

**HEALTH CARE REFORM:
AN ECONOMIC PERSPECTIVE**

HEARING
BEFORE THE
COMMITTEE ON FINANCE
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HEALTH CARE REFORM: AN ECONOMIC PERSPECTIVE

WEDNESDAY, NOVEMBER 19, 2008

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:08 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Rockefeller, Bingaman, Wyden, Stabenow, Salazar, Grassley, Hatch, and Snowe.

Also present: Democratic Staff: Bill Dauster, Deputy Staff Director and General Counsel; Elizabeth Fowler, Senior Counsel to the Chairman and Chief Health Counsel; Yvette Fontenot, Professional Staff; Shawn Bishop, Professional Staff; Renee Carter, Fellow; and Elise Stein, Detailee. Republican Staff: Mark Hayes, Health Policy Director and Chief Health Counsel; Kristin Bass, Health Policy Advisor; and Jason Foster, Investigator.

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

The CHAIRMAN. The committee will come to order.

Before we begin our hearing today, I would like to make an announcement and also commend one of the smartest, most intelligent persons who has served in the Senate, not as a colleague, but as a member of staff, and that is Bill Dauster.

Today marks Bill's 20 years of service in the Senate. Bill Dauster is sitting behind me. He started his Senate career when he joined the Senate Budget Committee staff on December 22, 1986, and served a decade as Chief Counsel to that committee, then went on to be the Democratic Staff Director. Bill has also served as Democratic Chief of Staff for the Labor Committee and as Legislative Director for Senator Russ Feingold.

For the past 5½ years, Bill has served as Deputy Staff Director and General Counsel here at the Finance Committee. Bill is the expert, the Senate expert, on budget law and trade law procedures. He literally wrote the book on both. So, Bill, I congratulate you today on your 20 years of service in the U.S. Senate. [Applause.] Those of you who know Bill know that that is no idle statement: he is that good.

In Washington, people often present choices between alternatives, between option A and option B, and it is often the case that the right choice between option A and option B is neither, but "yes." The right choice is often to reject the false choice. We can

often, I think, in LBJ's famous phrase, "Walk and chew gum at the same time."

We are clearly facing, today in America, a significant recession. That economic challenge commands a significant investment of government resources. Some say that we will have to choose between fixing the economy and enacting comprehensive health reform. I reject that false choice. I say we can, and should, do both. We can walk and chew gum at the same time—not only can we, but we have to.

Health care reform is not a distraction from addressing the economy. Health care reform is central to restoring America's economy. The costs of inaction, both in human terms and in financial terms, are greater than the costs of reform.

The Nation's economy is hurting. Since January, we have lost more than 1.2 million jobs. That is the highest number in 14 years. The unemployment rate has soared to 6.5 percent; it was 4.4 percent just a year ago. The number of Americans who cannot find enough work jumped to 6.7 million, its highest level since 1993.

Some industries have been hit especially hard: manufacturing, construction, and retail trades have shed the most jobs. The unemployment rate in construction is now close to 11 percent, double what it was a year ago. It is clear that the economy is in a recession. Some economists even believe that we are headed for a deep recession. The question for Congress should no longer be whether to pass another stimulus bill, but how much, and what kind of stimulus is needed to get the economy on the right path.

This moment in history is not unlike the one faced by Franklin Roosevelt and the New Deal generation. Now, as then, solving America's economic challenges will require us to go forward with bold efforts. It will require a multi-faceted response. Comprehensive health reform legislation must be part of any successful economic recovery plan.

Last week, I released a white paper that calls on Congress to act on meaningful health care reform in 2009 that achieves coverage for all Americans, while also addressing the underlying problems of cost and quality. We need immediate action on health care reform. Health care costs and the economy are linked. The key challenges of our health care system are high costs, low quality, and insufficient access. Those challenges have a direct effect on family budgets. They have a direct effect on American businesses and American businesses' ability to compete, and they have a direct effect on government spending.

Americans' anxiety about the economy is connected to the concerns about health care. Health care costs have grown 5 times faster than wages over the last decade. Since 2001, real wages and household income have been flat. The economic downturn means more individuals could lose health care coverage for themselves and their families, and that is at a time when savings are low and credit card debt and medical costs are high. Medical bills could force a growing number of families into bankruptcy.

We need to reform the health system. First, we must ensure meaningful coverage and care to all Americans. Second, we must emphasize higher quality, greater value, and less costly care. Third, reform should contain an absolute commitment to weed out

waste, eliminate overpayments, and design sustainable financing that works for taxpayers as well as the Nation's recipients and providers of health care. We all need to be in this together. This has to be a solution where all Americans participate, all bear responsibility. That is the only way this is going to work.

