paying in many respects for the education of the medical students, that Medicare ought to be able to put a condition on here, that is, a number of docs who go into one speciality as opposed to another.

At the same time, we are just going to have to increase the reimbursement for primary care docs and not allow an increase in reimbursement for the others, for the specialists and subspecialists in Medicare. I doubt the subspecialists are going to want to cut back very much; that is not going to be near and dear to their hearts.

Dr. ROBERTS. They are not going to want to fund primary care.

The CHAIRMAN. They are not going to want to fund it, but the increases that they received in the past can just be stopped—

Dr. ROBERTS. Right.

The CHAIRMAN [continuing]. So that the primary increase goes to the primary care physicians, and also the GME reimbursement.

Dr. ROBERTS. Yes. It is going to be hard to force doctors to go into primary care in a situation where they cannot make a living in primary care.

The CHAIRMAN. That is why reimbursement has to be addressed.

Dr. ROBERTS. There has to be a change in that, and not to beat the drum, but it is not about the primary care doctors. We have already lost—

The CHAIRMAN. That is right.

Dr. ROBERTS. We are not practicing anymore if we can get out of it. It is about the health of this country.

The CHAIRMAN. Right.

Dr. ROBERTS. We cannot have a health care system that is not based on primary care, and we are trying to do that right now.

The CHAIRMAN. Right, right. No, it is way out of whack; it has lots of adverse consequences, that is true.

**STATEMENT OF RAY OROTT, INDEPENDENT
CONTRACTOR, MISSOULA, MT**

Mr. OROTT. Senator Baucus, my name is Ray Orott, and I am an independent contractor. My question is basically for the panel there. I understand that, when they pass away, people who had Medicare or Medicaid, their pharmaceuticals are already paid for. How can we recycle those pharmaceuticals without throwing them away?

The CHAIRMAN. Good question. What about that? Okay. We will look into it. I do not know. Maybe someone else can address that. Ray, I will try to find an answer to that question. I do not know. I will get back to you. Leave your name and address with one of our persons here. That is Carla. Great, Carla, that is great. Thanks, Carla, very much.

Okay.

STATEMENT OF DR. JAN NEWMAN, FELLOW, AMERICAN COLLEGE OF SURGEONS AND AMERICAN BOARD OF HOLISTIC MEDICINE, MISSOULA, MT

Dr. NEWMAN. Hi. I am Dr. Jan Newman. I am a Fellow of the American College of Surgeons and the American Board of Holistic Medicine. I have been retired from practice for several years now due to injury. At this time I have been deeply concerned throughout my career with the quality of health care and medical education. The current system now is not health care, it is health abuse, and until we—

The CHAIRMAN. I am sorry, it is health—

Dr. NEWMAN. Abuse.

The CHAIRMAN. Abuse. Thank you.

Dr. NEWMAN. Abuse. Until we change our priorities where the patient is the primary focus of health care, the system is not going to change, and currently the system is oriented to money. It is interesting that this is the Senate Finance Committee that is looking at this and not Health and Human Services, and so that means that the incentive for physicians and for insurance companies is always the bottom line rather than proper care. When proper care is the goal, then the money will follow in the appropriate way.

Currently the system is such that it is overregulated and inappropriately regulated. There is no certificate of needs for things like CAT scanners, et cetera. We here in Missoula have within the catchment of 200, over six CAT scanners. It is unnecessary. There are two helicopters to provide emergency services. It is all duplications of services. St. Pat's has added OB. When there used to be cooperation, Community handled it, and until this competitive idea of having to have services is eliminated and there is cooperation and not competition, this cannot be helped.

As a physician, there are over 50 insurance companies you deal with. Each patient has different deductibles, has different policy limits, and the physician in a private office just cannot deal with that kind of administrative burden. There has to be some sort of uniformity in deductibles.

Physicians are turning away patients because they do not have insurance or they have not paid up or they cannot pay preprocedure, and once again, it is that sort of incentive. So the idea of getting a reward in medicine by caring for patients and being a proper practitioner has gone by the way, and that is one of the main incentives for students not wanting to go into primary care—they do not see it as a personally rewarding experience. It is also one of the main incentives for physicians to retire early, and until the incentives start to come back in terms of personal job satisfaction rather than stress, it is not going to change.

The CHAIRMAN. But your main point is to encourage cooperation as opposed to competition among providers. Is that the basic point?

Dr. NEWMAN. Yes, and I think that there have to be certificates of need for scanners and that sort of thing.

The CHAIRMAN. Right.

Dr. NEWMAN. That is so costly.

The CHAIRMAN. Thank you, Doctor. I very much appreciate it. Thank you very much.

Okay, sir.

**STATEMENT OF DR. BYRON OLSON,
RETIRED PHYSICIAN, MISSOULA, MT**

Dr. OLSON. Hello, I am Byron Olson, retired physician, urologist. I practiced in Missoula for my career. I really admire what you are doing, and I applaud it. I am going to read fairly rapidly a very short statement, and it is solution-based.

In respect to health care, we have clearly trapped ourselves in an extremely complex and costly box. The structure of that box, unfortunately, is founded on a widespread misconception these days that somebody else is footing the bill. That has to change or there

is no way out. We have to pay the bill ourselves. The only way I see to do this that is at all doable and fair is the same way we pay our other major collective costs. Both the income tax and the property tax are progressive taxes. If you earn more or have more, you pay more.

Right now those who have employment-based insurance think they do not pay as much because their employer pays a large chunk of the premium cost. Well, the employer definitely passes that cost along to the consumer; as much as \$4,000 to \$5,000 of the price of a new car is paying the health insurance for the auto worker. We are all carrying the massive burden of the unpaid premiums of the 47 million uninsured in this country. Yes, we pay. We just somehow have convinced ourselves we do not pay and, if we are covered and facing major personal health problems, we do not worry now as much because our insurance, meaning somebody else's money, will pay for it, so cost is not the issue. We want the best, so test away.

The way out of the box, as I see it, is to call a spade a spade. Change the system so that everyone pays a health care tax according to ability to pay, the revenues of which are kept clearly separate from the general Federal budget. In return, everyone receives a voucher that enables them to obtain an insurance policy for the taxpayer and his dependants. This policy must meet certain basic standards, and Pat Williams outlined a number of them. The policy would provide coverage for catastrophic costs so that no one is without this prevention, yet the policy would have to have a significant deductible carefully designed so that everyone is aware of cost implications in their choice of provider, evaluation, and care.

The vouchers would create a competitive insurance market. Without competition and cost awareness at every level of the system, there is no way to control the escalating costs. Even Medicare and Medicaid could eventually be rolled into this system. There is no reason that ability to pay should not apply to someone just because they are older. Clearly the costs of those unable to pay would be absorbed into the system. It is crucial to get everyone covered, which will eliminate the totally confusing problem of cost shifting that obscures real costs.

There are many other problems, but one step, the first step is to break out of that box.

The CHAIRMAN. Thank you, sir. Thanks, Dr. Olson, very much. Okay, we are going to—this is very popular. We are going to have to wrap up pretty quickly here, and two or three more speak, then the rest are going to have to give written statements, and I guarantee I will personally read every one of your statements and you will get an answer from me personally. In the meantime for everybody here, there is up on the screen here, I think, an e-mail address to send statements to and write to us at any time, but we are going to have to wrap up, because we have to be out of this room and I have other appointments.

Yes, go ahead.

**STATEMENT OF SHEILA JAMES, MEDICARE AND
MEDICAID RECIPIENT, MISSOULA, MT**

Ms. JAMES. Mr. Baucus, my name is Sheila James.

The CHAIRMAN. Hi, Sheila.

Ms. JAMES. I have cerebral palsy, and I have to take plenty of medications, and I do receive Medicaid and Medicare, but I only receive Medicaid because I pay half of my income on a spend-down basis to do so. And when they switched from Medicaid to Medicare to pay for medications, it was really hard because now the private insurance companies can decide if they want to pay for the medicine that you take, and so I have to often look at them and switch providers, and I get really frustrated and confused because, when I was with Medicaid, I did not have to do that. So, I want to know what we have to do to be able to make sure that we can receive our medications, because sometimes it is a choice between if we want to pay to eat or if we want to pay for the medications, because some of them are up to \$200 for a month of medication. Thank you.

The CHAIRMAN. Thank you, Sheila. Some people may have individual health care issues they want to raise with us that are not medical. I am no doc, but maybe I can help with reimbursement financial case work, so, if anybody has any issue or issues they want to raise with us, sometimes we can help out, get on the phone, talk to the relevant agency, whether it is VA or Medicare/Medicaid, what it is. So just get a hold of us and we will individually try to help each of you out with that. So, in addition to the general hearing here, I want you to know that our office wants to help all of you with individual cases as well.

Yes?

**STATEMENT OF DR. ANNE MURPHY, GENERAL INTERNIST, ST.
PATRICK HOSPITAL AND HEALTH SCIENCES CENTER, MIS-
SOULA, MT**

Dr. MURPHY. My name is Anne Murphy. I am a general internist, and I worked for 25 years in the Western Montana Clinic. I am now a half-time hospitalist here at St. Pat's, and I have been on the board of directors here for 9 years. I want to second what Pat Williams had to say about leaving single-payer on the table. I think the problem with single-payer—I mean, I do not think we have discussed it in any real way in recent years. I know that polls are being done and, if you just ask people in terms of, you know, do you want one, that name has gotten out there as a bad name. I do not see that there is any way to pay for the kind of health care that we all would like without a single payer. My suggestion, however, is that it be based on a better Medicare system. Medicare is a financing system, but it also needs to be a quality-based system. There also needs to be significant Medicare reform with regard to how they audit and monitor the health care system. It really should be based on, rather than going out and assuming that people are guilty before proven innocent, it should really be based on, can their regulations demonstrate improvement in the quality of health care that is provided. Right now that does not happen. So I think single-payer is essential, and whatever we start out with, we will waste a lot of time if we do not put that on the table right

away because, if you look at the cost savings, they are tremendous. Thank you.

The CHAIRMAN. Thank you very much, Anne. Your outline has made a very interesting point, and you have basically said it yourself by discussing single-payer. It helps inform people about some of the causes of the problems in our current health care system. That alone is of great value. I found that very much to be the case personally, because it helps again to flesh out some of the reasons why our current health care system has a big problem.

Yes, sir?

STATEMENT OF BILL LACROY, ORGANIZER, MONTANA HUMAN RIGHTS NETWORK, MISSOULA, MT

Mr. LACROY. Okay. My name is Bill Lacroy, and I am—

The CHAIRMAN. This is going to have to be the last speaker. Sorry.

Mr. LACROY. Sorry about that.

The CHAIRMAN. It is Bill?

Mr. LACROY. My name is Bill Lacroy. I am an organizer for the Montana Human Rights Network, but I am also here speaking for my deaf daughter and me and my neighbor who called me up the other day and asked if I might have some extra venison this winter because, same reason they do not answer their phone anymore—the bill collectors call up 12 hours a day because her husband successfully fought off cancer, thanks St. Pat, but it busted him.

We do not believe that access to health care insurance is a fundamental human right any more than we believe access to car insurance is a fundamental human right. We do believe that access to health care is a fundamental human right just like education, and we out here—the world is a different place than it was a month ago, obviously, and we out here need to hear better and new discussions on issues that affect our lives so deeply, these financial issues that are really crushing us. And I guess since I am the last speaker, just ironically and serendipitously, I want to underscore what Pat Williams said. Every Canadian I know and have talked to about it loves their health care system, notwithstanding what has been drilled into us the last 3 decades by the people who got us into this financial mess. Single-payer is not socialized medicine. More folks are paying attention to details. I just want to urge you, Senator Baucus, and your colleagues to take advantage of this tremendous opportunity we have to elevate the discussion to include single-payer health care in a meaningful way. Thank you.

The CHAIRMAN. Thank you very much. Thank you, Bill. We have to wrap up here. Just a couple points I want to make. First, if people want to, they can give their written statements to either Carla Martin—Carla, did you want to raise your hand, stand up?—or Catherine Dratz, who is right up here. I guess I will give you Catherine's e-mail. You see the e-mail here on the board, right? Website. Address that website; that works—that works better.

And second, a lot of thanks here. First for you, Jeff—Jeff Fee—for helping provide the forum here. Lynn Sconce, the executive director to you, Jeff; I want to thank Lynn. April Buffington for catering. Thank you. Tim Chopp, who is the supervisor of facilities engineering, and the entire engineering staff. Laura Shadwick, di-

rector of marketing, and the entire marketing staff. Mary Anne Sladich-Lantz, vice president of Mission Leadership. Kyle Larson, director of Environmental Services, and the entire Environmental Services staff. Mary Kramer, conference coordinator. Tim Karst, St. Pat's audio technician. Mary Sullivan, who has been our reporter here. And Montana Party Time for staging and drapes, and I am sure there are many more here, but thank you very, very much. And special thanks to all of you here who came and participated, and also to our panelists. Some have come great distances, and I thank you all very much.

This is the first of many hearings. It is a huge problem, and we are going to tackle it. This is probably the most difficult challenge I will ever have in my professional career, trying to solve this problem. With the help of an awful lot of people working with Republicans and Democrats, all of the communities have jurisdictions here, we have just got to do this. I encourage all of us to keep an open mind on everything, nothing is off the table. Let us keep our minds open so we can work together to find a solution here.

Thanks everybody, very, very much. The hearing is adjourned.
[Whereupon, at 12:44 p.m., the hearing was concluded.]

A P P E N D I X

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Leif Bjelland

High Health Care Costs: A State Perspective

Testimony to the Senate Finance Committee

October 21, 2008

Good Morning. Thank you for giving me the opportunity to be here today. My name is Leif Bjelland and I own a small bakery here in Missoula called Le Petit Outre. I understand that today's hearing will focus on high health care costs and how they affect folks like me right here in Montana. I'm glad that someone is paying attention to this problem.

As a small business owner, I have a unique experience to share with you today. High health care costs have made it very difficult for me to provide much needed health coverage for my employees. I always hear that small businesses are the backbone of our economy and that we help provide the most jobs in the country. In order for the backbone to be strong, it needs to remain financially viable. I'm here to tell you that high health care costs are threatening the financial viability of America's small businesses.

My story is not a complicated one. And I am afraid that it is one that is all too common throughout the United States. I started my bakery business 10 years ago. Since then, it has grown to employ over 30 employees. About 5 years ago, I began to offer health insurance to my employees. When I first offered insurance, I was able to provide a much more comprehensive benefits plan for my employees than I can today. The reason I have had to scale back on benefits is that I simply cannot afford the same coverage I could 5 years ago.

While some coverage is better than no coverage, the less generous package I currently provide has had real life implications for some of my employees. For example, one of my managers has diabetes and cannot afford the cost of his care under the limited benefits that I can provide.

Over the past few years, the costs of providing health insurance to my employees have increased dramatically – upwards of 20% each year. This rate of increase is unsustainable for my business because it far outpaces the increases in my profits. As much as I would like to continue to provide health coverage for my employees, I do not believe that I will be able to do so.

Small business owners who want to do the right thing and offer health coverage to their employees are faced with a terrible dilemma. On one hand, we want to ensure our workers' safety and well-being by providing them comprehensive health benefits; but on the other hand, maintaining our businesses would become much more difficult to do so if costs continue to increase at this rate.

Providing health insurance to my workers is both good for them and good for me. It keeps them healthier and more productive. It helps cut down on the costs to my business associated with my employees getting sick.

So I'm here to put a human face to this crisis. I would like to know how we can lower these costs and help other small businesses provide health insurance to their employees. I hope that my story will shed some light on this all too common situation and help you with the reform process.

Again, I would like to thank you very much for giving me the opportunity to share my story with you. I am happy take any questions you may have for me.



**RISING HEALTH CARE COSTS: IMPLICATIONS FOR THE
HEALTH AND FINANCIAL SECURITY OF U.S. FAMILIES**

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Invited Testimony
Committee on Finance
United States Senate
Hearing on
“High Health Care Costs: A State Perspective?”
Missoula, Mont.

October 21, 2008

The author thanks Sheila Rustgi for research assistance and Karen Davis and Cathy Schoen for helpful comments and acknowledges coauthors Jennifer Nicholson, Michelle Doty and Sheila Rustgi of the *Losing Ground* report on which much of this testimony is based.

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**RISING HEALTH CARE COSTS: IMPLICATIONS FOR THE
HEALTH AND FINANCIAL SECURITY OF U.S. FAMILIES**

Sara R. Collins, Ph.D.

Executive Summary

Thank you, Mr. Chairman, for this invitation to testify on high health care costs and the implications for U.S. families. The soaring costs of health care and stagnant household incomes are leaving many working families without insurance or with medical expenses that consume a large share of their budgets. An analysis of the Commonwealth Fund Biennial Health Insurance Survey found that nearly two-thirds of working-age adults—an estimated 116 million people—either were uninsured for a time during 2007, had such high out-of-pocket costs relative to their incomes that they were “underinsured,” reported a problem paying medical bills, or did not get needed care because of costs. Over the past seven years, these problems have spread inexorably up the income scale. The nation now faces a potentially severe economic downturn that could have potent financial implications for lower-income and middle-income families—those most at risk of being uninsured or underinsured. There is now an urgent need for a national solution that will provide families with affordable coverage options to ensure access to timely health care and provide protection against catastrophic financial losses.

Rising Health Care Costs Are Leading Employers to Drop Coverage or Increase Cost-Sharing

- In 2006, national health expenditures increased at a rate of nearly 7 percent per year, more than two times the rate of growth in the economy. Similar annual rates of growth are projected through 2017.
- Americans spend two times as much on out-of-pocket medical expenses than do residents of other industrialized countries.
- Premiums are growing at rates more than twice that of other indicators, such as wages and consumer price inflation. The average annual cost of family coverage in employer-based health plans, including employer and employee contributions, topped

\$12,680 in 2008—more than the average yearly earnings of a full-time worker earning the minimum wage.

- Employer coverage remains the predominant form of health insurance coverage for U.S. families; 99 percent of companies with 200 or more employees offer health benefits. But rising premiums have weakened the ability of small firms to offer comprehensive coverage. About 49 percent of employers with three to nine employees offered health insurance to their employees in 2008, down from 57 percent in 2000.
- Employers have tried to hold their premiums by increasing employee cost-sharing. In-network deductibles for single coverage in PPO plans have tripled since 2000. Among employers with fewer than 200 employees, deductibles have risen by greater than a factor of four.

Increasing Numbers of People Are Uninsured or Underinsured

- Rising health care costs over the past decade have occurred as incomes for working families have barely budged. Real incomes among working-age families have yet to regain levels prior to the 2001 recession: median income among households headed by someone under age 65 was \$56,545 in 2007 compared with \$58,721 in 2000.
- This dynamic is captured in the increasing numbers of Americans who are spending large shares of their income on health care. Between 2001 and 2007, the share of adults under age 65 who spent 10 percent or more of their incomes on health care costs, including premiums, climbed from 21 percent to 33 percent. Adults in all income groups spent more of their incomes on health care.
- As employer coverage has declined, the number of people without health insurance has surged, rising from 38 million in 2000 to 46 million in 2007.
- An increasing number of adults who are insured have such high out-of-pocket costs relative to their income that they are effectively “underinsured.” In 2007, an estimated 25 million adults were underinsured, up from 16 million in 2003.

Increasing Numbers of Adults in All Income Groups Are Not Getting Needed Health Care Because of Cost

- The share of adults under age 65 who reported problems getting needed health care because of costs increased dramatically between 2001 and 2007, rising to 45 percent

from 29 percent. Cost-related problems getting needed care rose across all income groups, with adults in low- and moderate-income families reporting the highest rates.

- Among adults with chronic health problems, more than 60 percent of those who were uninsured and nearly half of those who were underinsured reported skimping on medications because of cost. Both groups were more likely than those with adequate insurance to go to an emergency room or stay overnight in a hospital for their condition.
- McWilliams and colleagues found that previously uninsured adults with chronic health problems who acquire Medicare coverage at age 65 report significantly greater increases in the number of doctor visits and hospitalizations and in total medical expenditures than do previously insured adults, with the difference persisting through age 72.

Increasing Numbers of Adults Are Struggling to Pay Medical Bills

- Forty-one percent of working-age adults, or 72 million people, reported problems paying their medical bills or were paying off accrued medical debt during the past year, up from 34 percent or 58 million people in 2005. An additional 7 million adults 65 and older also reported bill or debt problems.
- This increase occurred across all income groups but families with low and moderate incomes were particularly hard hit: more than half of adults with incomes under \$40,000 reported medical bills problems in 2007. Adults with gaps in health insurance coverage or those underinsured were most at risk of having problems with medical bills.
- One-quarter of adults with medical debt were carrying \$4,000 or more in debt and 12 percent had \$8,000 or more.
- Among adults who reported any problems with medical bills or accumulated debt, 29 percent said they had been unable to pay for basic necessities like food, heat, or rent because of medical bills; 39 percent had used all their savings; 30 percent had taken on credit card debt; and 10 percent had taken out a mortgage against their home
- Three-quarters of adults under age 65 who reported a problem with medical bills said they had not pursued needed health care because of cost, compared with one-quarter of those who had not reported such problems.

Policy Implications

- The public's desire for relief from rising health care costs is evident in recent polling data. Eight of 10 adults said in a May 2008 Commonwealth Fund survey that the health care system is in need of a major overhaul or fundamental reform. A strong majority of adults across political parties said that it will be important for the next president to improve the quality of health care, ensure that insurance and health care are affordable, and reduce the number of people who are uninsured.
- The Commonwealth Fund Commission on a High Performance Health System has identified the following five key strategies for moving the health care system to a higher level of performance:
 - extending affordable health insurance to all;
 - aligning incentives to reward high-quality, efficient care;
 - organizing the health system to achieve accountable, coordinated care;
 - investing in public reporting, evidence-based medicine, information technology, and infrastructure needed to deliver the best care; and
 - exploring the creation of a national entity to set goals for improving health system performance and recommend best practices and policies.
- Universal coverage is a necessary, though not sufficient, condition for improving the overall performance of the health system. Moreover, the way in which policymakers design health insurance reform will affect whether everyone can be covered and sustained improvements in the quality and efficiency of care can be achieved. The Commission has identified the following principles of health insurance reform:
 - equitable and comprehensive insurance for all;
 - benefits should cover essential services with financial protection;
 - premiums, deductibles, and out of pocket costs should be affordable relative to family income;
 - broad health risk pools; competition based on performance, not risk or cost shifting;
 - simple to administer: coverage should be automatic, stable, seamless;
 - choice of health plans or care systems;
 - dislocation at the outset should be kept to a minimum—people could stay in the coverage they have, if desired; and

- financing that is adequate, fair, and shared across stakeholders.
- Universal coverage must be pursued along with strategies geared to improving quality and efficiency and reducing the growth in health care costs.
- A report by the Commission, *Bending the Curve*, examined the impact on health care costs of several strategies to improve quality and efficiency, including increasing the use of health information technology and comparative effectiveness evidence in insurance benefit design, promoting better health and disease prevention, aligning incentives to improve quality and efficiency, and correcting price signals in health care markets.
- Potential health system savings from these strategies ranged from \$9 billion to \$368 billion over 10 years.
- Including savings to state governments, businesses, and households, the nation could actually save \$1.6 trillion over 10 years if universal coverage were coupled with efforts to reform the way the U.S. pays for health care, invest in better information systems, and adopt initiatives to improve public health.

The continuing loss of adequate health insurance—as well as the ability to afford it—is not only dangerous to the health and wealth of families, it also imperils the efficient functioning of the overall health system and the economic productivity of the nation. The U.S. is unique among industrialized nations in its failure to protect the population against the uncertainties of health. This failure has now turned into crisis for many working families facing economic pressures in nearly every aspect of their lives. The time has never been more urgent for policymakers to forge consensus around strategies for reform that have the greatest potential for success and move forward with pragmatic solutions to the worsening performance of our health system.

Thank you.

**RIISING HEALTH CARE COSTS: IMPLICATIONS FOR THE
HEALTH AND FINANCIAL SECURITY OF U.S. FAMILIES**

Sara R. Collins, Ph.D.

The Commonwealth Fund

Thank you, Mr. Chairman, for this invitation to testify on high health care costs and the implications for U.S. families. The soaring costs of health care, along with a faltering economy and stagnant wages, are leaving many working families without insurance or with medical expenses that consume a large share of their incomes. An analysis of the Commonwealth Fund Biennial Health Insurance Survey found that nearly two-thirds of working-age adults—an estimated 116 million people—either were uninsured for a time during 2007, had such high out-of-pocket costs relative to their incomes that they were “underinsured,” reported a problem paying medical bills, or did not get needed care because of costs (Figure 1). Over the past seven years, these problems have spread inexorably up the income scale. The nation now faces a potentially severe economic downturn that could have potent financial implications for lower-income and middle-income families—those most at risk of being uninsured or underinsured. There is now an urgent need for a national solution that will provide families with affordable coverage options to ensure access to timely health care and provide protection against catastrophic financial losses.

Rising Health Care Costs Are Leading Employers to Drop Coverage or Increase Cost Sharing

Spending on health care in the U.S. continues to climb apace. In 2006, national health expenditures rose at a rate of nearly 7 percent per year, more than two times the rate of growth in the economy.¹ Similar annual rates of growth are projected through 2017.² U.S. spending on health care comprised about 16 percent of gross domestic product in 2005 (and 2006), compared with 9.1 percent in the median Organization for Economic

¹ A. Catlin, C. Cowan, M. Hartman, et al., “National Health Spending in 2006: A Year of Change for Prescription Drugs,” *Health Affairs*, Jan./Feb. 2008 27(1):14-29; Council of Economic Advisors, *Economic Report of the President* (Washington D.C.: U.S. G.P.O., February 2008), Table B-4.

² S. Keehan, A. Sisko, C. Truffer, et al., “Health Spending Projections Through 2017: The Baby-Boom Generation is Coming to Medicare,” *Health Affairs* Web Exclusive (Feb. 26, 2008):w145–w155.

Cooperation and Development (OECD) country in 2005 (Figure 2). Per capita spending on health care in the U.S. totaled \$6,649 in 2005 (\$7,026 in 2006), twice that of the median for all 30 OECD countries at \$2,922 in 2005.³ In addition, Americans spend two times as much on out-of-pocket expenses than do residents of other industrialized countries (Figure 3).

Steady increases in health care costs have placed upward pressure on the cost of health insurance: premiums are growing at rates more than twice that of other indicators, such as wages and consumer price inflation (Figure 4). The average annual cost of family coverage in employer-based health plans, including employer and employee contributions, topped \$12,680 in 2008—more than the average yearly earnings of a full-time worker earning the minimum wage.⁴

Employer coverage remains the predominant form of health insurance coverage for U.S. families; 99 percent of companies with 200 or more employees offer health benefits. But rising premiums have weakened the ability of small firms to offer comprehensive coverage. About 49 percent of employers with three to nine employees offered health insurance to their employees in 2008, down from 57 percent in 2000 (Figure 5).⁵ People with low and moderate incomes are most at risk of lacking coverage through an employer and are most at risk of being uninsured. Only 22 percent of adults under age 65 in families with incomes of \$20,000 or less had coverage through an employer in 2006, down from 29 percent in 2000 (Figure 6). Employer-based coverage in the next income category—under \$37,800 annually—declined from 62 percent in 2000 to 53 percent in 2006.

Employers have tried to hold their premiums by increasing employee cost-sharing. In-network deductibles for single coverage in PPO plans have tripled since 2000, rising from \$187 to \$560 in 2008 (Figure 7). Among employers with fewer than 200

³ J. Cylus and G. F. Anderson, *Multinational Comparisons of Health Systems Data, 2006* (New York: The Commonwealth Fund, May 2007).

⁴ G. Claxton, J. Gabel, B. DiJulio et al., “Health Benefits in 2008: Premiums Moderately Higher, While Enrollment in Consumer-Directed Plans Rises In Small Firms,” *Health Affairs* Web Exclusive (September 24, 2008):w492-502.

⁵ G. Claxton, J. Gabel, B. DiJulio et al., “Health Benefits in 2008: Premiums Moderately Higher, While Enrollment in Consumer-Directed Plans Rises In Small Firms,” *Health Affairs* Web Exclusive (September 24, 2008):w492-502.

employees, deductibles have risen by greater than a factor of four, climbing to an average \$917 in 2008.⁶

Increasing Numbers of People Are Uninsured or Underinsured

Rising health care costs over the past decade have occurred as incomes for working families have barely budged. Despite the fact that the economy expanded between 2001 and 2007, real median incomes rose from \$49,455 in 2001 to \$50,233 in 2007, an increase of 1.6 percent.⁷ According to an analysis by the Center on Budget and Policy Priorities, real incomes among working-age families have yet to regain pre-recession levels: median income among households headed by someone under age 65 was \$56,545 in 2007, compared with \$58,721 in 2000.⁸

This dynamic is captured in the increasing numbers of Americans who are spending large shares of their income on health care. According to an analysis of Commonwealth Fund Biennial Health Insurance Surveys, 2001, 2003, 2005, and 2007, between 2001 and 2007, the share of adults under age 65 who spent 10 percent or more of their incomes on health care costs including premiums and out-of-pocket costs climbed from 21 percent to 33 percent (Figure 8).⁹ Adults in all income groups spent more of their earnings on health care. More than half of adults in families with incomes under \$20,000 and more than one-third of adults earning between \$20,000 and \$60,000 spent 10 percent or more of their income on health care. Among those earning between \$40,000 and \$60,000, the rate doubled from 18 percent in 2001 to 36 percent in 2007.

The relentless annual growth in health care costs has left many working families with few options for health insurance. As employer coverage has declined, the number of people without health insurance has surged, rising from 38 million in 2000 to 46 million

⁶ G. Claxton, J. Gabel, B. DiJulio et al., "Health Benefits in 2008: Premiums Moderately Higher, While Enrollment in Consumer-Directed Plans Rises In Small Firms," *Health Affairs* Web Exclusive (September 24, 2008):w492-502.

⁷ C. DeNavas-Walt, B.D. Proctor, J.C. Smith, *Income, Poverty and Health Insurance Coverage in the United States: 2007*, U.S. Census Bureau, August 2008.

⁸ A. Sherman, R. Greenstein, S. Parrot, *Poverty and Share of Americans Without Health Insurance Were Higher in 2007 – and Median Income for Working Age Households was Lower – Than at Bottom of Last Recession*, Center on Budget and Policy Priorities, August 26, 2008, <http://www.cbpp.org/8-26-08pov.pdf>.

⁹ S.R. Collins, J.L.Kriss, M.M. Doty, S.D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance is Burdening Working Families: Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001-2007* (New York: The Commonwealth Fund) August 2008.

in 2007 (Figure 9).¹⁰ There was a slight decline in the number of uninsured people in 2007 compared with the prior year. This is attributable to higher enrollment in public insurance programs, while the decline in employment-based coverage continued.

The individual insurance market—in which only about 6 percent of the under-65 population buys coverage—has proven largely inadequate to stem the rising tide of the uninsured.¹¹ While the number of people who have lost coverage through their employers has risen steadily over the past few years, the share of the population that buys coverage in the individual insurance market has stayed relatively constant. In most states individual market policies are underwritten so that older people or those with health problems are charged higher premiums than healthier and younger applicants. In addition, applicants may have a pre-existing condition excluded from their policy or may be declined a policy altogether.

The high costs of insurance administration and the lack of economies of scale also increase premiums in the individual market relative to employer-based plans. Coverage equivalent to an employer plan in the individual market is estimated to cost at least an additional \$2,000.¹² Nor do people with individual market coverage receive a tax-exempt premium contribution as they do from employers. The Commonwealth Fund Biennial Health Insurance Survey of 2005 found that 34 percent of adults who had individual coverage—or those who had thought about or tried to buy a plan in the individual market in the past three years—found it very difficult or impossible to find coverage they needed: 58 percent found it very difficult or impossible to find a plan they could afford; and 21 percent said they were turned down or charged a higher price because of a pre-existing condition (Figure 10).¹³ Nearly 90 percent said they never bought a plan.

For families with health insurance, the combination of rising exposure to health costs and stagnant incomes has led to an increasing number of adults with such high out-of-pocket costs relative to their income that they are effectively “underinsured.” As

¹⁰ C. DeNavas-Walt, B.D. Proctor, J.C. Smith, *Income, Poverty and Health Insurance Coverage in the United States: 2007*, U.S. Census Bureau, August 2008.

¹¹ Analysis of Current Population Survey 2007 by Bisundev Mahato, Columbia University, Mailman School of Public Health.

¹² T. Buchmueller, S.A. Glied, A. Royalty, K. Swartz, “Cost and Coverage Implications of the McCain Plan to Restructure Health Insurance,” *Health Affairs*, Web Exclusive (September 16, 2008)472-481.

¹³ S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families* (New York: The Commonwealth Fund, Sept. 2006).

reported in a recent *Health Affairs* article by Cathy Schoen and colleagues, between 2003 and 2007, the number of underinsured adults climbed from 16 million to 25 million (Figure 11).¹⁴ Underinsured adults in the 2003 and 2007 Commonwealth Fund Biennial Health Insurance Surveys were defined as those who reported: spending 10 percent or more of their income on out-of-pocket health costs, excluding premiums; spending 5 percent or more of their income, if their incomes were under 200 percent of poverty; or deductibles that amounted to 5 percent or more of their income. Almost one-quarter of adults with incomes under 200 percent of poverty were underinsured, up from 19 percent in 2003. The problem of cost exposure moved dramatically up the income scale. The share of adults with incomes of 200 percent of poverty or more who were underinsured nearly tripled over the four-year period, climbing from 4 percent in 2003 to 11 percent in 2007. Underinsured adults were more likely to have health plans with limits on physician visits and on the total amount plans would pay. They were also more likely to have plans with higher deductibles: more than one-quarter of underinsured adults reported a deductible of \$1,000 or more compared with 8 percent of insured adults who were not underinsured (Figure 11).

Increasing Numbers of Adults in All Income Groups Are Not Getting Needed Health Care Because of Cost

The purpose of health insurance is to provide timely and affordable access to care and to protect against the costs of catastrophic illnesses and injuries. However, the rising costs of health insurance and inadequate health insurance are straining limited family budgets and leaving people less protected. The Commonwealth Fund Biennial Health Insurance Surveys, 2001, 2003, 2005, and 2007, asked respondents whether they had not pursued needed medical care in the past 12 months because of cost. Specifically, respondents were asked if, because of cost, they did not go to a doctor or clinic when sick; had not filled a prescription; skipped a medical test, treatment, or follow-up visit recommended by a doctor; or did not see a specialist when a doctor or the respondent thought it was needed.

¹⁴ C. Schoen, S.R. Collins, J.L. Kriss, M.M. Doty, "How Many are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive (June 10, 2008): w298-w309.

The share of adults who reported problems getting needed health care because of cost increased dramatically between 2001 and 2007. In 2007, 45 percent of adults under age 65 reported any one of these cost-related access problems, up from 29 percent in 2001 (Figure 13). Cost-related problems in getting needed care rose across all income groups, with adults in low- and moderate-income families reporting the highest rates. Notably, reported problems getting needed care rose up the income scale. Among adults earning between \$40,000 and \$60,000, more than two of five reported they had not received care because of cost, up from 24 percent in 2001. In fact, the rate of adults reporting not getting needed care in this income group in 2007 is at the same level that low- and moderate-income adults reported in 2001. Even adults in households earning more than \$60,000 a year reported not getting needed care at double the rates they did in 2001.

Across all four years of the Biennial Survey, adults who were uninsured or underinsured experienced the highest rates of cost-related problems accessing health care (Figure 14). In 2007, more than 70 percent of adults who were uninsured at the time of the survey or spent some time uninsured in the past year cited cost-related problems accessing needed health care, up from just over half in 2001 (data not shown). Underinsured adults reported not getting needed care at rates that were nearly as high as those who were uninsured: three of five underinsured adults reported at least one cost-related problem getting care in 2007.

There is considerable evidence that exposure to costs can have a negative effect on the ability of adults with chronic conditions to effectively manage their diseases. The Commonwealth Fund Biennial Health Insurance Survey asked respondents whether a doctor had told them they had any one of four chronic conditions: high blood pressure; heart disease; diabetes; or asthma, emphysema, or other lung disease.¹⁵ In 2007, among adults with chronic health problems who regularly took prescription drugs, more than three of five who had gaps in coverage (62%) or lacked insurance at the time of the survey (64%) reported skipping doses of medications or not filling prescriptions for their chronic conditions because of cost (Figure 15). Underinsured adults also reported poor rates of medication adherence: 46 percent of underinsured adults with chronic conditions

¹⁵ About 34 percent, or an estimated 59.7 million adults in the Commonwealth Fund Biennial Health Insurance Survey, 2007, reported at least one chronic health problem.

reporting skipping doses or not filling their prescriptions. In contrast, only 15 percent of adults with chronic conditions who were insured all year with adequate health insurance reported skimping on their medications. The survey also found that adults with chronic health problems and inadequate coverage reported seeking care in an emergency room, staying overnight in the hospital, or both, for their condition at higher rates than did those with adequate coverage.

Hadley found that uninsured patients who experienced an injury or were newly diagnosed with a chronic health condition received less medical care, were more likely to report not being fully recovered but no longer receiving care, and were more likely to report lower health status seven months after the event than were insured patients who experienced a similar medical event.¹⁶ The Commonwealth Fund Commission on High Performance Health System's *National Scorecard on Health System Performance* found that 63 percent of uninsured adults with diabetes had their illness under control compared with 81 percent of insured adults with diabetes. In addition, uninsured adults reported their high blood pressure was under control at half the rates that insured adults did (Figure 16). A study by Hsu and colleagues of Medicare beneficiaries found that people with capped drug benefits had lower drug utilization than those without capped benefits. Consequences included poorer adherence to drug therapy and worse control of blood pressure, lipid levels, and glucose levels.¹⁷ Moreover, cost savings from the cap were offset by increases in the costs of hospitalization and emergency room use.¹⁸

The health care incentives of inadequately insured families—to delay or avoid care when conditions are relatively inexpensive to treat, before they become serious and costly—run counter to long-held notions of the need for chronic care management and preventive care to promote healthy and productive lives, as well as to control long-term costs. McWilliams and colleagues found that among adults with chronic conditions, previously uninsured adults who acquired Medicare coverage at age 65 reported significantly greater increases in the number of doctor visits and hospitalizations and in

¹⁶ J. Hadley, "Insurance Coverage, Medical Care Use, and Short-Term Health Changes Following an Unintentional Injury of the Onset of a Chronic Condition," *Journal of the American Medical Association*, Mar. 14, 2007 297(10):1073–84.

¹⁷ J. Hsu, M. Price, J. Huang et al., "Unintended Consequences of Caps on Medicare Drug Benefits," *New England Journal of Medicine*, June 1, 2006 354(22):2349–59.

¹⁸ See also, S.R. Collins, et al, *A Roadmap to Health Insurance for All: Principles for Reform* (New York: The Commonwealth Fund) October 2008.

total medical expenditures than did previously insured adults, with the difference persisting through age 72 (Figure 17).¹⁹ The findings suggest that the costs of providing health insurance for uninsured near-elderly adults may be partially offset by subsequent reductions in health care use and spending once they enter Medicare.

Increasing Numbers of Adults Are Struggling to Pay Medical Bills

More adults are struggling to pay their medical bills and are accumulating medical debt over time. The Commonwealth Fund Biennial Health Insurance Surveys of 2005 and 2007 asked respondents whether they had experienced problems with medical bills over the past year, including whether they were able to pay their medical bills, if there were times when they had difficulty or were unable to pay bills, whether they had been contacted by a collection agency concerning outstanding medical bills, or whether they had to change their lives significantly to meet their obligations. In addition, the survey asked respondents whether they were paying off medical debt over time. In 2007, more than two of five (41%) adults under age 65, or 72 million people, reported any one of those problems, up from 34 percent, or 58 million people, in 2005 (Figure 18).²⁰ An additional 7 million adults ages 65 and older also reported bill or debt problems.²¹ This increase occurred across all income groups but families with low and moderate incomes were particularly hard hit: more than half of adults with incomes under \$40,000 reported problems with medical bills in 2007 (Figure 19). Adults with gaps in health insurance coverage or those underinsured were most at risk of having problems with medical bills: in 2007 three of five reported any one medical bill problem or accrued medical debt, more than double the rate of those who had adequate insurance all year (26%) (Figure 20).

Of the estimated 50 million adults who were paying off medical debt in 2007, many were carrying substantial debt loads that had accrued over time. One-quarter of adults with medical debt were carrying \$4,000 or more in debt and 12 percent had \$8,000

¹⁹ J. M. McWilliams, et al., "Use of Health Services by Previously Uninsured Medicare Beneficiaries," *NEJM* 357:2, Jul 12 2007.

²⁰ S.R. Collins, J.L. Kriss, M.M. Doty, S.D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance is Burdening Working Families: Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001-2007* (New York: The Commonwealth Fund) August 2008.

²¹ M.M. Doty, S.R. Collins, S.D. Rustgi, J.L. Kriss, *Seeing Red: The Growing Burden of Medical Bills and Debt Faced by Families* (New York: The Commonwealth Fund) August 2008.

or more (Figure 21). Adults who were uninsured at any time during the year had the highest debt loads: more than one-third (34%) of those who were uninsured at the time of the survey reported debt of \$4,000 or more, as did one-quarter (24%) of those who were uninsured for a period in the past year. And 18 percent and 12 percent of these two groups, respectively, had more than \$10,000 in debt. In addition, many people are carrying debt incurred over multiple years. More than one-third (37%) of adults with medical debt were carrying overdue bills from care received more than one year ago.

In the face of mounting medical bills and debt, many adults are making stark trade-offs in their spending and saving priorities. Among adults who reported any problems with medical bills or accumulated debt in 2007, nearly one of three (29%) said they had been unable to pay for basic necessities like food, heat, or rent because of medical bills; nearly two of five (39%) had used all their savings; one of three (30%) had taken on credit card debt; and one-tenth (10%) had taken out a mortgage against their home (Figure 22). Rates of reported trade-offs were especially high among people who had spent any time uninsured or those underinsured. Nearly half of adults who had spent any time uninsured and reported medical bill problems had used all their savings to pay for their medical bills and two of five were unable to pay for food, heat, or rent. Underinsured adults made similar trade-offs: 46 percent said they had used all their savings, 33 percent took on credit card debt, and 29 percent were unable to pay for basic life necessities.

Adults burdened with medical debt are significantly more likely to report cost-related problems getting needed health care. In the 2007 Commonwealth Fund Biennial Health Insurance Survey, three-quarters of adults under age 65 who reported a problem with medical bills said that they had not pursued needed health care because of cost compared with one-quarter of those who had not reported a problem with medical bills (Figure 23). Fifty-six percent said they had not filled a prescription when it was needed and 57 percent said they had not gone to the doctor when they were sick.

Policy Implications

The public's desire for relief from the mounting pressure of health care costs is evident from recent polls.²² In a May survey by The Commonwealth Fund, eight of 10 adults said the health care system is in need of a major overhaul or fundamental reform.²³ A strong majority of adults across political parties said it will be important for the next president to improve the quality of health care, ensure that insurance and health care are affordable, and reduce the number of people who are uninsured.