Yes, reforming health care will cost money, but investments now will reap savings a decade from now. Spending now will also provide needed stimulus for the economy as well. I hope that my paper offers a starting point, a starting point for the dialogue that we will have on health reform next year. I intend to work with Senator Grassley, my colleagues on this committee, as well as members of the HELP Committee to craft a bipartisan bill we can send to the President next year. We all must work together.

A recently released report from the New America Foundation states it well. It says, "We must reform our struggling health system not in spite of our economic crisis, but rather because the impact health care has on the American economy. The economic and social impact of inaction is high and will only rise over time."

Today's hearing will examine the need for health care reform from an economic perspective. Is health care reform an economic imperative? What are the economic costs of inaction? If current health care trends continue, can we remain competitive?

Today's hearing is the tenth in a series on health care reform this committee has held this year. It is my hope that these hearings will help to prepare the committee for the hard work we will do next year.

And so let us reject false choices. Let us show that we can walk and chew gum at the same time. Let us rebuild the economy and bring affordable, meaningful health coverage to all Americans.

Senator Grassley?

**OPENING STATEMENT OF HON. CHUCK GRASSLEY,
A U.S. SENATOR FROM IOWA**

Senator GRASSLEY. Thank you, Senator Baucus, for holding this hearing. Because of your leadership over the last year we have done a lot of work in this committee on this issue and a lot of other issues, so we are well-positioned to make real progress on health care reform in 2009. As we have examined our health care system this year, it has become even clearer how much our system needs fixing. I look forward to working with you to get that job done.

Health care reform will be a test of our will and our ability to make tough choices. Those tough choices have become much more challenging as we have seen our economy falter. Right now, we already have a deficit of at least \$400 billion for the coming year, and that is before the \$700 billion bail-out and the economic downturn are factored in.

Congressional leaders have also discussed another economic stimulus package that may be taken up next year that would add several hundred billion dollars more. Rising health care costs, record deficits, and the growing liability of Social Security, Medicare, and Medicaid create big challenges for the financing of health care reform. It is hard to paint a very rosy scenario. In post-World War II history, the deficit has never been above 6 percent of the

economy. It seems like we are heading towards a deficit that might be 10 percent of the economy.

Increasing access for the uninsured is not going to come cheaply, and it is clear to me that our economy cannot stand much further deficit spending. We also must acknowledge the problem that spiraling increases in health care spending create for our economy, because it is having that impact that the chairman has spoken about, and the relationship is very definitely there.

Rising health care costs affect family budgets because costs of that care are rising much faster than inflation. Rising health care costs affect jobs when employers struggle to cope with the cost of providing health coverage to workers, and those costs affect our competitiveness internationally when health costs here make products produced in the U.S. more costly, making us uncompetitive with foreign competition.

The rising cost of health care is also a threat to State budgets, as we are hearing now from Governors. More and more State budget dollars are going for health care, and just for their current obligations, not new obligations. In fact, when it comes to the States, very soon States are going to reach a point where paying for increased health care costs, maintaining infrastructure, and providing post-secondary education simply cannot all be done by most of the States.

Senator Baucus and I requested testimony from the Government Accountability Office that speaks to this point, which will be submitted for this record.

[The prepared statement from the Government Accountability Office appears in the appendix on p. 44.]

Senator GRASSLEY. The recent Medicaid Actuary's Report showed the costs of that program doubling over the next 10 years, and rising health costs are affecting the Federal budget, as has been pointed out so many times.

According to the most recent trustees' report, the Medicare trust fund begins deficit spending this year and funds will be completely exhausted in 2019. Federal spending for Medicare alone is projected to double, from about 3 percent of the economy today to 6 percent by 2030. It is clear, then, that the growing cost of health care is already an untenable burden for both the Federal and State Governments, so obviously doing nothing is not an option. We must find ways to address health care costs and we must do it soon, and we must do that while also making coverage accessible and affordable for more.

As I said before, we face difficult choices. We have an economy in distress. Increasing record-breaking deficits is not a legitimate option. Ignoring the burden inefficient spending in health care places on our economy is also not an option. We must find ways to address these difficult problems, and soon.

So I hope we have adequately responded to the chairman's request for a bipartisan consensus, working towards that. We have had meetings already, we will have other meetings, and we will have innumerable meetings. We may spend all of our time meeting on health care. [Laughter.] I am very much looking forward to the testimony of our witnesses as we start down this very difficult road.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator.

Senator Rockefeller would now like to make a brief statement.

**OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV,
A U.S. SENATOR FROM WEST VIRGINIA**

Senator ROCKEFELLER. Mr. Chairman, I thank you for this courtesy. It has been 15 years since we tried doing comprehensive health care reform, and there are all kinds of ways to blame why it did not happen. The point is, it did not happen. We have become a Congress of incrementalists since then.

It is simply not debatable, the substantial burden that health care has become for individuals, families, businesses, and the economy as a whole without the absence of this broad reform which we now have to pledge ourselves to, and do.

Our current health care system simply does not work, and it is time for a major overhaul. I have been working on health care policy for more than 25 years, and I have never been more hopeful about the prospect of reform or more convinced of the overwhelming need for reform than I am now. The current economic crisis, as the chairman has indicated, is also a crisis of health care. They are one and the same.

Stabilizing our health care system is a critical component of putting our economy back on track. Leading economists have all agreed that our costly and inefficient health care system is perhaps the biggest threat to the Nation's budget. So, health care is not just health care, it is 47 million uninsured people, all kinds of others who are underinsured, and it is also, as I say, stability for our country.

It is long past time for the Federal Government, in my judgment, to make the investment necessary to achieve comprehensive health care reform. If the government must intervene to do that, then the government is going to intervene to do that. That is my view. We have to do this, we have to do it all, and we have to do it soon. I say that not in spite of the current economic crisis, again, as the chairman said, but because of the economic crisis.

I believe there are three broad goals of comprehensive health care reform: increasing coverage and affordability; improving quality; and also eliminating unnecessary health care spending, which is a very broad statement but nevertheless is rich with text.

While each of these goals must be undertaken in earnest, the foundation of comprehensive reform is coverage for the 47 million Americans, including nearly 9 million children and, as we so often forget to say, more than 2 million veterans who are uninsured. I have been chairman of the Subcommittee on Health Care for a while. I look forward to working actively with the House and Senate leadership, the House and Senate committees of jurisdiction, and, importantly, the Obama administration to avoid the pitfalls of the early 1990s. We could do it this time because we have experienced failure and hopefully learned from it, so we can finally realize the goal of comprehensive health care reform. We have to do it.

Mr. Chairman, I thank you.

The CHAIRMAN. Thank you, Senator.

Now I welcome our witnesses to the hearing. First, we will hear from Ivan Seidenberg, chairman and chief executive officer of Verizon. Next, Mr. Andy Stern, our second witness, is president of the Service Employees International. Welcome, Mr. Stern. The third witness is Dr. Uwe Reinhardt, the James Madison professor of political economy from the Woodrow Wilson School of Public and International Affairs at Princeton University. Uwe, thank you for making the extraordinary effort to be here today. I understand you flew from halfway around the world, arriving at about 3 a.m. this morning just for this hearing. We deeply appreciate that. Finally, we will hear from Amitabh Chandra, assistant professor of public policy at the John F. Kennedy School of Government at Harvard University.

Mr. Seidenberg, why don't you begin?

STATEMENT OF IVAN G. SEIDENBERG, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, VERIZON COMMUNICATIONS, INC., NEW YORK, NY

Mr. SEIDENBERG. Chairman Baucus, Senator Grassley, members of the committee, thank you very much for the opportunity to be here to discuss health care reform. I am very heartened by all of your positive statements about the need to focus on this particular urgent need for our country.

For the business community, the stakes for an affordable and sustainable health care system are important. As you said, health care costs are the number-one cost pressure for the Business Roundtable CEO, the number-one cost issue that all of us talk about when we get together.

Escalating cost increases for health care mean we are paying a lot more but getting less value. These increased costs, as you know, inhibit job creation, damage our competitiveness, and impose a major strain on household incomes. With most Americans' health benefits tied to their jobs, people clearly worry that they will not be able to afford coverage for their families, move to a new job, try to start a new business, or, in the worst case, how they pay for health care if they are unemployed. That is why we are grateful for your leadership in keeping this issue at the forefront of the congressional agenda.

We also encourage the Congress not to lose focus on medical liability reform and hope, Mr. Chairman, that you will reintroduce S. 1481, the Fair and Reliable Medicare Justice Act, with Senator Enzi.

Now, at the Business Roundtable, we have devoted considerable time to studying the health care reform issue. We have learned a lot. In September, we released a plan containing many suggestions that are somewhat similar to Chairman Baucus's proposal. As you well know, when it comes to scientific advances, medical technology, and the quality of our doctors and hospitals, we believe that American health care—not the system, but health care—is really the gold standard for the world. We know how to take care of people.

But it is beyond the reach of an increasing number of Americans, and this is the problem. From our perspective, the problem with the current health care market is that it does not really function

as an integrated market. It leaves major consumer needs unmet, costs unchecked by competition, and basic practices untouched by the productivity revolution that has transformed every other sector of the economy.

So our plan is based on four pillars.

(1) Creating greater consumer value and efficiency through use of health information technology, value purchasing, and medical liability protection. We can drive efficiency by doing those things.

(2) Providing more affordable health insurance options for all Americans by tackling insurance reform. We need more products in the marketplace to cover more people.