State and federal policymakers are responding to the public's call for reform. Massachusetts and Vermont have moved ahead of the federal government to expand insurance coverage in those states.²⁴ The 2008 presidential candidates have developed proposals to reform the health care system, and members of Congress have introduced bills to expand health insurance coverage.^{25,26} In addition, other policy experts have outlined frameworks and ideas for reform.²⁷

The Commonwealth Fund Commission on a High Performance Health System has identified the following five key strategies for moving the health care system to a higher level of performance.²⁸

²² S.R. Collins and J.L. Kriss, *The Public's Views of Health Care Reform in the 2008 Presidential Election*, (New York: The Commonwealth Fund, Jan. 2008); K. K. Shea, S. R. Collins, K. Davis, *Health Care Opinion Leaders' Views on The Presidential Candidates' Health Reform Plans* (New York: The Commonwealth Fund, Jan. 2008); S.K.H. How, A. Shih, J. Lau, and C. Schoen, *Public Views on U.S. Health System Organization: A Call for New Directions*, (New York: The Commonwealth Fund, August 2008).

²³ S.K.H. How, A. Shih, J. Lau, and C. Schoen, *Public Views on U.S. Health System Organization: A Call for New Directions*, (New York: The Commonwealth Fund, August 2008).

²⁴ S. K. Long, "On the Road to Universal Coverage: Impacts of Reform in Massachusetts at One Year," *Health Affairs* Web Exclusive (June 3, 2008) w:270-w284; J. E. McDonough et al., "Massachusetts Health Reform Implementation: Major Progress and Future Challenges," *Health Affairs* Web Exclusive (3 June 2008)w285-w297.

²⁵ S.R. Collins, J.L. Kriss, S.D. Rustgi, K. Davis, *The 2008 Presidential Candidates' Health Reform Proposals: Choices for America* (New York: The Commonwealth Fund, Oct. 2008); S. R. Collins and J. L. Kriss, *Envisioning the Future: The 2008 Presidential Candidates' Health Reform Proposals* (New York: The Commonwealth Fund, Jan. 2008).

²⁶ S. R. Collins, K. Davis, and J. L. Kriss, *An Analysis of Leading Congressional Health Care Bills, 2005-2007: Part I, Insurance Coverage* (New York: The Commonwealth Fund, Mar. 2007).

²⁷ C. Schoen, K. Davis, and S. R. Collins, "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance," *Health Affairs*, May/June 2008 27(3):646-57; L. Ku and M. Broaddus, "Public and Private Health Insurance: Stacking Up the Costs," *Health Affairs* Web Exclusive (June 24, 2008)w318-w327.

²⁸ For more detail, see The Commonwealth Fund Commission on a High Performance Health System, *A High Performance Health System for the United States: An Ambitious Agenda for the Next President* (New York: The Commonwealth Fund, November 2007).

- extending affordable health insurance to all;
- aligning incentives to reward high-quality, efficient care;
- organizing the health system to achieve accountable, coordinated care;
- investing in public reporting, evidence-based medicine, information technology, and infrastructure needed to deliver the best care; and
- exploring the creation of a national entity that would set goals for improving health system performance and recommend best practices and policies.

Universal coverage is a necessary, though not sufficient, condition for improving the overall performance of the health system. Moreover, the way in which policymakers design health insurance reform will affect whether everyone can be covered and sustained improvements in the quality and efficiency of care can be achieved. The Commission has identified the following principles of health insurance reform as essential in moving the health system toward high performance.²⁹

Access to Care

- Provide equitable and comprehensive insurance for all.
- Insure the population in a way that leads to full and equitable participation.
- Provide a standard benefit package for essential coverage and financial protection.
- Make premiums, deductibles, and out-of-pocket costs affordable relative to family income.
- Ensure coverage is automatic and stable, with seamless transitions between plans to maintain enrollment.
- Provide a choice of health plans or care systems.

Quality, Efficiency, and Cost Control

- Foster efficiency by reducing complexity for patients and providers, and by reducing transaction and administrative costs as a share of premiums.

²⁹ For more detail, see S.R. Collins, C. Schoen, K. Davis, A.K. Gauthier, S.C. Schoenbaum, *A Roadmap to Health Insurance for All: Principles for Reform* (New York: The Commonwealth Fund, Oct. 2007).

- Work to improve health care quality and efficiency through administrative reforms, provider profiling and network design, utilization management, pay-for-performance payment models, and structures that encourage adherence to clinical guidelines.
- Minimize dislocation, so that people can maintain current coverage if desired.
- Be simple to administer.
- Pool health risks across broad groups and over life spans, and eliminate insurance practices designed to avoid individuals with high health risks.
- Have the potential to lower overall health care cost growth.

Financing

- Financial commitment is necessary to achieve these principles.
- Financing should be adequate and fair, based on the ability to pay, and should be the shared responsibility of federal and state governments, employers, individual households, and other stakeholders.

Achieving universal coverage will require a serious financial investment by federal and state governments, employers, households, and other stakeholders. But universal coverage must also be pursued along with strategies geared to improving quality and efficiency and reducing the growth in health care costs. A Commission report, *Bending the Curve*, examined the impact on health care costs of several strategies to improve quality and efficiency (Figure 24).³⁰ These include: increasing the use of health information technology and comparative effectiveness evidence in insurance benefit design; promoting better health and disease prevention, for example through efforts to reduce tobacco use and obesity; aligning incentives to improve quality and efficiency, such as paying hospitals for improved outcomes; and correcting price signals in health care markets, for example, by allowing Medicare to negotiate drug prices with pharmaceutical companies.

The Lewin Group estimated the impact these strategies would have on national health expenditures and spending by major stakeholders over a 10-year period. Many of the options include initial investments, such as expanding the use of health information

³⁰ C. Schoen, S. Guterman, T. Shih et al., *Bending the Curve :Options for Achieving Savings and Improving Value in the U.S. Health Spending* (New York: The Commonwealth Fund, Dec. 2007).

technology, that would result in returns in later years. Potential health system savings from these strategies ranged from \$9 billion to \$368 billion over 10 years.³¹ For example, by promoting the diffusion of health information technology through a 1 percent assessment on insurance premiums and Medicare outlays, net health system savings could reach \$88 billion over 10 years. Establishing a center on medical effectiveness, along with the creation of payment and cost-sharing incentives for providers and consumers to draw on the results of medical effectiveness research, could yield savings of up to \$368 billion over 10 years, shared across all payers. Implementing a medical home model within the Medicare program in which primary care providers are paid for improved care coordination, care management, and improving access to appropriate care could result in savings of up to \$194 billion over 10 years. The potential savings associated with resetting the benchmark payment rates for Medicare Advantage plans closer to the per capita costs of people enrolled in the traditional Medicare program would be an estimated \$50 billion over 10 years. Allowing the federal government to directly negotiate prescription drug prices available through the Medicare program with pharmaceutical companies could result in savings of \$43 billion over 10 years (although without provisions to prevent cost-shifting, payers other than the federal government could experience a net increase in spending).

These cost-saving strategies could potentially offset some of the costs of expanding health coverage. For example, Schoen and colleagues outlined a framework for universal coverage referred to as *Building Blocks* which is similar in structure to the reform implemented in Massachusetts and proposed by presidential candidate Senator Barack Obama (although *Building Blocks* includes an individual requirement to have insurance). The estimated federal cost of the *Building Blocks* approach in 2008 is just over \$82 billion.³² The Lewin Group modeled how some of the savings options outlined in *Bending the Curve* would affect the costs of the *Building Blocks* coverage proposal. Specifically, it modeled the effects on costs of: increasing the use of health information technology; creating a center on medical effectiveness; reforming provider payment; increasing the tobacco tax; lowering Medicare Advantage plan payments to the level of traditional Medicare coverage, and allowing Medicare to negotiate prescription drug

³¹ Schoen, Guterman, Shih et al., *Bending the Curve*, 2007.

³² C. Schoen, K. Davis, S.R. Collins, "Building Blocks for Reform: Achieving Universal Coverage With Private and Public Group Health Insurance," *Health Affairs* (May/June 2006):646-657.

prices with pharmaceutical companies.³³ With these cost-saving strategies in place, The Lewin Group found that net federal spending on the *Building Blocks* proposal would fall to \$31 billion in the first year (Figure 25). Savings from the initiatives increase over time, so that spending offsets are estimated to be even larger in future years. By 2017, the federal costs of expanding coverage according to the *Building Blocks* proposal—without the savings strategies in place—would climb to \$205 billion. The savings strategies would reduce that cost to just \$10 billion. Including savings to state governments, businesses, and households, the nation could actually *save* \$1.6 trillion over 10 years if health insurance expansions were coupled with efforts to reform how the United States pays for health care, invest in better information systems, and adopt initiatives to improve public health.

Conclusion

The continuing loss of adequate health insurance—as well as the ability to afford it—is not only dangerous to the health and wealth of families, it also imperils the efficient functioning of the overall health system and the economic productivity of the nation. The deterioration of insurance coverage points to a need for a national solution that will give families affordable options to ensure access to timely health care and provide protection against catastrophic financial losses. The U.S. is unique among industrialized nations in its failure to protect the population against the uncertainties of health. This failure has now turned into crisis for many working families facing economic pressures in nearly every aspect of their lives. The time has never been more urgent for policymakers to forge consensus around strategies for reform that have the greatest potential for success and move forward with pragmatic solutions to the worsening performance of our health system.

Thank you.

³³ K. Davis, C. Schoen, S.R. Collins, *The Building Blocks of Universal Coverage and Health System Savings* (New York: The Commonwealth Fund, May 2008)

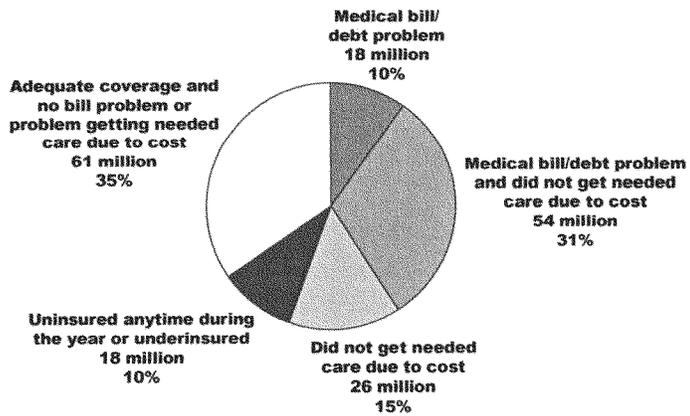


Rising Health Care Costs: Implications for the Health and Financial Security of U.S. Families

Sara R. Collins, Ph.D.
Assistant Vice President
The Commonwealth Fund

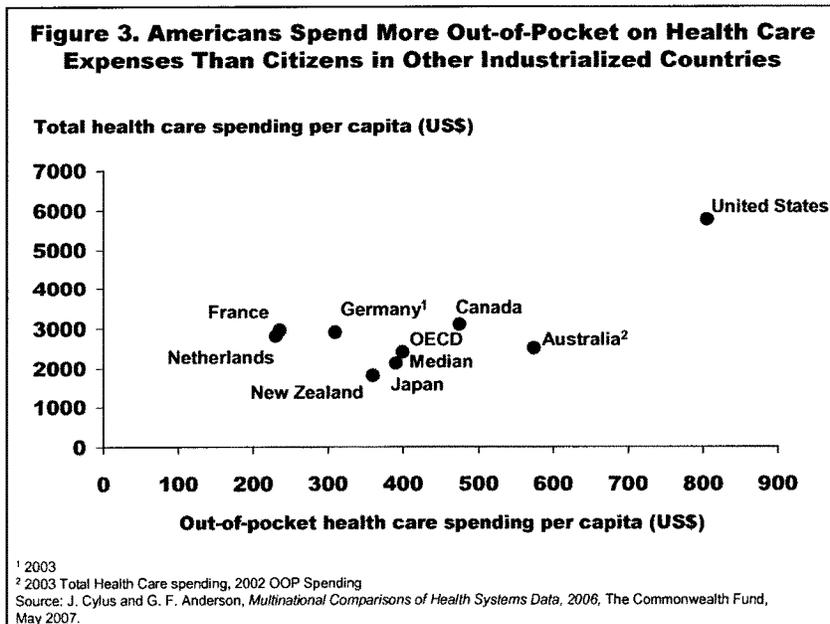
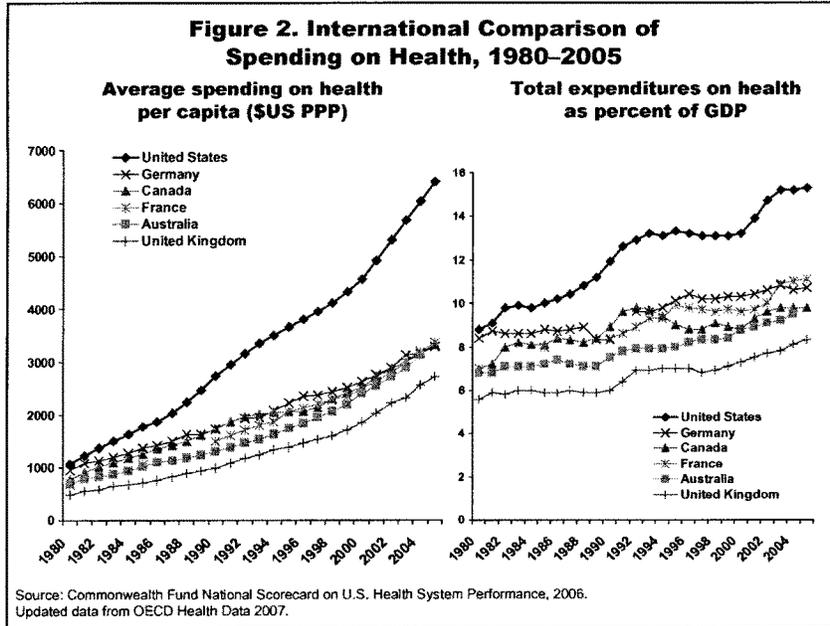
Invited Testimony
U.S. Senate Finance Committee
Hearing on “High Health Care Costs: A State Perspective?”
October 21, 2008

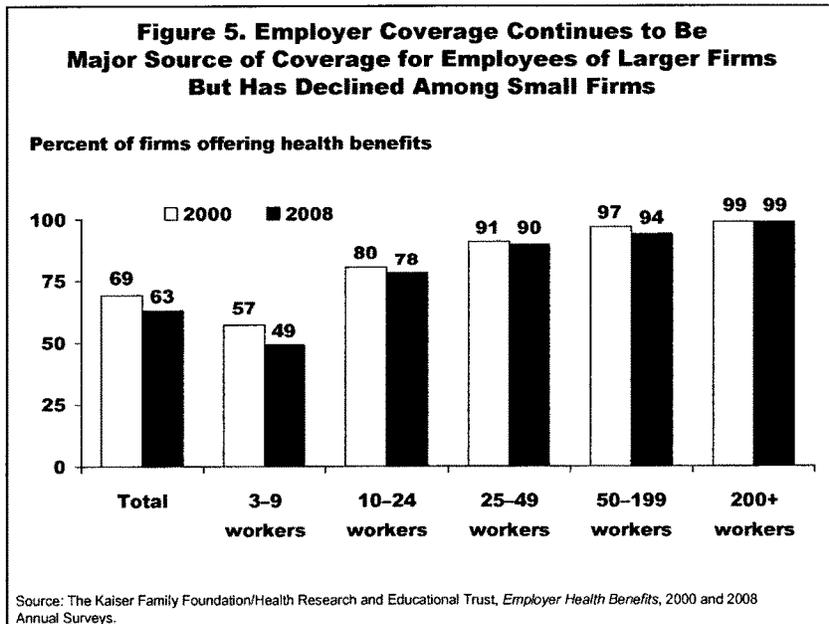
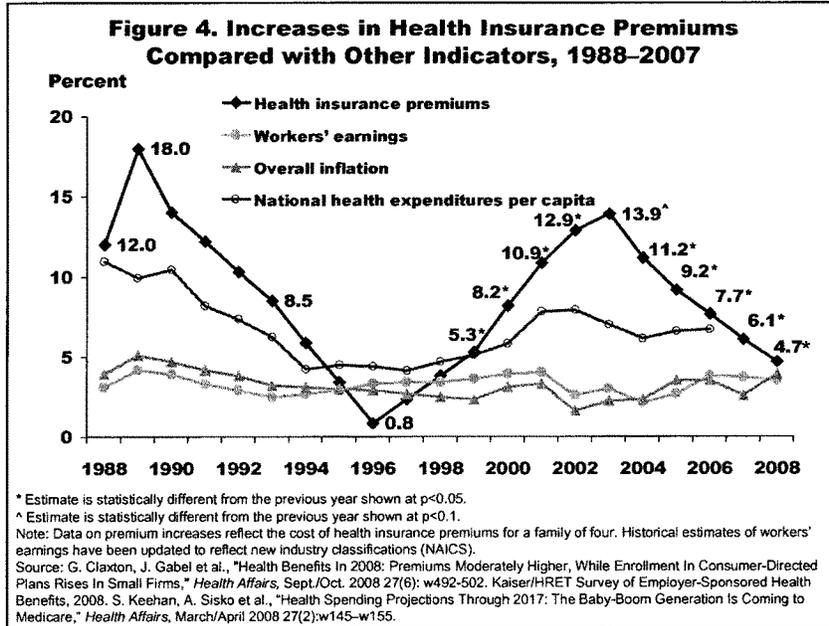
Figure 1. 116 Million Working-Age Adults Were Uninsured, Underinsured, Reported a Medical Bill Problem and/or Did Not Access Needed Health Care Because of Cost, 2007

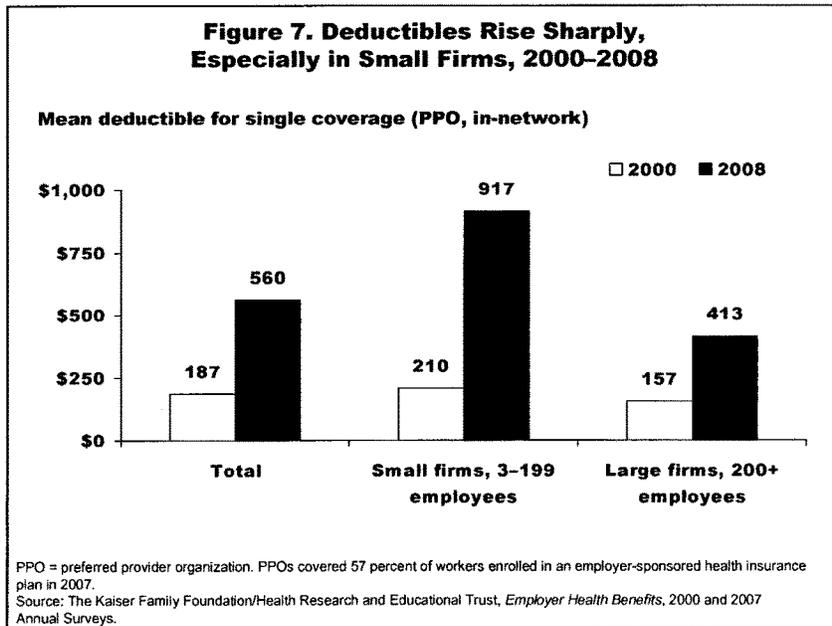
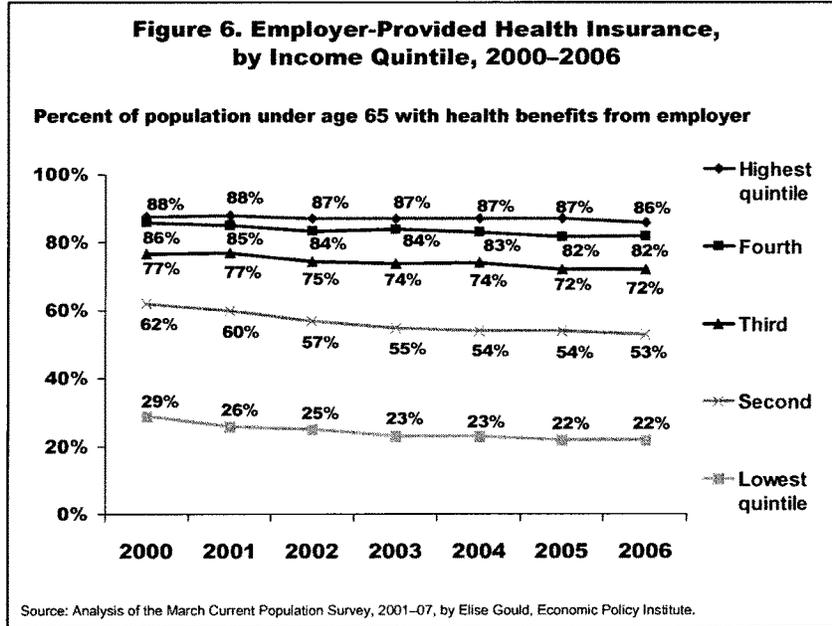


177 Million Adults, Ages 19–64

Source: S. R. Collins, J. L. Kriss, M. M. Doty and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families*, The Commonwealth Fund, August 2007.







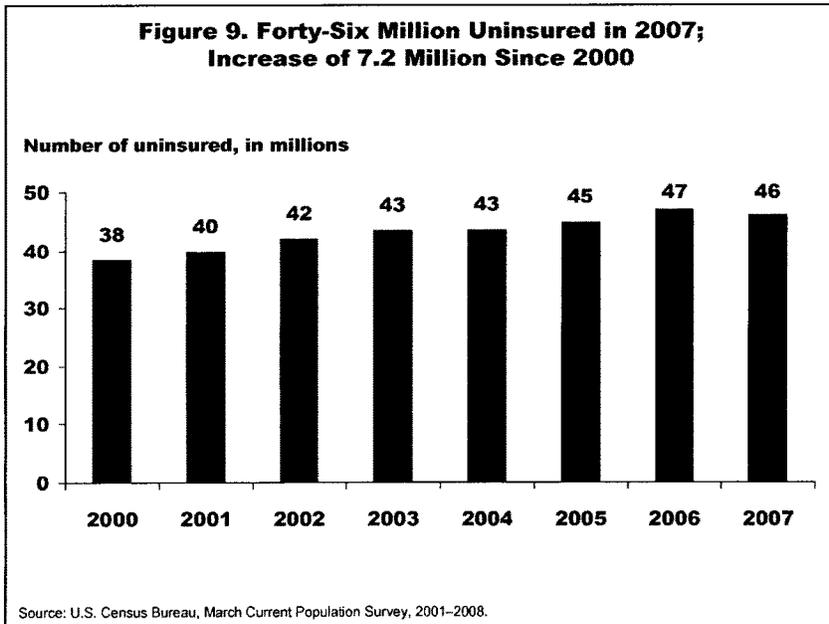
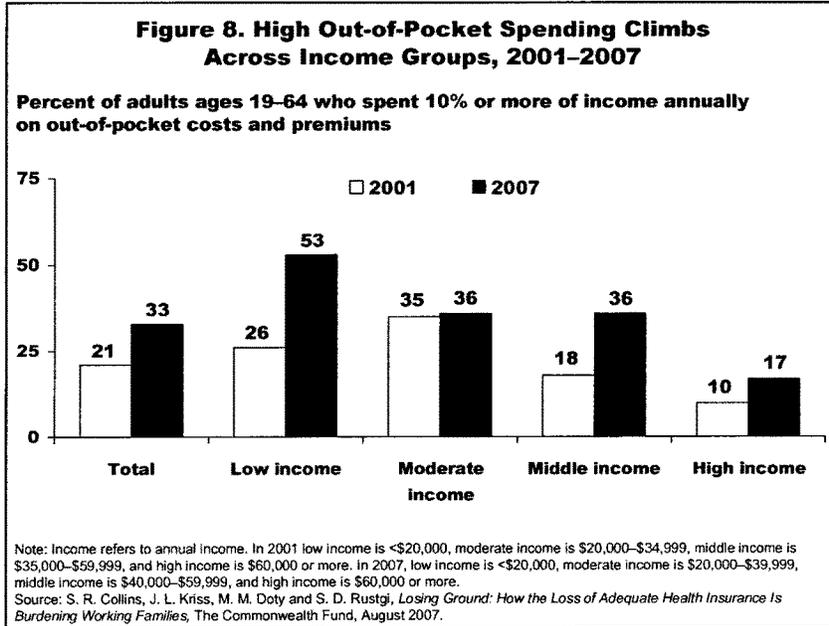
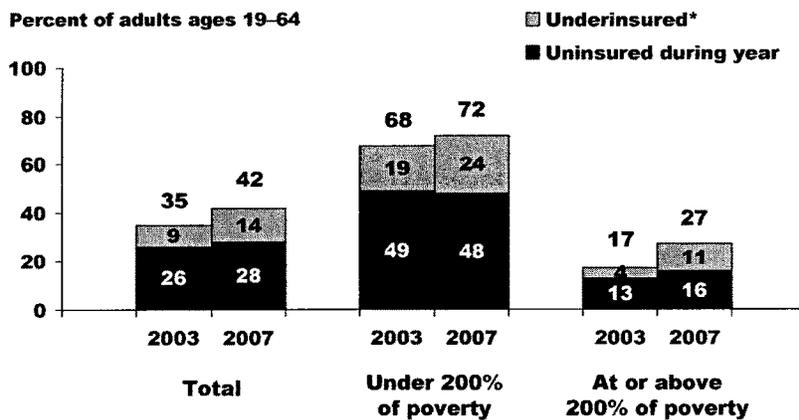


Figure 10. Individual Market Is Not an Affordable Option for Many People

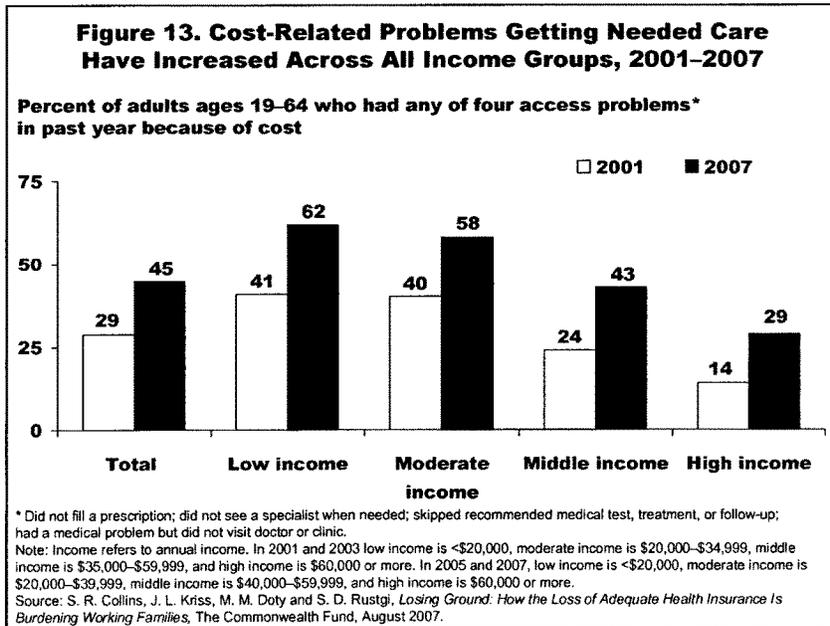
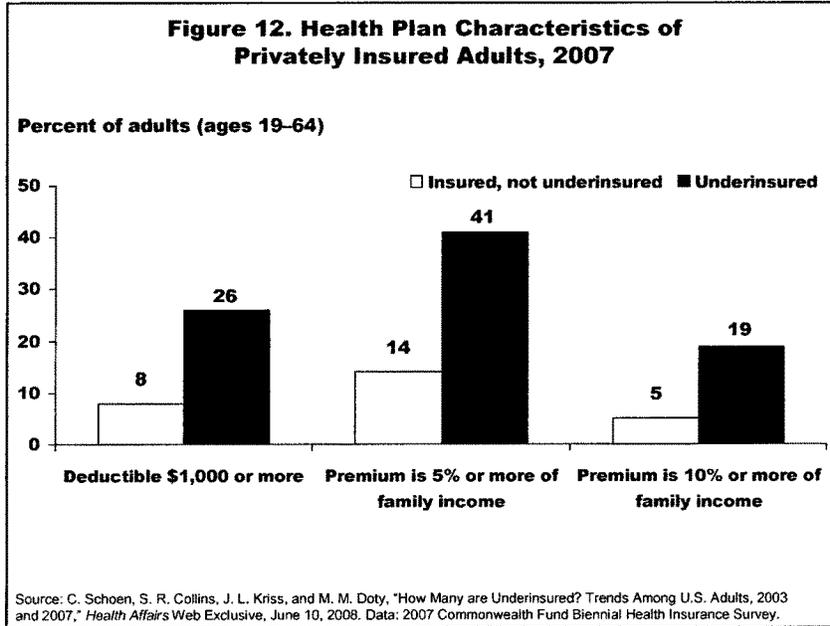
Adults ages 19-64 with individual coverage or who thought about or tried to buy it in past three years who:	Total	Health problem	No health problem	<200% poverty	200%+ poverty
Found it very difficult or impossible to find coverage they needed	34%	48%	24%	43%	29%
Found it very difficult or impossible to find affordable coverage	58	71	48	72	50
Were turned down or charged a higher price because of a pre-existing condition	21	33	12	26	18
Never bought a plan	89	92	86	93	86

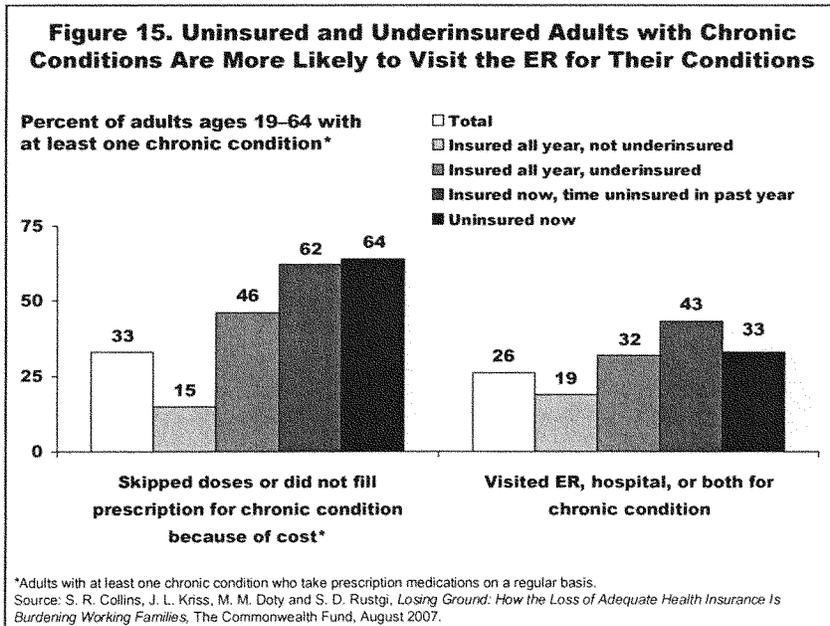
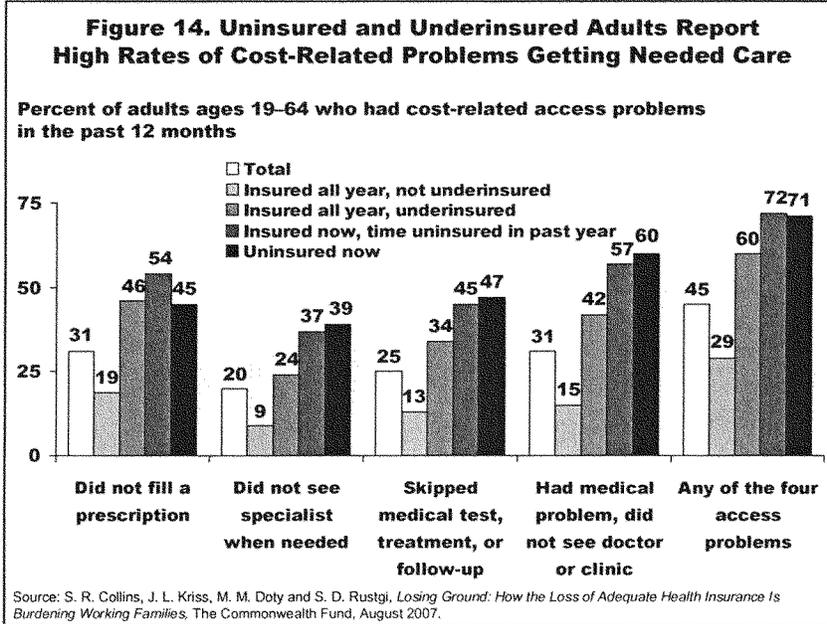
Source: S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well Being of American Families*, The Commonwealth Fund, September 2006.

Figure 11. The Number of Underinsured Adults Under Age 65 Rose to 25 Million in 2007, Up from 16 Million in 2003



*Underinsured defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.
 Source: C. Schoen, S. R. Collins, J. L. Kriss, and M. M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008. Data: Commonwealth Fund Biennial Health Insurance Surveys (2003 and 2007).





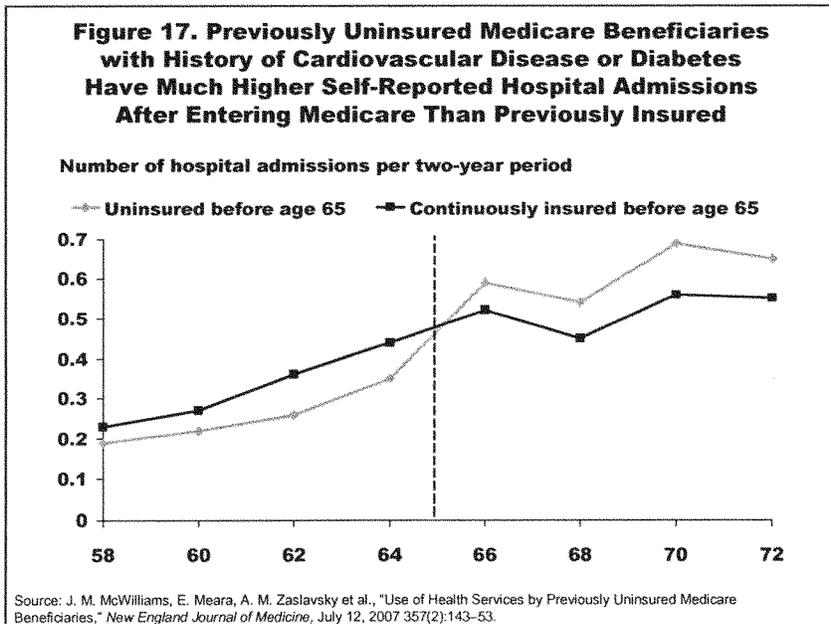
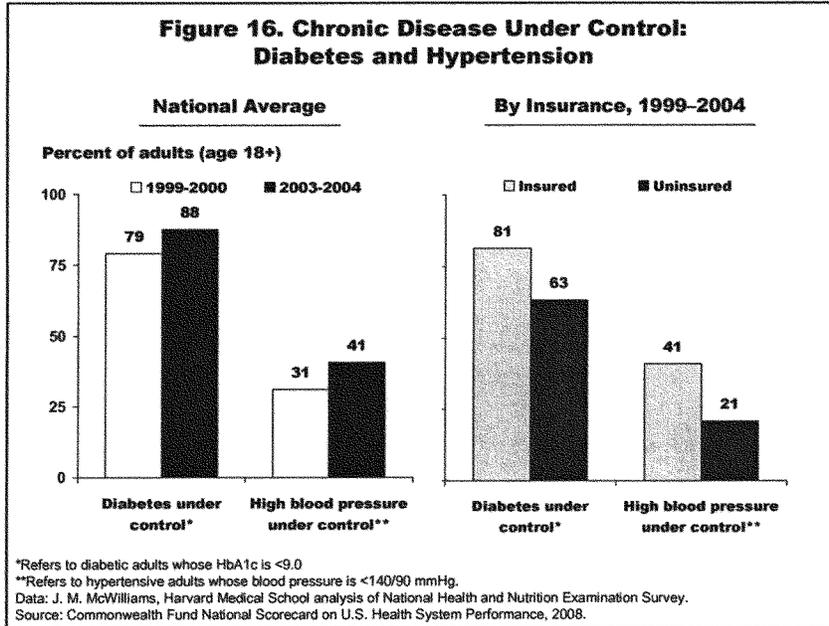


Figure 18. Medical Bill Problems and Accrued Medical Debt, 2005-2007

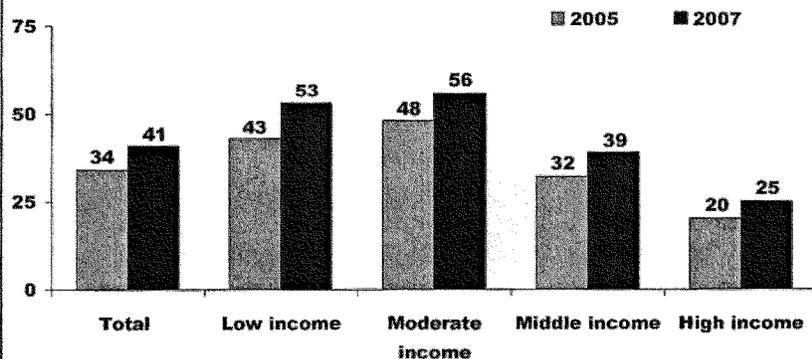
Percent of adults ages 19-64

	2005	2007
In the past 12 months:		
Had problems paying or unable to pay medical bills	23% 39 million	27% 48 million
Contacted by collection agency for unpaid medical bills	13% 22 million	16% 28 million
Had to change way of life to pay bills	14% 24 million	18% 32 million
Any of the above bill problems	28% 48 million	33% 59 million
Medical bills being paid off over time	21% 37 million	28% 49 million
Any bill problems or medical debt	34% 58 million	41% 72 million

Source: S. R. Collins, J. L. Kriss, M. M. Doty and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families*, The Commonwealth Fund, August 2007.

Figure 19. Problems with Medical Bills or Accrued Medical Debt Increased, 2005-2007

Percent of adults ages 19-64 with medical bill problems or accrued medical debt



Note: Income refers to annual income. In 2005 and 2007, low income is <\$20,000, moderate income is \$20,000-\$39,999, middle income is \$40,000-\$59,999, and high income is \$60,000 or more.
Source: S. R. Collins, J. L. Kriss, M. M. Doty and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families*, The Commonwealth Fund, August 2007.

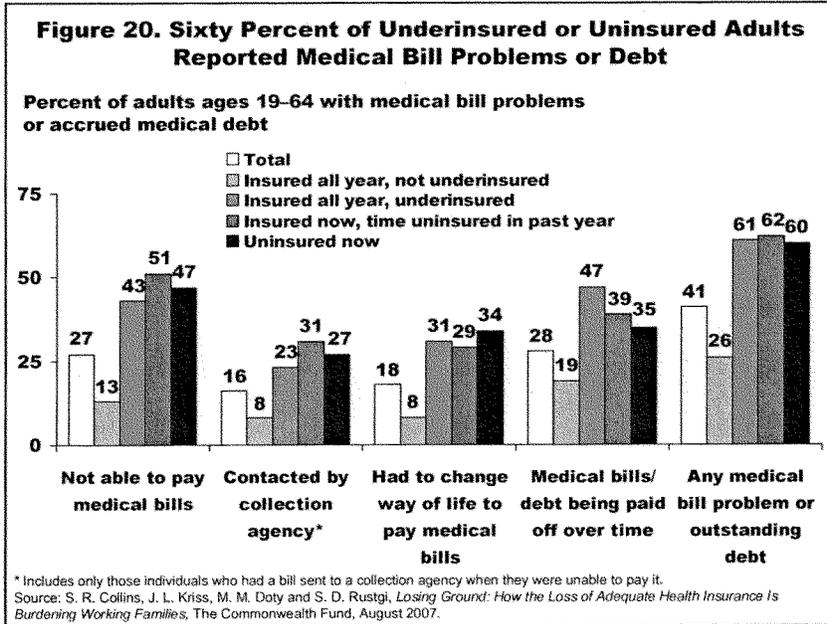


Figure 21. Uninsured Adults Are More Likely to Be Paying Off Large Amounts of Medical Debt Over Time

Percent of adults ages 19–64 who are paying off medical bills over time

	Total	Insured all year	Uninsured Anytime in Past Year	
			Insured now, time uninsured in past year	Uninsured now
How much are the medical bills that are being paid off over time?				
Less than \$2,000	51%	57%	46%	38%
\$2,000–\$3,999	21	20	25	22
\$4,000–\$7,999	12	11	11	14
\$8,000 or more	12	9	13	20
Was this for care received in past year or earlier?				
Past year	54	57	53	43
Earlier year	37	38	37	44
Both	8	7	9	12

Source: S. R. Collins, J. L. Kriss, M. M. Doty and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families*, The Commonwealth Fund, August 2007.

Figure 22. More Than One-Quarter of Adults Under Age 65 with Medical Bill Burdens and Debt Were Unable to Pay for Basic Necessities

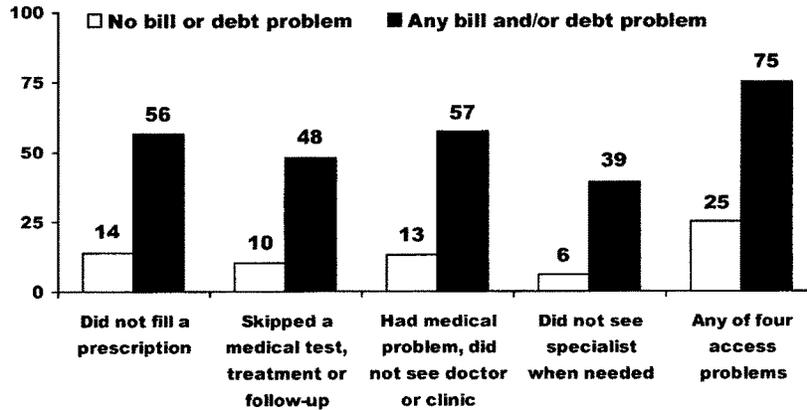
Percent of adults ages 19-64 with medical bill problems or accrued medical debt

Percent of adults reporting:	Total	Insured All Year		Uninsured Anytime During Year	
		No underinsured indicators	Underinsured	Insured now, time uninsured in past year	Uninsured now
Unable to pay for basic necessities (food, heat, or rent) because of medical bills	29%	16%	29%	42%	40%
Used up all of savings	39	26	46	46	47
Took out a mortgage against your home or took out a loan	10	9	12	11	11
Took on credit card debt	30	28	33	34	26
Insured at time care was provided	61	80	82	46	24

Source: S. R. Collins, J. L. Kriss, M. M. Doty and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families*, The Commonwealth Fund, August 2007.

Figure 23. Adults with Medical Bill Problems Report High Rates of Cost-Related Problems Getting Needed Care

Percent of adults ages 19-64 who had the following problems in the past year



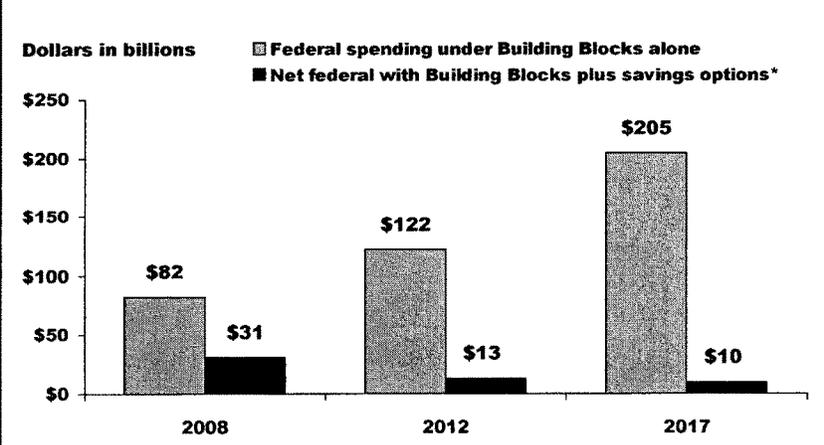
Source: The Commonwealth Fund Biennial Health Insurance Survey, 2007.

Figure 24. Policy Options and Distribution of 10-Year Impact on Spending Across Payer Groups (in billions)

	Total NHE*	Federal Government	State/Local Government	Private Payer	Households
Producing and Using Better Information					
1. Promoting Health Information Technology	-\$88	-\$41	-\$19	\$0	-\$27
2. Center for Medical Effectiveness and Health Care Decision-Making	-\$368	-\$114	-\$49	-\$98	-\$107
3. Patient Shared Decision-Making	-\$9	-\$8	\$0	\$0	-\$1
Promoting Health and Disease Prevention					
4. Public Health: Reducing Tobacco Use	-\$191	-\$68	-\$35	-\$39	-\$49
5. Public Health: Reducing Obesity	-\$283	-\$101	-\$52	-\$57	-\$73
6. Positive Incentives for Health	-\$19	\$2	-\$12	-\$4	-\$5
Aligning Incentives with Quality and Efficiency					
7. Hospital Pay-for-Performance	-\$34	-\$27	-\$1	-\$2	-\$4
8. Episode-of-Care Payment	-\$229	-\$377	\$18	\$90	\$40
9. Strengthening Primary Care and Care Coordination	-\$194	-\$157	-\$4	-\$9	-\$23
10. Limit Federal Tax Exemptions for Premium Contributions	-\$131	-\$186	-\$19	-\$55	\$130
Correcting Price Signals in the Health Market					
11. Reset Benchmark Rates for Medicare Advantage Plans	-\$50	-\$124	\$0	\$0	\$74
12. Competitive Bidding	-\$104	-\$283	\$0	\$0	\$178
13. Negotiated Prescription Drug Prices	-\$43	-\$72	\$4	\$17	\$8
14. All-Payer Provider Payment Methods and Rates	-\$122	\$0	\$0	-\$105	-\$18
15. Limit Payment Updates in High-Cost Areas	-\$158	-\$260	\$13	\$82	\$27

Note: A negative number indicates spending decreases compared with projected expenditures (i.e., savings); a positive indicates spending increases.
 * In some cases, because of rounding, the sum of the payer group impact does not add up to the national health expenditures total.
 Source: C. Schoen, S. Guterman, A. Shih et al., *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending* (New York: The Commonwealth Fund, December 2007).

Figure 25. Savings Can Offset Federal Costs of Insurance for All: Federal Spending Under Two Scenarios



* Selected options include improved information, payment reform, and public health.
 Data: Lewin Group estimates of combination options compared with projected federal spending under current policy.
 Source: Schoen et al., *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending* (New York: The Commonwealth Fund, December 2007).

Testimony of Jeff Fee, M.B.A

President and Chief Executive Officer, St. Patrick Hospital and Health Sciences Center
Western Montana Service Area
Providence Health & Services
October 21, 2008

Good afternoon, Chairman Baucus. I am Jeff Fee, President and Chief Executive Officer of St. Patrick Hospital and Health Sciences Center here in Missoula, Montana. Founded in 1873, St. Patrick Hospital is the largest community hospital in Western Montana and is part of Providence Health & Services, a Catholic, not-for-profit health system serving communities across Montana, Washington, Oregon, Alaska and California that includes hospitals, long term care, physician groups and a health plan.

This year, the emergency department at St. Patrick Hospital is expected to treat nearly 26,000 patients; this has increased an average of eight percent each year over the past three years. Montana has one of the nation's highest rates of uninsured, many of whom have no other option for health care than emergency rooms such as those at St. Patrick's and other hospitals around the state. Moreover, an increasing number of seniors eligible for Medicare are unable to find a primary care physician who will care for them and seek care at our emergency room.

In 2007, the cost of charity care at St. Patrick was \$6.3 million, an increase of \$300,000 over the previous year. We take great pride in providing charity care as an essential and central element in fulfilling our mission. However, we are concerned about the added pressure on our charity care program that will likely result by the current economic downturn as families struggle to cope with difficult financial times.

Perhaps more troubling to us is the growing number of patients we serve who have health insurance but who are unable to pay for part or all of their deductibles and co-pays. This is a stark illustration of the unsustainable growth in the cost of health care.

From our perspective, we are caught in a vicious cycle: as health care costs increase, employers drop coverage, driving more people into Medicaid or the uninsured ranks. Inadequate reimbursement from government payers forces providers to increase their rates to private insurers, who then must pass along these costs to policyholders. This cost shift, in turn, leads to increased private insurance premiums and employee cost-sharing, reduced benefits or worse, more companies dropping insurance coverage for employees and their families. For physicians, especially primary care doctors, it becomes increasingly difficult to remain financially viable with more Medicaid and Medicare patients on their panels. This has fueled a shortage of internal medicine and family practice doctors in our community. According to a 2006 community needs assessment by the Medical Development Specialist consulting group, the Missoula area had slightly more than half of the internists needed to support our population.

The situation we find ourselves in is symptomatic of the horribly dysfunctional structural incentives that have been built into our health care system over the past several decades: our system is focused *not* on improving the health of our people and communities, rather it is oriented toward "sick care" and the notion that problems can be solved simply by doing more medical services or procedures:

- Physician payment, driven by the Medicare fee schedule and reinforced by the private insurance system, encourages over-utilization of high cost procedures over basic care management;
- Hospital payment structures encourage increasing the volume of high-cost procedures that are more profitable to offset those services that are not;
- An increasingly complex administrative structure has grown around the delivery and financing of health care as a result of layers upon layers of state and federal regulation, leading to substantial overhead costs for hospitals, physicians and health plans. The cost to hospitals and physicians of overhead related to coding, billing, claims and compliance with regulations is estimated to be well into the billions;
- The state and federal governments are consumed with, and are solely focused on, restraining the burgeoning costs created by these dysfunctional incentives. As a result, public programs must de-emphasize promoting wellness in lieu of cost-containment.
- Our health care delivery system is highly fragmented. Providers compete for sick patients, rather than collaborate to improve health.

Some Potential Solutions:

Any effort at reforming our health care system must tackle these dysfunctional incentives as a first order of business. Otherwise, achieving universal coverage will be a hollow, and short-lived, victory.

We urge the Congress, and our next President, to consider:

- Overhauling provider payment systems to re-orient them toward collaboration aimed at improving the health and wellness of individuals and communities. Our health care system, rather than emphasizing high-tech acute care, should instead emphasize care management through primary care. Potentially promising structural models include the Patient-Centered Medical Home, which is currently in the Medicare demonstration phase, and Accountable Care Organizations, a concept developed by the Dartmouth Institute for Health Policy and Clinical Practice, which reorganizes the delivery system around local integrated systems of care.
- Shifting the direction of Value-Based Purchasing toward shared provider incentives across the continuum of care: rather than rewarding individual providers based on their own unique sets of measures, physicians, hospitals, long term care and other participants in patient care should share any performance incentives that improve the health of the individuals in their charge.
- Rewarding providers for helping to improve the overall health of their communities. Develop value-based purchasing structures that allow all providers within a specified geographic area to share incentive payments based on community-based quality and efficiency measures.

These are just a few possible ideas for reform the health care delivery system. In addition, St. Patrick Hospital and Providence Health & Services are involved with a number of community-based initiatives that we believe hold promise toward moving our system in the right direction:

- Project Access – A collaborative effort between local government, community health centers, hospitals and physician groups to create an infrastructure that facilitates volunteer physician care for uninsured patients. Successful Project Access efforts can be found in Spokane, Olympia and Seattle, Washington, as well as Portland, Oregon and Anchorage, Alaska. Nationwide, Project Access is a growing model in large and small communities.
- Program for All-Inclusive Care for the Elderly (PACE) – A comprehensive care management program for frail elderly patients, PACE utilizes a combined Medicare/Medicaid capitated payment to provide necessary medical and social services. Providence has five PACE sites in Portland, Oregon and Seattle, Washington.
- Utilization of Community Health Workers – lay members of communities who work either for pay or volunteers in association with the local health care system who assist patients in navigating the health care system, including making and meeting appointments, provide English translation if needed and other support. Providence has worked with “promotores” in Latino communities in Los Angeles and Portland to improve access to care.

Our Vision For Health Reform:

Providence Health & Services believes health care is a fundamental right. To that end, we are committed to work with our Members of Congress, the White House and our local, state and national partners to bring about structural modifications that will change the course of our health care system. We’ve developed a vision for health care reform that calls for both a redesign of our insurance system and the delivery system. This vision includes the following elements:

- How doctors, hospitals and other providers work together is critical to making health care more affordable, safe and effective. This requires an aggressive effort to effectively utilize the latest technology and an equal dedication to information sharing.
- Establish Health Care Accountability – Accurate and robust information is key to ensuring patients access the right care at the right time. Provider payment and insurance reforms should encourage the appropriate use of services. Establishing voluntary benchmarks for transparency in cost and quality can help patients choose the best care options, improve care and reduce waste. Additionally, hospitals, providers and insurers must collaborate and share the responsibility to control costs.
- Improve and Expand Health Care Coverage – The percentage of employers offering health insurance coverage is declining and the type of coverage offered is increasingly inadequate. Everyone deserves access to a basic set of health insurance benefits designed to be portable and not exclusively tied to employment. Although consumers should have the option to purchase additional coverage, the design of a basic plan should be comprehensive enough to include preventive medical services adequate to support good health management.

- **Strengthen Public Programs – Government-funded health insurance programs play a larger role in the health status of seniors, low income families and children. Medicare and Medicaid must continue to be reformed to be more patient-centered and focused on covering patients across the continuum of care, from primary to long term care.**

We thank you, Chairman Baucus and the Finance Committee as a whole for your continued strong leadership in working to bring about needed structural reforms to our health care system. We look forward to working with you in 2009 and beyond on this important issue.

Julie Foster

**Testimony before the Senate Committee on Finance
Hearing on:
“High Health Care Costs: A state Perspective?”**

My name is Julie Foster. I'm a cosmetologist from Missoula, Montana. I am here to share my story about accessing healthcare and how it has impacted me and my family.

I have been a hard worker my entire life. After graduating from high school, I worked my way through cosmetology school and have never been unemployed. As a single mother, I have always worked to pay the medical bills for my daughter and myself. I have never been able to afford health insurance and have made "too much money" to qualify for assistance programs. To pay for the birth of my daughter, I made arrangements for monthly payments and worked for several years to pay off the debt.

When my daughter was one year old, she had spinal meningitis and was in the hospital for nine days, five of which were in intensive care. As a result of the huge medical bill, I had to file for bankruptcy.

There were two other medical situations that have caused extreme financial hardship during my life. I sustained a broken arm and leg when I was hit by an uninsured motorist crossing the street. Luckily, I had tremendous family support during this time and my daughter and I were able to live with my parents.

I have been a patient of Partnership Health Center for many years. Partnership Health Center is the local community health center that offers services on a sliding fee scale. The Health Center was able to help me when I had a broken ankle.

I continue to seek services at Partnership. Although I have a tough time making ends meet with my current salary, I make too much to qualify for the sliding fee scale. As a result, I only seek medical advice when it is an absolute emergency and rarely go to the doctor for my annual exams. Additionally, I am too young to qualify for the State of Montana Breast and Cervical Health Program. I am 47 years old and have never had mammogram due to the cost of it. I know that preventative care is essential to ensure a healthy future, but I simply cannot afford it.

My employer does not provide insurance coverage for me, nor do they have an option for me to purchase it. I am able to afford dental and eye-care coverage through a private company, which I pay for by myself. However, there is no way that I can afford medical insurance.

I take great pride in myself and my work. I also take great pride in instilling my work ethic in my daughter. I have worked hard to be a homeowner and have lived in the same place for over 20 years. I do not spend my money on frivolous things and make sure that I am able to cover the basics on my salary. I hesitate to think what would happen if a major medical event or chronic disease were to happen to me.

I would like to thank you for taking the time to listen to my story. Unfortunately, my story is not uncommon and I work with and know many people who are in the same situation that I am. Addressing the lack of coverage for people in our county is very important and I appreciate you taking the time to work on this problem.

Thank you!

Rising Costs of Health Care

Testimony before United States Senate Finance Committee

Field Hearing
Missoula, Montana

October 21, 2008

Fred Olson, MD
Chief Medical Officer, Blue Cross and Blue Shield of Montana

Mr. Chairman and Members of the Senate Finance Committee: Thank you for inviting me here today to testify on the important topic of rising health care costs. For the record, my name is Dr. Fred Olson and I am the Chief Medical Officer at Blue Cross and Blue Shield of Montana (BCBSMT).

Blue Cross and Blue Shield of Montana provides services to approximately one-third of the population of Montana and almost 50% of the fully insured market. We administer the Children's Health Insurance Program for the State of Montana, and through Tri-West; we handle the health insurance of Montana's military families.

The cost of health care, which is rising at unsustainable rates, is of paramount importance to Blue Cross and Blue Shield of Montana. We are pleased to be able to provide our thoughts on what we consider to be some of the top drivers of healthcare costs.

Consumerism

The US consumes approximately twice as much health care as other industrialized nations. Many factors have been identified as contributing to this over-utilization of healthcare services.

- o Insurance has tended to insulate patients from true healthcare costs by covering the majority of services. Studies show that patients choose to receive 40% more healthcare services when the cost is born by someone else. We support publication of cost and quality information that will allow patients to become more cost-effective consumers, and insurance products that reward cost-effective behavior.
- o Many consumers feel that more healthcare results in superior outcomes, in spite of numerous studies that have

- shown that excessive consumption of healthcare to be counterproductive.
- In the US, we approve therapies without consideration of cost, in contrast to other nations, which consider benefits as well as costs in their approval processes.
 - As we learned at the Senate Finance Committee's health care summit in June, 30% of health care spending goes toward ineffective, inappropriate, or redundant care. I applaud Senator Baucus for introducing the Comparative Effectiveness Research Act, which will help support evidence-based medicine. We need more information on what works best in medicine, and we need to support use of electronic medical records that can help prevent redundant care.

Relative Shortage of Primary Care Physicians

Patients today are increasingly frustrated at being unable to locate a primary care physician who is accepting new patients. The United States has the highest ratio of specialist physicians to primary care physicians found among industrialized nations. Comparing nations, there is a clear correlation between an increasing percentage of primary care physicians and more cost effective health care. Comparing States within the US, analysis of Medicare cost and quality metrics shows the same relationship: States with higher percentages of primary care physicians as compared with specialist physicians have shown lower healthcare costs, and higher quality metrics.

US trained physicians are increasingly less likely to become primary care physicians. A 2007 survey of 1,177 fourth-year medical students at 11 US medical schools showed that only 24 students (2%) were planning on becoming internal medicine generalists. The US needs to address the growing shortage of

primary care physicians by actively managing its physician training programs, and by enacting changes in the physician compensation system that pays specialists 2 to 3 times more than primary care physicians.

Unhealthy Lifestyle Choices

Unhealthy lifestyle choices including smoking, exercise, and eating habits that lead to obesity add significantly to health care costs. According to the Centers for Disease Control and Prevention (CDC), 33 percent of adults, and 14-18 percent of children are obese. The CDC also found 24 percent of men and 18 percent of women still smoke. More often than not, these personal choices lead to chronic diseases, such as diabetes, hypertension, and heart disease. As a result, 6 out of 10 adults in US have at least one chronic condition.

To contain healthcare costs, we must add additional support to programs that promote wellness through improved lifestyle choices and reduce the prevalence of chronic conditions.

Costs Attributable to Malpractice Litigation

Medical malpractice suits increasingly target bad outcomes rather than true malpractice. Malpractice insurance varies by specialty, with direct costs varying between \$5,000 and \$200,000 per physician per year. In addition, physicians learn to practice "defensive medicine": Ordering services that help protect themselves from litigation rather than helping to define or treat a patient's medical condition. The total costs of malpractice litigation are difficult to quantify, but continue to substantially contribute to rising healthcare costs.

Excess Capacity/Duplication of Services

We often see facilities duplicating very expensive services, such as cancer treatment, as they compete within the healthcare market. Competition in healthcare, in contrast to competition in other economic sectors, does not seem to lower cost. US consumers pay the costs of these duplications. We need a mechanism to constrain deployment of these duplicative medical services in some areas, while assuring the provision of necessary services in others.

Cost Shifting

While cost shifting does not increase the overall cost of healthcare, it does lead to higher health care costs and higher insurance costs for individuals insured through the private sector. Cost shifting occurs when the uninsured cannot afford to pay their healthcare costs, and when Medicare and Medicaid pay less for healthcare services than providers find acceptable. In Montana, the Department of Public Health and Human Services (DPHHS) reported that current Medicaid payments to hospitals cover only 68 to 70 percent of the costs for providing the services. Health care providers in Montana tell us that the cost shifting from Medicare and Medicaid to the commercially insured is approximately 35%. That 35% cost shift translates into an approximate increase in paid claims of \$700 per year for each BCBSMT insured member.

Cost shifting will become more problematic as our population continues to age. By 2030, it is estimated one-fourth of the population of Montana will be over age 65, resulting in additional cost shifting to the commercially insured. Blue Cross and Blue Shield of Montana believes that the reimbursement rates for Medicare and Medicaid must be adjusted to reduce cost shifting. We also support universal coverage, which will eliminate cost shifting for care of the uninsured.

Thank you for your time today. Blue Cross and Blue Shield of Montana appreciates the focus the Senate Finance Committee is putting toward health care reform. We believe your efforts will bring about substantive reform, from which all Americans will benefit.

I am happy to answer any questions you may have.

COMMUNICATIONS

October 14, 2008

Dear Senator Baucus,

I am a resident of Kalispell and have lived in the State of Montana all of my life, except for a short time while I served my country in the United States Navy, (1977-1981). Growing up in Kalispell, MT, I have witnessed the changes that this community has undergone over the years. If you were to look at only the surface of this community you would think that it is a very prosperous and booming city and in some ways it is. When you dig a little deeper you begin to realize that there are a lot of problems that the residents of this community face everyday.

Lack of Quality Affordable HealthCare is one of them and I believe that something of this magnitude really shows the true wellbeing of a community. Access to Quality Affordable Healthcare I believe should be a right and to leave anyone behind on this issue means to me that we all suffer in some way or another. I feel that it is time that we as a nation become leaders once again and do what other developed countries have done. Provide quality, affordable, health care for everyone.

My father was able to provide healthcare coverage including dental and vision to his entire family (his wife Roxanne and nine children) since 1960 when it became available. I have been able to provide the same but see that slowly slipping away due to the fact that my wage increases are going more and more towards my healthcare premiums. My sister told me the other day that most of the wage that she earns goes towards paying for her healthcare coverage. How many more go uninsured before we fix the problem? You will have my support when you sign on to "Health Care for America NOW!".

One more thing in closing. Would you please consider holding these sessions at a time that is more conducive to the working people so that we can have more input into shaping the future for our children.

Thank you for your time.

Sincerely,

David Brothers

October 21, 2008

Honorable Senator Baucus
1821 South Avenue West
Suite 203
Missoula, MT 59801
(406) 329-3123

Dear Senator Baucus:

I appreciate your work on health care reform. I believe that everyone should have access to medical care and that care must include dental.

I have seen first hand how important dental care is as I've watch a dear friend of 80 years old plagued by dental issues. The pain in her mouth is so severe that she cannot eat. She's as thin as a rail and before my very eyes, she is wasting away.

We each have our one body and every part of it needs attention and care.

Please support the Montanans for health care. And be sure to include dental care in your plan for reform.

Sincerely,
Karen Kelly Chadwick
13575 Crystal Creek
Clinton, MT 59825
406-258-5439



Dear Senator Baucus,

Thank you for taking up the important issue of healthcare reform at the national level. I sincerely appreciate all the time you are spending on this complicated issue and that you brought the Senate Finance Sub-Committee hearing to Missoula. I was lucky to be in the audience, along with YWCA Missoula's executive director, Cindy Weese.

If I had a dollar for every time I heard a horror story about the women and children we serve being denied the access or quality care they deserve, I might just have enough money to fix the system myself! As you know, many women come to the YWCA after they leave an abusive relationship. These women, and their children, have nowhere else to go. They are scared, literally beaten down, and have limited economic options. Most of them are low-income, and many are Native American. The YWCA works to eliminate racism because we see it as a women's issue. We can't fulfill our mission to empower women without also tackling racism head on.

For example, we recently had a Native woman seeking pain medicine for a legitimate health problem. She had to leave her pills and prescriptions at home when she left her abuser, so she had to go to a doctor. She was intimidated by doctors and hospitals, she told us, because she didn't have insurance and felt she was looked down on. Unfortunately, her fears were exacerbated when this new doctor assumed, simply because she was Native, that she was abusing pain killers and not really in need. The woman came back in a second time, bringing a white YWCA staffer with her. This time, she received the care she needed and told our staff how differently she felt she was treated because a white person was with her.

The YWCA is a partner organization with Montanans for Healthcare because we believe healthcare is a human right. All people deserve access to quality, affordable care, not just health insurance. I hope you will keep the single-payer option on the table as you begin to reform the healthcare system.

Please contact me if the YWCA can be of any help to you or your committee as you continue your good work in the service of our country.

Best wishes,

Caitlin Copple
Marketing Coordinator
 YWCA Missoula
 1130 W. Broadway
 Missoula, MT 59802
 Phone: 406.543.6691
 Fax: 406.543.6777
 Email: ccopple@ywcaofmissoula.org
 Web: www.ywcaofmissoula.org

Use the Profit Motive to Drive Down Health Care Costs

The economy benefits from healthy working people. An investment in basic biomedical research benefits the economy in the long term because of breakthroughs that improve health. Such breakthroughs must be translated into therapy, and financial incentives are appropriate to recruit talented people to provide health care. The way it is now, however, there are large financial incentives to develop drugs and medical procedures, but health may not be the primary goal. Money derived from health care is highly concentrated in the hands of a few health care providers and drug companies, syphoned excessively into insurance bureaucracy, and parasitized by lawyers. Because of this, the economy as a whole has suffered, as well as public health. There is substantial evidence that the profit motive is responsible for widespread use of drugs and procedures that have little or no health benefit, or worse, are iatrogenic (cause illness derived from therapy).

The problem is not the profit motive; the profit motive is a force of human nature, like gravity is for objects with mass. The problem is that money is made from sickness rather than from health. The key is to set up the rules so that the profit motive brings down health care costs instead of driving them up. To make this work, health care providers must profit from healthy clients just as the economy benefits from healthy working people. Imagine a medical practice where no extra fees are charged for drugs and treatments. Since the practice buys all drugs and medical devices, and contracts lab tests, they will negotiate prices directly with drug companies, laboratory testing services, and medical device manufacturers. A tax structure could be devised that rewards the practice through successively lower taxes the longer the patient stays with the practice. In cities, patients could choose a practice based on price and performance. This "outcomes" focus would select the best and most cost-effective treatments including drugs, procedures, and preventative care. When health is the source of profit, market forces will bring health care costs down.

Specific problems and solutions can be examined with this principle in mind. The example above can be directly applied to the prepaid group practice and health network models. For rural or under-doctored professions such as primary care physicians, a medical scholarship with a payback agreement such as that used for graduate students in science would help fill vacancies. Pay-for-performance initiatives for health care providers are a first step away from the perverse incentives created by the bill-per-procedure reimbursement system, and importantly, focus on outcomes, but do not go far enough to curtail costs. A single-payer system may help cut costs by eliminating the insurance middleman, but if the single payer system preserves the procedure-code reimbursement system, there is no incentive for cost control. This raises fears of an ever-expanding government bureaucracy and health care rationing. In contrast, the single payer system that uses a per-person rather than per-procedure reimbursement scheme can enforce the principle of profit derived from health. This could augment care for people who can pay extra for health care and provide health maintenance and accident recovery for the uninsured.

The main point is to use the principle of profit derived from health rather than illness to establish market forces that bring health care costs down. The key feature is to have patients pay one medical fee that covers all treatments, including drugs. A single payer system can level the playing field by providing extra reimbursement for high-risk patients (*e.g.*, those who suffer from genetic diseases). Most importantly, a single payer system can enforce the principle of profit derived from health by paying per person rather than per procedure. This, coupled with a tax incentive for long-term doctor-patient relationships, would drive towards long term, preventative, cost-effective health care.

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October 21, 2008

Honorable Senator Baucus
1821 South Avenue West
Suite 203
Missoula, MT 59801
(406) 329-3123

Dear Senator Baucus:

As we look forward to reforming to our health care system, I would like to reiterate the important role Registered Nurses (RNs) can play in developing a new system—a system that works for everyone.

RNs are the glue that keeps this current dysfunctional health care system functioning. We are the care providers that must constantly find ways to fill in the gaps in patient care, while juggling many of our other duties. People trust us because we are always there to meet the needs of both the infirmed, and their families.

As we look to new solutions and new strategies, RNs must be at the table to share our valuable perspective. Our case management skills and understanding of patient care will come in handy as we address issues of administration and cost cutting.

Senator, this information is not new. The health care crisis has been boiling over for some years now. For this to work, we must use all of our available resources.

I look forward to the day when we have guaranteed, quality, affordable health care for everyone as the Montanans for Health Care coalition have expressed.

Sincerely,

Representative Teresa K. Henry, MS, RN

Missoula, MT

406-444-4800

www.tkhenry.com

**Testimony for October 21 Senate Finance Committee Field Hearing
Matt Hisel, Home Resource**

My name is Matt Hisel. I am Co-Director of Home Resource here in Missoula. Home Resource is a building materials re-use center. Our mission is to collect and resell usable building materials to reduce waste and help build healthier communities.

We've been in business for five years. We have four full-time employees and 10 part-time or temporary employees. We're currently working on an expansion plan and moving to a new location, and anticipate adding another 3-5 jobs in the process.

Senator Baucus, I would like to applaud your commitment to health care for all. I read on your list of health care principles that you believe "every Montanan and American has a right to affordable health coverage."

Based on my experience as a small employer, though, I don't see how we can trust the private insurance industry to deliver on the promise of quality, affordable coverage.

As an employer, we are committed to doing our best to provide good health coverage for our staff. We've learned the hard way that small businesses get the short end of the stick in the current health care system. We started with a seemingly decent plan... and then it went up 39 percent after just one year. We've been forced to switch to another, and then another and another plan, because every time the second year the cost goes up far more than we project or can afford. We're at the mercy of the insurance companies.

Cost is not my only concern, either. Quality of coverage is equally important to me, and equally troubling. The only plans we can afford are high deductible plans that don't do us much good. We've even tried health savings accounts and found them completely difficult to manage with our employees.

To be honest, I don't have any confidence that if I did come down with a serious illness or injury, the insurance company would pay out to cover it. Based on what I've heard from other people needing to fight tooth and nail to get their insurance companies to follow through on their word, I expect this to be a real battle.

I don't think we can trust private insurance companies to solve the problems they themselves have created. We need a strong public alternative, so we're not just held hostage to the private insurance industry. With that in mind, I want to urge you all, and Senator Baucus especially, to support the Health Care for America Now statement of principles.

October 21, 2008

Max Baucus, Chairman
Senate Finance Committee
Field Hearing Testimony Missoula, MT

Dear Max,

Thank you for the work you are doing on behalf of our country to address the health care crisis. The primary principles that you outlined last week in Missoula seem to reflect a positive step in addressing the inadequacies that currently exist in the health care systems. It is encouraging to see groups locally, such as HCAN, representing the issues that are important for reform, and to have the Commonwealth Fund bringing the quality perspective into the discussion.

One of the principles that you discussed included **case management** as a tool in decreasing over-utilization. You also commented on the need to **compensate providers for discussing care options** with patients in addition to health care procedures and diagnosis. This touches on an important feature of comprehensive health care. At Blue Mountain Clinic one of our core values is to discuss options for treatment in the context of an individual's financial means and assist our clients in making efficient care decisions. This consultation is not necessarily recognized as a reimbursable service, however it is crucial to quality health care. Blue Mountain Clinic has been supporting clients' access to affordable health care for over thirty years.

Another point that you made is how **expanding prevention efforts** will be crucial in the containment of costs related to disease and treatment. One key point that I hope to see addressed in upcoming reform is **reproductive health care issues** that correlate to innumerable negative health care outcomes in our country.

Blue Mountain Clinic is often associated with abortion care, which is frequently at the center of political debate in the context of prevention. I would like to emphasize our position on this aspect of health care. **We need to take a long hard look at the reasons for abortion, lack of birth control use, access to preventative care, and the economic burden placed on women and the health care system.** The average woman will have approximately thirty years of reproductive health care over the course of her lifetime. This will include STD prevention and birth control management for the years she is sexually active. Following pregnancy, the cost of prenatal care, delivery and care for herself and her children will be added to the other reproductive health care needs. This is central to primary care and represents a significant

portion of health care costs over the span of thirty years. There is good economic analysis about unintended pregnancies and how this impacts health care costs, particularly for women with limited resources and necessary reliance on public assistance after pregnancy.

The prevention of unintended pregnancy needs to go beyond the assignment of responsibility. **Our health care systems need to address comprehensive sexuality education for youth**, access to birth control, regardless of age, and complete options for women facing an unintended pregnancy. **Please push the envelope and discuss the necessity of prevention efforts that go beyond individual ideology and encompasses the realities that face today's youth.** We can agree that parents should be providing information to their kids about sexual health, and that different family values influence the decision making youth face with sexuality. The truth is that we don't do enough to protect our youth. **The increasing incidence of STDs and teen pregnancy reflect the real issue that needs to be addressed.** We can no longer accept confusing and misleading rhetoric about healthy sexuality issues when it comes to the needs of our youth. For too long the guiding message has been that providing information and resources causes youth to engage in riskier behaviors. I challenge us to look at models of inclusive reproductive health care where more access to birth control and abortion decreases rates of disease and unintended pregnancy. As a parent of two teenage daughters I find it imperative on both a personal and professional level that we change the dynamic of reproductive health care for the next generation.

A basic premise of health care quality is evidence based medicine and use of research to guide practice decisions and increase efficiency of service delivery. **In reproductive health we have experienced too often in the last decade a cloak of conservative values taking precedence over science.** Until we can accept the individual choices that need to be available, accessible and addressed in primary care we can never match the efficacy of other industrialized nations' health care. I believe this aspect will be key to a long term solution in the health care crisis.

Funding for comprehensive sexuality education, birth control and access to abortion care is essential to public health. I urge the Senate Finance Committee to utilize reproductive justice models to outline reform to State and National health care systems.

In reviewing reports outlining the profit levels of Montana's insurance companies, it is exceedingly clear that the balance is tipped in the wrong direction of profits, without consideration for patients or the clinicians who take care of them. **Health insurance, malpractice premiums and medication costs are three primary culprits in the health care crisis.**

Increasing amounts of administrative time and technological upgrades are required to process insurance claims and advocate for patients seeking insurance reimbursements. Continuous

follow up and re-submission of claims becomes necessary to get reimbursements in many cases. **Managing the billing process has changed significantly in health care provision to match the complicated, erratic and sometimes arbitrary third party process.** Often the provider is left to explain the lack of coverage to patients who expect their claims to be covered by their insurance, for which they or their employers pay significant premiums.

Blue Mountain Clinic's mission reflects our commitment to patients and therefore we do not limit access based on the type of insurance clients have.

The income Blue Mountain Clinic receives for care is impacted by the levels of reimbursements dictated by insurance carriers. Public insurance is paid out at a rate that in some cases doesn't match the actual costs to provide care, leaving many who are covered under this system with a lack of provider options. Some health care systems have limited their acceptance of new patients with public assistance. Recent Medicare changes have resulted in a dynamic where some providers are not willing to accept their long time patients who are insured under this program. Our clinic is not a federally recognized health center, which would designate a higher reimbursement rate for public insurance. We are also not funded to provide sliding scale or free care. The discrepancies in our income for services and the cost of provision is balanced by the private donations of individuals and Foundations willing to fund the inadequacies of our system. Many care facilities do not accept insurance of any kind and provide care for cash only. The administrative costs are reduced and the clients are responsible for paying at the time of service. This option is a growing trend, however this model is not always conducive for consistent care and patient management. **These instances of profits dictating access to care need to be recalibrated for true reform of the health care system.**

In 2008 Blue Mountain Clinic initiated an employer based health care plan for our staff. After reviewing the plans offered by the key insurers in the state, we finally accepted a plan with a fairly high deductible. The premium rates were more expensive in several cases than those rates from self-insured plans. We anticipate a premium increase at renewal in 2009. Many of our staff are not in a position to cover the entire expense of the deductible and may have challenges in paying out of pocket expenses for care not included in the small preventative allowance. As a clinical provider we include a care benefit for all employees that helps offset this gap. **What was highlighted in the process of reviewing options for a health plan is how little is offered for the price, and that having insurance is not always a guarantee for affordable health care.**

This experience also speaks to the small business/employer dilemma of maintaining coverage for employees that was central in your principles. Please also consider how non-profit small businesses will be impacted by mandates to insure their employees. **Another principle of**

health care reform discussed is the use of internet technology and electronic medical records to create more comprehensive systems. In this aspect of reform it is critical to consider the costs for implementing these systems to small businesses providing health care. Subsidies will need to be created for health care providers such as Blue Mountain Clinic, in order to keep our practice sustainable.

Health insurance reform is a key aspect to improving the health care system in the United States. Primary health care needs to be accessible to everyone without regard for profit in order to change the tide of this crisis. **Blue Mountain Clinic has been independently offering low cost, high quality primary and comprehensive reproductive health care for thirty-two years.** This model of health care is efficient, comprehensive and based on patient centered care principles. It is our hope that we will be invited to the negotiating table and assist in the formulation of a successful health care model for our future.

Best regards,
Anita Kuennen, RN
Executive Director



October 21, 2008

My name is Molly Moody and I am the statewide organizer for Montanans for Health Care, a branch of the Health Care for America Now campaign. For over three months, I have spoken with hundreds of Montanans about the Health Care for America Now! campaign. To date we have a coalition of 29 organizations statewide who support the HCAN principles. In our coalition we have health care providers, small business owners, community members, clergy, and educators among others.

Our broken health care system affects not only the uninsured but also people who have coverage they can't count on. Earlier this month, we sent letters to Blue Cross Blue Shield of Montana and New West Health Services, asking them questions about their practices on handling claims, rejection of applicants with preexisting conditions, and premiums. Since we are concerned that we are paying more money for less coverage, we also asked a question on the cost shift from insurers to the insured. These are critical questions. So far, we haven't heard back.

The Montanans for Health Care coalition supports you and your commitment to health care reform and believe it will take all of us to make universal coverage a reality here in Montana and across the nation. Our first step is to have agreement on our HCAN principles which have a lot in common with yours. Senator, we ask that you sign-on to our campaign and join the ranks of lawmakers who have—as of Wednesday, Oct 15 we have 95 members of congress that have signed on (House: 85, Senate: 10)

Jan B. Newman, M.A. M.D. , FACS, ABHM
3436 Mountain Dr.
Clinton, MT 59825
10/20/2008
jnewman@whitehorseheaven.com
406-258-6284

Senator Max Baucus

Dear Senator Baucus,

I am writing this to convey my deep concern about the current state of medical practice in the US. As you know we have fallen from first place in health care to ranking in the twenties. There is great disparity of the health care delivered to the wealthy and that which is delivered to the remainder of the population. We have gone from a care driven "the patient must come first" to a financially driven system of the "money comes first." This has led to a system where the health care system is a patient in critical condition in the intensive care unit who is hemorrhaging itself and society to death.

I will give you examples of the problem from my personal experience. About one year ago I was diagnosed as having a large benign tumor in my colon which would require surgical intervention. I also had a paraesophageal hernia which could potentially be life threatening. I had an extensive workup here in Missoula and then elected to have surgery performed by one of my laparoscopic surgery mentors at USC. So both major procedures could be performed in the same operation. He was an esophageal specialist and he would have an expert in laparoscopic colon surgery perform the colon resection. The offices of these surgeons called my insurance company and got approval from World Insurance as did I.

Two days prior to my leaving for California I received a phone call from USC's financial department requesting a \$5000 up front payment as my policy had a deductible. I refused, stating that the workup I had had here had consumed the deductible.

I had the remainder of my workup at USC and the surgeries were performed without complications. On Friday afternoon at 4:30 p.m, less than 24 hours after 2 major surgeries I received a call from the USC billing office informing me that my insurance company would not cover my medical care, how was I planning to pay for my care? In that this was Friday afternoon I was unable to reach the insurance company. Needless to say, this was somewhat stressful. The following Monday I reached my insurance company who said they would check into it, however, the approval that we had received was approval of medical necessity and not approval of reimbursement. The hospital was "out of network" and they might pay 60% of the bill. After further discussion they

agreed to pay as the hospital indeed was a subscriber of Beech Street which was the "mother company".

The surprises were not over. When I got home they refused to pay the physician fees. They would consider paying the out of network rates, but I would have to appeal. The out of network rates began the deductible over again and would pay 60/40. This would leave me with a minimum additional liability of \$10,000 for an out of pocket total of \$20,000.

At the same time I found out that one of my line of credit had been pulled. When I checked my credit score it had dropped from the high 700's to 626. It turned out that my brother had defaulted on a loan I had cosigned for him for emergency dental care. He had moved from Forth Worth Texas to Austin, Tx. And the mail had not caught up with him. He was late and the account was with G.E. Money Bank. Once the payment was late they locked him out of their computer and phone pay system. When he had tried to speak with someone to rectify the problem, he was put on perpetual hold, then told the bill was in collections. No one had made any attempt to contact me to let me know there was any problem with this account. After a myriad of phone calls to the collection agency who said they didn't have that account, to numerous departments at G.E. Money and hours and hours on hold, I was finally able to find someone who allowed me to pay off the account. They continued to show a balance on this account despite the fact it was paid. Months later they sent a report to the credit agency stating I was 60 days late on a payment of 0 dollars. This once again sent my credit score down. G.E. has refused to take any responsibility for their part in this fiasco and have refused to amend my credit report.

It turns out that these financial instruments are now being utilized in large numbers of of physicians and dentist offices. They have zero percent rates if the balance is paid in full by the designated time. If it is not they accrue close to 30% interest for the term of the loan and late fees. My brother's \$1000 dentist bill was over \$2000 by the time I found out there was a problem.

The money issue pervades medicine now with doctors and hospitals refusing treatment unless they receive money up front.

Another surprise I was to have was that the hospital billed me usurious amounts for supplies. Two days of nasal oxygen was over \$2000. A \$2.00 I.V. fluid bag was \$200, etc. There were numerous supplies for which I was billed that I never received.

I have medical students complaining to me that they are not being taught to be doctors. They are being taught to order tests and push drugs.

What are the solutions?

- 1.) Insurance and finance companies should be phased out of medicine. They add 15-20% overhead to health care and drain physician time and resources. The requirements of approval and billing have almost precluded solo practitioners from the practice of medicine as they have to employ a separate person solely to handle insurance.
- 2.) There needs to be better auditing of patient bills and if hospitals are found to "salt" patient bills they need to be fined or prosecuted
- 3.) The Hippa laws need to be repealed. The preexisting confidentiality laws gave ample protections
- 4.) For profit hospitals need to be phased out. It pushes physicians to order more tests and procedures.
- 5.) Insurance companies must be phased out of the health care industry. The *administrative costs of insurance and their multiple costs.*
- 6.) Optimally there needs to be a single payer system. There should not be multiple tiers of medical care.
- 7.) There should be certificates of need for MRI'S, CAT scanners etc. Currently there are atleast 6 scanners in Missoula's catchment area.
- 8.) Programs need to be instituted to reeducate medical students and physicians for compassionate care of patients
- 9.) Hospital administrations need to be trimmed and a return to the emphasis of bedside care must occur.
- 10.) Exorbitant salaries for hospital administrators need to be curtailed.
- 11.) Appropriate independent oversight needs to look at the appropriateness of medical intervention on a case by case evidence based approach.

Thank you for your attention.

Sincerely,

A handwritten signature in black ink, appearing to read "Jan B. Newman". The signature is fluid and cursive, with the first name "Jan" and last name "Newman" clearly legible.

Jan B. Newman, MD



**Testimony of Tannis Hargrove
Grassroots Organizer, Public Affairs Department
Planned Parenthood of Montana**

For the Hearing on High Health Care Costs: A State Perspective

**Before the United States
Senate Finance Committee**

October 21, 2008

Summary of Testimony of Tannis Hargrove

Chairman Baucus and members of the Committee, thank you for the opportunity to testify today on behalf of Planned Parenthood. For more than 90 years, Planned Parenthood has been the nation's leading reproductive health care provider, educator, and advocate. With a presence in all 50 states and the District of Columbia, Planned Parenthood operates more than 880 health centers across the country. Here in Montana, Planned Parenthood operates six health centers and eight rural clinic sites. As a safety net health care provider serving more than 20,000 Montana patients annually, Planned Parenthood of Montana understands the impact of rising health care costs and the need for reform to ensure that all Americans can access quality, affordable health care.

Planned Parenthood is on the front lines of the health care delivery system. For many uninsured and underinsured women, Planned Parenthood may be the only health care provider they see.

At Planned Parenthood, we believe we can build a better health care system, one that guarantees:

- Affordable and high-quality health care, including comprehensive reproductive health care, for all;
- Direct access, including self-referral, to trusted providers of choice;
- A sufficient supply of adequately compensated providers;
- Investment in prevention as a top priority; and
- Real efforts to reduce health disparities.

When designing health care reforms, women's needs must be taken into consideration.

- Women are more frequent users of health care services than men
- Women tend to have higher out-of-pocket medical expenses than men
- Women are more likely than men to require prescription medications, like hormonal contraception
- Women suffer chronic illnesses more often than men
- Women are more likely to make health care decisions for their families
- Because women are on average paid less than men, they are less able to afford premium hikes and large out-of-pocket costs

Moreover, we must address the many and varied barriers that make health care inaccessible for millions of Americans, including:

- High Cost: 25 percent of women report delaying or skipping care because of cost.
- No Insurance Coverage: Uninsured women are more than twice as likely as those with insurance to have not received a pap test in the last year.
- Limited Hours of Service: 1 in 5 employed women report delaying or going without care because they could not take time off work.
- No Neighborhood Providers: 17 percent of low-income women report that lack of transportation has impacted their access to health care – this is 6 times the rate for women with higher incomes.

- Shortage of Nurses: The United States is facing a critical shortage of nurses, which is expected to grow to more than one million by 2010.

With the growing economic crisis in this country, America cannot continue to lag behind the world, wasting billions on inefficient health care that fails to adequately protect our nation's health. As we work to address the soaring cost of health care, we have an important opportunity to include key reforms that will ensure affordable, accessible, high-quality, comprehensive, culturally appropriate care for all. We can afford nothing less.

Planned Parenthood – Helping to Fill the Growing Need for Quality Health Care

Our health care system is broken and needs immediate attention. With 45.7 million Americans lacking health insurance (153,000 in Montana), safety-net providers like Planned Parenthood are helping to fill the growing need for affordable health care.^{1,2} Nationally, the vast majority of Planned Parenthood's patients live at or below 150 percent of the federal poverty level, earning less than \$32,000 for a family of four. For many uninsured or underinsured women, Planned Parenthood is the only health care provider they know.

Planned Parenthood is on the front lines of the health care delivery system, providing basic preventive health care to millions of individuals every year. In fact, ninety-seven percent of Planned Parenthood's health services are focused on prevention; we help to keep women, men, and teens healthy, and empower women and couples to plan their families.

One in four women has visited a Planned Parenthood health center in her lifetime. Our unique position has earned us the trust not only of our patients, but also of more than four million supporters, donors, and activists who mobilize behind the Planned Parenthood women's health agenda. Based on our unique personal connection with women and our status as a trusted health care provider, women place a premium on Planned Parenthood's voice in advocating for important health care issues. We do not take that trust lightly.

We see the disparate state of health care access in America as a fundamental call to action. Planned Parenthood is committed to advocating for health care reform efforts that ensure women's health care is protected and that every person has access to high quality, affordable, and confidential care.

America's Growing Health Care Crisis

The demand for quality, affordable health care is urgent. More than 70 million Americans do not have the insurance coverage necessary to meet their health care needs because they are either uninsured (45.7 million) or underinsured (25 million).^{3,4} Rising premiums and growing out-of-pocket health care costs are taking up an increasingly large chunk of American families' budgets. In 2007, one quarter of women (25%) reported delaying or skipping health care because of cost.⁵

¹ DeNavas-Walt, C et al., *Income, Poverty, and Health Insurance Coverage in the United States: 2007*, U.S. Census Bureau, August 2008.

² Kaiser Family Foundation, *Health Insurance Coverage of the Total Population, States (2006-2007)*, U.S. (2007), www.statehealthfacts.org (Accessed October 20, 2008).

³ DeNavas-Walt, C et al., *Income, Poverty, and Health Insurance Coverage in the United States: 2007*, U.S. Census Bureau, August 2008.

⁴ Schoen, K et al., *In the Literature: How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007*, Commonwealth Fund, June 2008.

⁵ Kaiser Family Foundation, *Women and Health Care: A National Profile*, July 2005, <http://www.kff.org/womenshealth/whp070705pkg.cfm> (Accessed August 15, 2008).

While lack of insurance coverage is often a huge barrier to getting care, even for those with insurance a host of other obstacles may exist. For example:

- 1 in 5 employed women report delaying or going without care because they could not take time off work.
- 17% of low-income women report that lack of transportation has affected their access to health care – this is 6 times the rate for women with higher incomes.⁶
- In the United States, about half of all pregnancies are unintended, with 42% ending in abortion. Yet only 62% of states require that comprehensive drug benefit plans include contraception.⁷
- The United States is facing a critical shortage of nurses across all sectors of the health care system. In 2007, U.S. hospitals alone needed an estimated 116,000 registered nurses to fill vacant positions, and the number of nurses needed overall is expected to grow to more than one million by 2020.⁸

The United States continues to rank far below many countries on health care quality. While we spend almost twice as much on health care as any other country, we rank only 37th in the world on overall health care system performance.^{9/10} Among 19 industrialized nations, the U.S. ranks last in the number of deaths that could have been prevented with quality health care.¹¹ Strikingly, the U.S. ranks 41st among 171 countries in the United Nation's ranking of maternal mortality.¹²

High quality, accessible health care is essential to improving health outcomes for all Americans. Simple improvements like increased access to prenatal care can make an enormous difference. With 6.9 deaths per 1,000 live births, the U.S. ranks 27th in the world on infant mortality. But the rate is six times lower among women who begin prenatal care in the first trimester compared to those women who receive no prenatal care.¹³ Focusing on health care reforms that meet women's needs is critical to the health and prosperity of our nation.

⁶ Kaiser Family Foundation, *Women and Health Care: A National Profile*, July 2005, <http://www.kff.org/womenshealth/whp070705pkg.cfm> (Accessed August 15, 2008).

⁷ V.C. Bunce and J.P. Wieske, *Health Insurance Mandates in the States 2008*, Council for Affordable Health Insurance, http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2008.pdf.

⁸ Steinwald, AB, *Primary Care Professionals: Recent Supply Trends, Projections, and Valuation of Services*, Testimony Before the Committee on Health, Education, Labor, and Pensions, U.S. Senate, United States Government Accountability Office, 2008, <http://www.gao.gov/new.items/d08472t.pdf> (Accessed September 4, 2008).

⁹ Total national health care spending in the United States topped \$2 trillion in 2007. (Centers for Medicare and Medicaid Services, *National Health Expenditures, Forecast Summary and Selected Tables*, Office of the Actuary, 2008.)

¹⁰ World Health Organization, *World Health Organization Assesses the World's Health Systems*, http://www.who.int/whr/2000/media_centre/press_release/en/ (Accessed August 15, 2008).

¹¹ The Commonwealth Fund on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance*, 2008, July 2008.

¹² World Health Organization, *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA and the World Bank*, 2007, http://www.who.int/whosis/mme_2005.pdf (Accessed August 28, 2008).

¹³ Mathews, TJ and MacDorman, MF, "Infant mortality statistics from the 2005 period linked birth/infant death data set," *National Vital Statistics Report*, 2006, 57(2):1-29.

Meeting Women's Needs

Women consume health care differently than men, and therefore face unique problems when it comes to access. Women are more frequent users of health care services than men, in part because women's reproductive health care needs require regular check-ups throughout their lives. Women are more likely than men to see a health care provider regularly, more likely to suffer from chronic conditions requiring regular care, and more likely than men to use prescription drugs (like hormonal contraceptives) regularly.¹⁴ This greater use of services, combined with women's lower average income, leaves women with higher out-of-pocket medical expenses than men as a share of their income.¹⁵

In addition to utilizing health care differently than men, women are more vulnerable to problems accessing affordable health care. In 2007, 63 percent of non-elderly adults were covered by private, employer-sponsored health insurance. Among women, 38 percent were insured through their own employer and 25 percent were covered as dependents on another person's job-based coverage.¹⁶ Accessing coverage through their spouse's employer leaves women more vulnerable during times of divorce, retirement, death, or other disruptions. In the individual insurance market, women face other unique barriers to accessing coverage: women may be charged higher premiums than men, women may be denied coverage because they are survivors of domestic violence, and women may be unable to purchase coverage that includes maternity care.¹⁷

Women have a critical stake in health care reform. As the primary health care decision makers in most families, women's unique health care needs must be considered in any reform effort. Eighty-four percent of women believe that guaranteeing access to health care is a very important priority for Congress and the President.¹⁸

Key Reproductive Health Issues

Any health care reform effort must ensure access to the full range of reproductive health care services. Women, men, and teens need access to affordable, quality reproductive health care. At present, over 17 million women need access to publicly-funded family planning services, yet America's family planning program is dramatically under-funded, Medicaid lacks parity in access to family planning services, and birth control prices have skyrocketed for low-income women and college students. With improved access to affordable birth control, more women can take individual action to manage their fertility and reduce the more than 3 million unintended pregnancies that occur every year in the U.S.

¹⁴ Kaiser Family Foundation, *Women and Health Care: A National Profile*, July 2005, <http://www.kff.org/womenshealth/whp070705pkg.cfm> (Accessed August 15, 2008).

¹⁵ Patchias, EM and Waxman, J, *Women and Health Coverage: The Affordability Gap*, The Commonwealth Fund, April 2007.

¹⁶ DeNavas-Walt, C., Proctor, BD and Smith, J, *Income, Poverty, and Health Insurance Coverage in the United States: 2007*. U.S. Census Bureau, August 2008.

¹⁷ National Women's Law Center, *Nowhere to Turn: How the Individual Health Insurance Market Fails Women*, 2008.

¹⁸ Poll by Peter D. Hart Research Associates of 1,001 women and 307 men across the U.S. (July 17-24, 2008).

The rate of sexually transmitted infections (STIs) is also a grave public health concern. One in four teenage girls in the U.S. has an STI, and among African American girls, the rate is almost one in two.¹⁹ These infections can result in lifelong health and fertility complications. More than half of preventable infertility in the U.S. is related to STIs, principally Chlamydia and Gonorrhea. Chlamydia screening programs can reduce the incidence of pelvic inflammatory disease and potentially resulting infertility by up to 60 percent.²⁰

Access to comprehensive reproductive health care is essential to reducing the incidence of cervical cancer in the U.S. as well. The National Cancer Institute estimates that more than 11,000 new cases of cervical cancer will be diagnosed in 2008.²¹ Regular Pap screenings every three to five years could prevent four out of every five cases of cervical cancer.²² Unfortunately, uninsured women are more than twice as likely as those with insurance to have not received a pap test in the last year.²³ Access to vital reproductive health care services is critical to the reduction of preventable diseases and deaths.

Priorities in Health Care Reform

The numbers are undeniable: we have a health care crisis in this country and the effects on women are devastating. Planned Parenthood believes that all of us benefit from healthy communities and healthy families, in which every person has access to high-quality, affordable, and confidential health care from a provider of choice. Ensuring such access is a critical step in eliminating the poor health and gross health care disparities experienced by so many in this country. We support a health care system that prioritizes prevention and ensures that all individuals have the information and services they need to stay safe and healthy.

At Planned Parenthood, we believe we can build a better health care system, one that guarantees:

- High-quality, affordable health care, including comprehensive reproductive health care, for all – this means access to abortion, contraception, STI screenings and treatment, and maternity care among other services;
- Direct access to trusted providers of choice;
- A sufficient supply of adequately compensated providers;
- Investment in prevention as a top priority; and
- Real efforts to reduce health disparities.

Affordable: We must eliminate the cost barriers – the copayments, deductibles, and skyrocketing premiums – that prevent millions of Americans from accessing the health care services they

¹⁹ Centers for Disease Control and Prevention, *2008 National STD Prevention Conference*, <http://www.cdc.gov/stdconference/2008/media/release-11march2008.htm> (Accessed August 15, 2008).

²⁰ Centers for Disease Control and Prevention, *Report to Congress: Infertility and Prevention of Sexually Transmitted Diseases 2000-2003*, November 2004, <http://www.cdc.gov/std/infertility/ReportCongressInfertility.pdf> (Accessed September 12, 2008).

²¹ National Cancer Institute, *Cervical Cancer*, <http://www.cancer.gov/cancertopics/types/cervical/> (Accessed October 20, 2008).

²² National Committee for Quality Assurance, *The State of Health Care Quality 2007*, http://www.ncqa.org/Portals/0/Publications/Resource%20Library/SOHC/SOHC_07.pdf (Accessed September 12, 2008).

²³ Kaiser Family Foundation, *Women's Health Insurance Coverage*, February 2007.

need. Individuals should never have to choose between filling their birth control and filling their car with gas to get to work. Health care can be made more affordable by streamlining burdensome administrative procedures, promoting and reimbursing innovative and alternative delivery models like community-based services, and better utilizing cost-effective licensed professionals such as advanced practice clinicians and community outreach workers.

Accessible: Addressing access issues is absolutely key. An insurance card will not do any good if there are no providers in the area, hours are limited, or public transportation scarce. That is why Planned Parenthood health centers and other safety net providers in underserved communities play a central role in health care reform. For millions of women, we are their only access point to the health care system – they rely on us for the full range of reproductive health care services. We must ensure that they always have a place to go for that care.

High-Quality: High quality health care is essential to improving health outcomes for individuals and to improving the overall health of our nation. Seventeen years is the average time it now takes for new, more effective forms of treatment to be incorporated into routine patient care.²⁴ We must facilitate and reward the timely provision of evidence-based health care that is fully evaluated and supported by providers. Over 40 percent of Americans reported that they or a family member had received the wrong care at some point in time.²⁵ We must work to eliminate medical errors and promote patient-centered health care that is responsive to individual patient preferences and needs, and values the role of the patient in all clinical decision-making.

Comprehensive: The U.S. health care system is currently focused on treating illness rather than maintaining good health. Anticipating and addressing health care concerns before they become serious not only prevents unnecessary suffering, but also saves millions of dollars in health care costs. Wellness and preventive services are key components of comprehensive health care. Prevention is good health policy, and it is essential to the effective and efficient management of our limited health care resources. Prevention has always been the cornerstone of clinical services at Planned Parenthood. In fact, 97% of our health services are prevention-based to keep women, men, and teens healthy.

Culturally Appropriate: Serious health care differences exist in the U.S. based on race and ethnicity, many directly linked to economic hardship, cultural and language barriers, and discrimination in the delivery of services. Ensuring high-quality health care means recognizing unfair health care access and treatment and proactively seeking to ensure that everyone has access to the medical care and information they need, in a culturally and linguistically appropriate manner. We must create a pipeline of culturally competent providers by supporting appropriate education and ongoing training, and we must also cultivate and maintain a robust pool of culturally competent providers. Reimbursing for the extra cost associated with providing culturally and linguistically appropriate health care services and health education is essential to ensuring adequate access to these services.

²⁴ Greiner, AC and Knebel, E, *Health Professions Education: A Bridge to Quality*, Institute of Medicine, National Academy Press, Washington, DC.

²⁵ McGinnis, M., *Case for Evidence-Based Medicine*, Institute of Medicine Background Brief, <http://www.iom.edu/CMS/28312/RT-EBM/55066/55225.aspx> (Accessed August 15, 2008).

Conclusion

With the growing economic crisis in this country, America cannot continue to lag behind the world, wasting billions on inefficient health care that fails to adequately protect our nation's health. As we work to address the soaring cost of health care, we have an important opportunity to include key reforms that will improve the health and wellness of our people. We can do so by focusing on the principles outlined above, which will ensure affordable, accessible, high-quality, comprehensive, culturally appropriate care for all. We can afford nothing less.

October 27, 2008

Hon. Max Baucus
Chairman
U.S. Senate Committee on Finance
Washington, DC

Re: Hearing on "High Health Care Costs: A State Perspective,"
October 21, 2008, Missoula, MT

Dear Senator Baucus:

I attended the hearing last week and had a comment. I didn't really hear anything mentioned about healthcare and end of life issues. We (society as a whole) already spend a large portion of Medicare dollars on end of life care—typically the last six months of life. Obviously, with the aging population, this will become even more of an issue over time. Research tells us that our healthcare teams (primarily physicians but most all on the healthcare team) are neither effective nor pro-active in engaging aging patients, patients with chronic life-limiting illnesses, or the general public in conversations around end of life. I am not talking about limiting treatment or care. I am talking about facilitating a meaningful patient/family-centered conversation about goals of treatment—the meaning of quality of life as relates to ongoing care and treatment—and revisiting the conversation early and often throughout the trajectory of either aging or illness—documented through an Advance Directive or Living Will or document of choice. The MAIN issue is the meaningful conversation. Research also tells us that many times our patients do not want extended treatment and would like to spend final days with family in a setting of their choice—which in many cases is NOT the hospital setting. So, while healthcare reform is on the agenda, I feel end of life issues need to be on the table as well.

Thanks much,
Shelly Roy

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October 20, 2008
Missoula Montana

Health Care Provider/Physician

Hello Senator, my name is Megan Sarnecki and I work for Partnership Health Center, Missoula's Federally Qualified Community Health Center.

As a health care provider that serves primarily those without any insurance, or those who are uninsured, I am at the front line of the crisis in the American health care system. As you are well aware the American health care system is broken. I see patients who are disabled and sick but have treatable conditions if they only had the means to pay for their treatment. I see patients who regularly use the emergency room because they cannot afford to seek health care in a clinic where they are asked to pay up front for their health care. I see patients who die of treatable cancers, diabetes, mental illness, and infections. Many of these patients work at low paying jobs that do not provide health care coverage –others have lost their health care coverage due to illness which renders them unable to work.

Patients whose illnesses were once easily treated in outpatient settings end up much sicker and with costlier care due to delays caused by lack of insurance. Day after day, I see people who are at the brink of financial and physical disaster. The use of the Emergency Room as primary care provider is out of control and as we all know, ER care is incredibly expensive.

People who are ill and cannot afford health care are constantly navigating systems of disability and medicare to try to help themselves and their families. I have a patient who hopes that her ex-husband's \$6.00 child support payments will quit arriving since that amount of money causes her to make more than the limit for her children to be eligible for Medicaid but obviously does not allow her to purchase health insurance. I have many patients who apply for disability because their medical conditions prevent them from working to support themselves – because they are untreated. If these people were to get health coverage for their conditions and get needed therapies and surgeries many of them could go back to work, but then they would lose their disability benefits – one of which is their health insurance. It is a difficult line they walk and a very expensive one for the American taxpayer!

Senator Baucus, I know you care deeply about our health care crisis and I believe in your commitment for quality, affordable health care for all. I have seen your principles for health care reform and I agree with them but I think that we can do more.

I think that you know as well as I do that in the United States we have created an excellent wealth care system and a very poor health care system. Our system continues to generate

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wealth for a select few and very little health for many Americans. Even for those with the best insurance money can buy the best care is not guaranteed as even these patients are more likely to get costly treatments than effective treatments.

As a member of Montanans for Health care and the HCAN campaign, I think your principles are somewhat vague. The HCAN principles are more explicit and build upon what you have laid out.

There are a few points I want to highlight:

We must have an affordable public option and we must limit the power of insurance companies.

We believe that health care should be accessible to everyone in America, which is very different than health care for every American.

And, in your principles you mention the importance of affordability. I want to reinforce that and state clearly that health coverage costs and the out-of-pocket costs are related to a person's income. As you know, right now the cost of coverage has no relation whatever to income; health insurance costs the same for everyone regardless of how much you make—this must be changed.

Actually I truly believe that health care should cost the same for every American – nothing. All other industrialized nations have realized that like education or roads – if left to the free market we do not get a healthier population for our money – we get a large health care industry that continues to increase its own profits.

Thanks again for giving the community the opportunity to talk with you about this crucial issue. All I ask is that you sign on to the HCAN principle and Statement of Common Purpose so we all have agreement on what we want to achieve: guaranteed, quality, affordable, health care for ALL. Thank you.

Sincerely,

Megan Sarnecki MD
Family Medicine Physician
Partnership Health Center
323 W. Alder St.
Missoula MT 59802

Statement for Senator Baucus and the Senate Finance Committee

**Senate Finance Committee Hearing, Missoula, MT
21 October 2008**

**Submitted by
Dr. Teresa Sobieszczyk**

Problems Gaining Access to Health Care Services in Remote Areas of Montana
By Dr. Teresa Sobieszczyk

Chairman Baucus and members of the United States Senate Committee on Finance, I am honored to have the opportunity to submit testimony to you about the problems of health care in rural communities of Montana and the United States. I am an associate professor in the Sociology Department of the University of Montana and am currently working on a cross-national research project on access to health care and health care decision making in remote rural areas of Montana and Thailand. I should note that my testimony represents my own views and not the views of the University of Montana or the Department of Sociology.

In the debate about health care reform, it seems to me that even if we find answers to the problems of insurance and under-insurance and manage to control rising health care costs, we will not have dealt with access to and quality of health care in rural areas of the United States. These are separate problems requiring separate solutions.

First I will review some evidence about problems in accessing high quality health care in rural America in general and Montana in particular. Then Second, I will examine some of the reasons why these problems exist. And finally, I will explain some promising solutions to these problems.

Problems in Accessing Quality Medical and Dental Care in Rural U.S.

The twenty percent of Americans living in rural areas faces higher rates of chronic illness and poorer overall health than their urban counterparts. Rural residents are older, poorer, and have fewer physicians and dentists to care for them. In U.S. states and territories, there are 2,157 Health Professional Shortage Areas (HPSAs) in rural and frontier areas, compared with 910 in urban areas (NRHA, 2007).

A nationwide shortage of doctors specializing in primary care is compounded by uneven geographic distribution. Similar problems exist for mental health professionals and pharmacists. In 1999, 87 percent of the 1,669 Mental Health Professional Shortage Areas in the U.S. were in non-metropolitan counties where more than 30 million people live (NRHA, 2007). Pharmacy vacancies particularly severe in Public Health (11 percent vacancy rate), with some VA and Native American Health centers experiencing vacancy rates of 50 percent.

According to a 2005 survey, nine percent persons aged 65 and over reported being unable to access health care because of cost cited transportation as the barrier (Okoro et al, 2005). Transportation costs are barriers to accessing needed health care, particularly an issue in remote rural areas or frontier communities where the nearest doctor or hospital may be 30 or even 100 miles away, and the nearest provider of cancer services such as radiology may be hundreds of miles away.

The disparity between rural and urban health access is intensified because rural residents are less likely than their urban counterparts to have employer-provided health care coverage or prescription drug coverage. Moreover, the rural poor are less likely to be covered by Medicaid benefits than their urban counterparts (NRHA, 2007).

Problems in Accessing Quality Medical and Dental Care in Rural Montana

What is the picture in Montana? In 2006, 16.6 percent of Montanans lacked health care coverage (BRFFS, 2007), a rate which parallels national rates (USDA Rural Assistance Center, 2007). More than

twenty-six percent of Montanans reported having no usual primary care provider, and over twelve percent reported not being able to see a doctor because of cost (BRFFS, 2007).

Geographic size, together with low population density, have made it financially less attractive or viable for private health care providers to set up shop in Montana, particularly in rural and frontier areas of the state. Most of Montana is classified as medically underserved, with most of the state in designated Health Professional Shortage Areas (HPSAs) (MDPHHS PCO, 2007). Similarly, most of the state, is designated as medically under-served areas or populations. According to Montana Medical Association Directory data, in 2007, nine Montana counties had no actively practicing physicians, while seven counties lacked hospitals altogether. Frontier communities (populations 1,000-2,500) are particularly likely to have no or only one active physician. There are already too few registered nurses in the state, with estimated shortages of 500 by 2010 and 1,500 by 2015. The state has a low ratio of dentists to population (51.5 per 100,000, less than national average of 63.6 per 100,000). Indeed, thirty-five of Montana's 56 counties (mainly rural ones) are classified as Dental Health Professional Shortage Areas. The state is likewise plagued by a chronic and expanding shortage of clinical laboratory personnel. Sadly, Eastern Montana has most severe mental health shortage area in the U.S.

Because of the limited number of providers statewide, traveling to health and dental care providers is a significant problem for a sizeable portion of the rural population, particularly the elderly, disabled, and poor. Distance, winter weather, and inadequate or absent public and/or private transportation options pose significant barriers to timely and adequate health care. To get to their regular health care provider, seven percent of Montanans must travel between 51 and 100 miles, and an additional six percent travel between 31 and 50 miles (Traci et al, 2006). Nearly 20 percent of Montanans with a disability must depend on public transportation, taxis, or getting a ride with another to travel to their regular health care provider (Traci et al, 2006).

Obtaining high quality emergency care is even more problematic for rural Montanans. About three-quarters of the state's rural emergency medical service providers are volunteers ("Getting our Hands around the Data for Montana's Rural Health Plan," 2005). This figure is especially disturbing given that Montana is projected to become the 3rd most aged state in the U.S. by 2020, with 25 percent of our population aged 65 and above. This population aging, in conjunction with the high and growing demand for EMS transport by seniors, suggests a crisis in emergency medical services in most rural parts of the state. A fire chief of one small remote rural community, better funded than almost any other frontier community in Montana state because of a local tourism tax revenues, nonetheless complained of the difficulty in recruiting and retaining EMTs or even one paramedic given competition with larger emergency serviced providers in nearby cities. The EMTs with whom he staffs his ambulance can only give an aspirin to the patient in the midst of a heart attack during the hour or hour and a half long ride to the hospital. Despite his best efforts to retain sufficient numbers of EMTs and even a single paramedic, he remains unable to provide the same quality of emergency medical services as larger towns. This staffing problem, together with the distance to the nearest hospital providing emergency services, may mean the difference between life and death to frontier residents.

Why access to high quality health care in remote rural areas is so uneven

In Montana, much as other predominantly rural states, we have a patchwork of payment schemes and service providers: Medicare, Medicaid, Veteran's Administration facilities, Indian Health Service Clinics, monthly visits from public health nurses, private health clinics, charity through hospitals or clinics, and so on. Unfortunately, this patchwork is not pieced together well, and people are falling through the cracks.

Having access to health insurance or government-provided health services does not necessarily enable access to adequate, timely, high quality health care for rural folk. Other issues such as the lack of providers of various services in rural areas, the quality of available providers in such areas, and the physical distance to labs, hospitals, dentists, and even primary care physicians make it hard for rural dwellers to gain access to the health and dental care they deserve.

In Montana, Rural Health Clinics, where they do exist, tend to be staffed only part-time, usually five days a week for limited hours per day. Frequently they are staffed by physician assistants or nurse practitioners, not physicians. Typically, such clinics have very limited laboratory services available. Where local health clinics are available in frontier communities, some residents complain of high costs; providers explain that they try to tweak the system to cover the uninsured by billing the insured or better-off more. Other frontier residents distrust the nurse practitioner or physician's assistant in their local rural clinic and so postpone or avoid obtaining needed medical care and monitoring of chronic health conditions.

Pharmacies are disappearing from the state's small communities. In one frontier community in Montana, a retiring pharmacist tried for several years to recruit his replacement, only to fail. His pharmacy is boarded up. In rural communities, mail order pharmacies may be an option—for example, Ridgeway or Wal-mart will send out prescriptions. But, as a frontier town pharmacist pointed out, if people rely on mail order pharmacies for their regular prescriptions, eventually they will put the small pharmacists out of business. Then what will they do when their child need a brand new prescription to be filled right away? How far will they have to drive to fill it? Can their condition wait two, three, four days or more for them to get the prescription from a mail order pharmacy?

Requirements that Medicaid/Medicare patients access in-state providers, even when out-of-state ones may be nearer and/or easier to reach makes accessing health care more time-consuming, difficult, and/or expensive for poor and elderly persons, especially those in frontier areas where public transportation, taxi services, and the like are limited or non-existent. Winter weather makes many rural dwellers, particularly the elderly, too afraid to drive themselves to non-local providers. The distance to treatment is an economic as well as health problem in that children, the elderly, the infirm are likely to need a caretaker or parent to drive them to a distant health provider, likely causing that person to miss work. Transportation difficulties, fear of lost income (even a day's wages can be too high a cost for someone barely squeaking by), and high insurance deductibles (or lack of health insurance or publicly provided health care) mean that some rural Montanans aren't seeking needed treatment for chronic or emergency issues or are letting problems escalate until they are much more serious.

Difficulty in recruiting and retaining staff given both lower salaries and relatively lower amenities in remote rural areas makes it more difficult to staff even the limited number of available rural clinics, Critical Access Hospitals, and pharmacies.

Based on my research, an unsustainable over-reliance on private foundations, churches, and other community groups is emerging—they are tasked with providing transportation funding so that the poor may obtain health care, buying prescriptions, and covering medical expenses for the under- or un-insured. In Montana, such charitable groups include the Salvation Army, churches, Christian coalitions, private donors, clinics, etc.). Such charitable resources are over-extended, especially given the current economic downturn that is negatively impacting voluntary giving, and thus are unlikely to be able to meet chronic

and growing needs for economic assistance to enable access even to primary care (Gross, 2008; Changing Our World, Inc., 2008). The situation is dire indeed.

Solutions

To achieve quality health and dental care service in the U.S. (including inner city areas, remote and frontier communities), a “single payer” health insurance system would likely be insufficient. An insurance program, no matter how comprehensive, would not, in my view, solve the key problem of health care access and quality of service for those in rural areas. Without government oversight to help ensure that at least a basic level of high quality health services are provided and relatively easily accessible to everyone, rural dwellers, particularly the infirm, disabled, and elderly, would likely still be unable to access the health care they need, given the sparsity of facilities, high gas costs, lack of public transportation and taxi services, and other transportation difficulties. In my view, a socialized (state-sponsored) medicine approach in which the system pays health care providers of various types at similar rates and ensures adequate staffing at health clinics and hospitals throughout the country, including both under-served rural and inner city areas, would enable us to achieve more equitable access to the high quality health care in the U.S.

While state-provided health and dental care may be a hard pill to swallow, it seems that we are in need of such a program given that current private and public medical care omits so many, including those in the inner cities or geographically remote areas, those too well-off to qualify for Medicaid and yet unable to purchase their own health insurance, and those with very high health insurance deductibles that block them from obtaining needed health care. Having lived for nearly five years in Great Britain and Thailand (both countries with state-sponsored health systems), and based on my research on the Thai health system, state-sponsored health systems can provide a solid level of health care and, importantly, far more equitable access to the population than provided in the U.S. at present. In Thailand and Great Britain, fewer people fall through the cracks than with our present public/private patchwork of health and dental services in the U.S. At the very least, a state-sponsored health care system would help reduce the costs associated with health care reimbursement by reducing overhead and staff time spent by individual clinics and practitioners to fill out the multifarious types of paperwork currently required. Moreover, a state-sponsored health system may achieve economies of scale in terms of administration, as opposed to the current administration of numerous separate programs by a variety of different local, state, and national offices. It is sad, indeed, that America, the world’s “super power” offers what in many ways is *worse* access to health care than a “developing” country like Thailand.

While a socialized (state-sponsored) health care approach may be a goal to work towards in the long run, in the short run the current patchwork approach needs to be tightened and expanded in several areas to better ensure that the health needs and issues of rural populations are being addressed. This need is particularly important for children, elderly, infirm or disabled, who, on top of geographic remoteness, may have transportation difficulties compounding their problems in accessing primary or more advanced dentistry, medical, and mental health care.

1. Increase number of and transportation to Community Health Centers (CHCs)

Federally-funded Community Health Centers (CHCs) are key to providing access to primary and preventative services to millions of persons who would otherwise lack them due to poverty, geographical isolation, lack of doctors, and/or lack of health insurance. Employing a sliding scale and focusing on wellness and prevention, Community Health Centers currently serve one of every twelve rural residents in the U.S., some 5.4 million people nationwide. Montana has 18 CHCs, which also provide limited satellite

programs to offer seasonal migrant health care. Numbers of medical and dental patients and visits have increased quite dramatically between 2000 and 2007 (Frideres, 2008). Nonetheless, given Montana's size, people in many parts of the state lack easy access to a Community Health Center. In the context of snowy winters and deficient or absent public and private transportation services to link more remote communities with CHCs, the number of CHCs seems too low. Gaining access to the CHCs is most difficult for the poorest of poor, disabled, children, and elderly, who either cannot drive, or have no personal vehicle to drive. To help address these problems, the number of CHCs should be expanded, and a program to reimburse transportation expenses for clients to get to CHCs should be instituted.

2. Maintain support of Certified Rural Health Clinics and move to re-staff them with physicians

Certified Rural Health Clinics (CRHCs) are primary health care providers that are able to bill at cost for Medicare and/or Medicaid visits. They encourage and stabilize the provision of out-patient primary care in underserved rural areas through the use of physicians, physician assistants, nurse practitioners, and certified nurse midwives. To be certified, the clinic must be located in a rural area, as classified by the Census Bureau, and also be an under-served Health Professional Shortage Area or Medically Underserved Area. CRHCs are a vital part of a stop-gap measure to retain at least some access to medical care in remote or rural areas, and as such, warrant further financial support and perhaps even expansion.

However, in my judgement, this program actually highlights part of the disparity in the overall health care system that requires fundamental revision. Based on my research findings, one concern among rural dwellers who have used Certified Rural Health Clinics is that in some places, physician's assistants (PAs), nurse practitioners, and certified nurse midwives staff these clinics but are neither as well trained as physicians nor able to offer the full range of needed medical services or treatment options. Some rural folk in my study have reported delaying or not obtaining needed medical assistance because they prefer NOT to go to the only available local health care provider because that individual is not actually a doctor. To improve the quality of rural health care, the long term goal should be to ensure that *physicians* staff Certified Rural Health Clinics.

3. Invest in Critical Access Hospitals and move to re-staff them with physicians

To deal with rural health care access, Critical Access Hospitals are a worthy investment and may be a way to retain a health care provider in a remote, economically depressed rural communities like Ekalaka or Big Sandy. Critical Access Hospitals are limited service hospitals designed to provide essential, short term health services to rural communities. Our state presently has 47, of which three are Indian Health Service contracts. As the Montana Health Research Foundation (2007) suggests, "because of relaxed staffing requirements and cost-based reimbursement for Medicare and Montana Medicaid patients, converting a struggling rural hospital to a Critical Access Hospital can allow the community to stabilize and maintain local health care access." Such hospitals can play an important role in strengthening the patchwork quilt of health services available to rural folk and so deserve continued support.

However, once again, in order to ensure that rural Montanans and rural Americans in general have access to the same quality of health care as is available in larger towns and cities, I would urge reconsideration of staffing these with PAs and suggest investment in recruitment and other programs needed to make it more attractive for *doctors* to staff them. Expanding the Department of Health and Human Service's telehealth connections such as remote diagnostic abilities linking rural clinics with doctors at larger regional hospitals through cameras and the internet seem to have some potential as a temporary solution until such a time that positions in rural clinics can be staffed by physicians.

4. Strengthen Emergency Medical Services in rural areas through training and subsidizing EMTs and paramedics and expanding medical transport systems

In addition, we must consider new programs to strengthen the provision of emergency medical services in rural areas. EMTs and particularly paramedics are needed. Subsidizing their training and re-certification hours may help make it more feasible to employ them in rural areas, even if they serve as volunteers.

Emergency medical transport programs such as one based at the Idaho Falls Regional Hospital are useful in a system where crisis centers are located mainly at regional hospitals. It would be useful to make such transport systems even more widely available, which may require additional government subsidies.

5. “Home Grow” health care staff

One long-term approach to dealing with the lack of staffing Critical Access Hospitals, Rural Health Clinics, and Tribal Health facilities, and thereby improve health care quality and access in rural areas, is to “home grow” future health care providers by recruiting and training individuals from rural communities with health service needs as health providers to help ensure that they return to their communities. Tribal leader and health care expert, Kevin Howlett, also suggests the “home grown” approach to dealing with chronic staffing shortages in Indian Health Services facilities in Montana. I recommend expanding subsidies to train and recruit nurse practitioners, P.A.s, dentists, doctors, paramedics, pharmacists, occupational therapists, and the like, with a strictly enforced regulation that they repay their college fees through a certain number of years of service in a remote or rural area. Such efforts have had some success in rural Thailand. Various programs at the community or state level such as the Montana Primary Care Association help with recruitment of health practitioners in rural areas, but such efforts should be expanded to ensure their success.

6. Subsidize providers of rural health care

Beyond such training and recruitment efforts, additional measures will likely be needed to expand the number of health practitioners in rural areas. Because primary care providers in rural areas often face limited and/or uneven profits, besides allowing them to bill Medicaid and Medicare at cost as with certified Rural Health Clinics and Critical Access Hospitals, another option would be to actually subsidize rural clinics to make them economically more viable and hence more attractive to potential providers. If we rely strictly on free market forces to fill those positions, I fear that fewer and fewer will be filled over time, further weakening access to health care in rural areas. Moreover, to improve the quality of rural health care, as suggested above, such subsidies may be needed to ensure that *physicians*, rather than merely P.A.s or nurse practitioners, fill those positions.

Conclusion

According to my research in Montana, as well as cases from Nebraska, Idaho, and Wyoming, rural and frontier communities are increasingly turning to private donations and fund raisers to try to scrape together enough money to retain a practicing doctor or build and staff a clinic. The fact that members of tiny, rural communities are willing to take this on is a powerful indicator of just how much they want improved, nearby access to a doctor, clinic, and the appropriate staff for basic lab tests. While some of these very localized, private fund raising efforts work, at least for a year or two, most fail, perhaps when a key health care provider retires or decides to take a more lucrative offer in a larger town or city, leaving the town once again without access to even primary medical care. Could the local, state, and federal governments step in to help meet the needs that private citizens, bake sales, car washes, and the free market cannot? Is the loss of health, productivity, and longevity of rural populations an acceptable cost of retaining a malfunctioning, free market health system with its for-profit insurance companies and

urban- and specialist-dominated health system? One hopes that the current patchwork of military, public, and private health care can be re-stitched, stretched, and improved, at least in the short run, by following some or all of the recommendations listed above. However, though a resewn patchwork quilt may hold for a time, ultimately, a whole new fabric in the form of a more comprehensive health care system may be needed.

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Billings Listening Session – October 20, 2008

Thank you, Senator Baucus, for providing us this opportunity to discuss the healthcare problem we face in Montana and across the country. My name is Ashley Stevick and I am a community organizer for Planned Parenthood of Montana. Planned Parenthood is a member of Montanans for Health Care and the Health Care for America Now campaign.

As a major health care provider in Montana, Planned Parenthood sees nearly 20,000 patients each year who rely on us for the basic healthcare. This healthcare addresses prevention to make sure our patients live long and healthy lives. It includes breast and cervical cancer screenings, access to affordable birth control, and accessible health education and counseling to help them make good decisions. Most of our patients are uninsured or underinsured and rely on Planned Parenthood as their primary healthcare provider.

Senator Baucus, I know you care deeply about the health care crisis and I believe in your commitment for quality, affordable health care for all. I would urge you when considering any proposal to keep our patients in mind – and consider the model that Montana law already provides the women and families of Montana. We are one of four states that require health insurers to cover maternity care in all health insurance packages, and pregnancy cannot be used as a “pre-existing” condition to exclude women from coverage. We are also the only state in the nation that protects women from higher insurance costs across the board – health, life, auto, home – and this protection has helped thousands of Montana women afford the insurance that they and their families need.

We work hard every day to insure the health of our patients and recent price spikes from pharmaceutical companies and other suppliers cripple our ability to do so. Senator Baucus, we are counting on you to be an advocate for the people of Montana and to give us the tools to continue to provide quality healthcare.

Thank you.

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**Written Testimony of Dirk C. Visser
CEO, Allegiance Benefit Plan Management, Inc., Missoula, MT
Field Hearing of the United States Senate Finance Committee, Missoula, MT
October 21, 2008**

High Health Care Costs – A Self-Funding Perspective

Thank you for the opportunity to submit written testimony for the Committee's consideration, and for arranging for the Committee's appearance in Missoula, Montana.

Allegiance Benefit Plan Management, Inc., and the national trade organizations to which it belongs, present a different perspective on a major realm of healthcare coverage in Montana, that of the self-insured plans. Under self-funding, the employer pays for the claims costs directly, rather than through an insurance company, which reduces the overall costs for the employer and their employees.

Our Company

Founded in Montana in 1981 as a third party administrator (TPA), our company is located in Missoula, with Montana offices in Helena and Billings. The company has been a leader in the health benefits business in Montana for many years. We recently organized a domestic life and health insurance company to offer health insurance to small employers in Montana and regularly employ 200 people in this state. Our clients include a number of Montana municipal groups of cities, counties, school districts, and many major private employers, comprising 145,000 members served in health plans administered by our company in Montana and throughout the West.

SPBA and SIIA

The trade organizations to which our company belongs include the Society of Professional Benefit Administrators and the Self-Insurance Institute of America. These are national associations whose membership consists of third party administrators, employers, excess/stop-loss insurance carriers, captive insurance companies and others involved in promoting and protecting the self-insurance risk financing alternative for all forms of risk, including, in our company's instance, health benefits.

Scope of TPAs

TPAs provide services under contract to employers with self insurance programs. Client employers and benefit plans receiving comprehensive benefit plan administration include privately held businesses, large publicly traded corporations, union, state and local government plans.

It is estimated that more than 55% of US workers, from every size and format of employment, are covered by employee benefit plans managed by regional and national TPA firms.

Employer-Based System of Healthcare: Montana

Employer coverage remains the predominant form of health insurance coverage in the United States and Montana. In Montana, the ability of small employers to offer coverage is substantially affected by the cost of that coverage. The rising cost of health insurance in Montana is driven by the inflated charges billed by providers to employee benefit plans and the self-pay patients, often at hundreds or thousands of percentage points above the allowable Medicare billed amounts. Disclosure of costs prior to treatment and full pricing transparency in advance of providing care would assist patients in making informed choices for elective and non-emergency health care services. Fair and consistent pricing of health care services to all patients, regardless of who their employer is or which insurance plan they enroll in would facilitate better competition among health insurance payers and reduce overall health plan premiums for employers and employees.

Benefits of Self-Funding

With self funding, the employer pays claims and administrative expenses directly rather than through premiums to an insurance company.

Employers, using the self-funding approach with TPA administration, hold premium costs in line through evolving benefit design and administrative efficiencies. Self-insurance of health benefits is an effective mechanism in the cost control climate. With self-insurance, an employer doesn't buy an "off the shelf" product. Nor does it pay, in many instances, for services or benefits its employees don't use. The billing cycle is tied to month by month utilization of services as opposed to a set dollar amount paid for a fully insured product.

Employer-sponsored plans are natural risk pools and allow for strong negotiating power. Sharing of administrative expenses helps make employer-sponsored plans competitive.

TPAs offer employer clients value, competitive pricing, customer service, and flexibility, since TPAs can tailor benefit structures unique to the particular plans served.

Health Coverage Issues in Need of Solutions

Cost containment. Health care costs are increasing faster than inflation or wages. We have to address the unsustainable growth in the cost of health care. Increasing charges billed by providers for medical services could be addressed to a significant extent through measures to restrain overutilization of specialization in practice and procedures. Disincentives to limit overutilization include standard fees across the board for specified procedures, regardless of which payer the patient is enrolled with.

Controlling duplicative services and a simplified, transparent pricing system are tools that are available now.

Other concerns include coverage options for the unemployed and marginally employed; coverage choices for those who aren't covered through the workplace; the lack of reliable, accessible information concerning health care costs and quality outcomes by the prospective health care providers.

Third party payment by a health plan or insurance company tends to isolate consumers from the true cost of health care services. Full disclosure of health care services pricing and transparency in cost and quality outcomes can help individual patients make informed choices about their own health and their choices for health care service providers.

Comparative effectiveness evidence for alternative treatments would greatly assist insurance benefit design that has substantial potential for cost savings and reduction of medical errors. For example, value-based plan design could pay 100% for generics, diabetic drugs, blood pressure medication and treatment of lipid problems.

Promoting better health and disease prevention can be addressed through plan design, with effective wellness and primary care benefits for plan participants.

The health care system is oriented to sick care with provider payments driven by episodes of care. High cost procedures are often suggested rather than basic care management alternatives, which often are just as effective.

Aligning provider incentives to improve quality and efficiency, rather than the current focus on sick care episodes with fair, consistent pricing for health care services disclosed in advance of the procedures, will help with making health care more affordable and accessible to all.

Conclusion

Our company, and the trade organizations to which we belong, appreciate the leadership of Senator Baucus in tackling this incredibly complex, but important, set of issues.

In short, none of the items I have listed are novel or surprising. What is needed is the determination to make changes, and to assure that providers receive fair, but not excessive compensation for their services. Health care patients need to understand why these changes are needed, and to become informed and efficient consumers of health care.

Our company is prepared to help in any way that we can. We would welcome the opportunity to be of assistance.