(3) Placing an obligation on all Americans to have health insurance coverage and encouraging widespread participation in prevention and chronic care programs. We have come to the point where, when you are born until you die, you need to be participating in the system so we can take care of you in a fashion that drives efficiency and quality of coverage through your lifetime.

(4) Lastly, offering assistance to uninsured low-income families to meet their participation in the plan.

Now, our written testimony discusses these pillars in more detail. As you will see, Chairman Baucus, some of our fundamental assumptions mesh with many elements in your plan, such as greater use of health IT, more transparency on cost, and quality to create greater efficiencies.

In our judgment, the key to finding a practical solution to health care reform is to fix what is broken while preserving what is working. So, in that spirit, the Business Roundtable strongly urges Congress to reinforce the existing employer-based system through which most Americans currently receive health benefits.

The Federal ERISA statute gives employers the flexibility to design and finance plans that meet their employees' needs, a successful system that makes coverage widely available to our workers. Tampering with this law at this time, in our view, is just unnecessary. For many uninsured, the problem of obtaining coverage is not just financial, it is also the inadequate structure of the health care market.

To fix that, we must also have a functional competitive private insurance market with affordable options. Our plan would restructure the private insurance market and, we believe, create a more rational insurance system with a wider variety of products to meet the different needs of the uninsured.

While it is obvious we may differ on some mechanics of how to achieve our objectives, the Business Roundtable stands united with this committee in our commitment to finding solutions to the American health care challenge that we are all facing. We firmly believe that by mobilizing the power of the market and 21st-century information technology, we can drive down costs, drive up quality, and improve access to health care for everyone.

We are committed to working with you and all interested stakeholders in achieving meaningful reform. In fact, we are doing so today. For example, the Business Roundtable has joined forces with AARP, with Mr. Stern and the SEIU, and the NFIB in a coalition called Divided We Fail to build bipartisan support for health care reform.

In our company, Verizon, we agreed with our two unions, the CWA and IBW, to work together to achieve comprehensive health care reform that covers every American, controls costs, shares the responsibility of paying for coverage, and improves quality. These are big steps for the business community.

There are many facets to this problem and many perspectives that must be taken into account, but we believe that any real solution to health care reform must emerge from the uniquely American principles that drive our economy: innovation, choice, competition, and a marketplace that serves everyone.

Now, if I could just beg your indulgence, I need to say just a word about pension funding. The sudden and unexpected decline in the markets, combined with the current credit crunch, has put defined benefit plan sponsors in a very tough spot. At a time when most companies need cash to grow, we are getting hit with unexpected pension funding that is far in excess of our most conservative forecasts and budgets.

We would like the Congress to act now, this year, to give business a little breathing room. We need to be able to smooth out the recent asset decline so that the losses are replaced over a more reasonable period, and we need a little bit more transition into tougher funding rules and some flexibility on how those rules are applied. Companies are making budgeting decisions for 2009 and 2010, and they need to know they are going to get some breathing room, otherwise many of those companies are going to have to make some painful cuts in jobs and benefits.

Senator, thank you very much.

The CHAIRMAN. Thank you, Mr. Seidenberg. In fact, I have been meeting with Senator Grassley on just that second issue, smoothing pension provisions and other asset provisions and the dates by which plans have to be funded, given the problems facing the economy. I think there is a decent chance we will get that enacted this week.

Mr. SEIDENBERG. Oh, that would be great.

The CHAIRMAN. Yes, it would be great.

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

The CHAIRMAN. Mr. Stern?

**STATEMENT OF ANDY STERN, PRESIDENT, SERVICE
EMPLOYEES INTERNATIONAL UNION, WASHINGTON, DC**

Mr. STERN. It would be great. Good morning, Mr. Chairman, Senator Grassley, members of the committee. On behalf of the 2 million members of SEIU, including more than a million who went to work in hospitals, nursing homes, and peoples' homes, I thank you for the invitation.

Our members recognize there are many economic challenges that you need to deal with that face our country, but we believe there is now a once-in-a-lifetime chance to finally address a strategic economic challenge that has been unsolved for too long, and that is to solve our health care crisis.

The facts for workers in health care are very clear: 8 of the 10 uninsured go to work every day; premium growth has now doubled or quadrupled the size of wage growth, as you said, Mr. Chairman;

and U.S. businesses are spending twice as much per person as their OECD competitors, and that is not good for American workers.

But those are facts for the head. To get to the heart of the matter, there are people like Paula Hall, a child care provider in Spokane, WA. In 2001, Paula's husband was hurt working in a machine shop, lost his job, could not afford COBRA, did not qualify for State aid because they made too much, so they played Russian roulette and went, like so many Americans, without health insurance.

Four years later, after open-heart surgery, three angioplasties, and \$250,000 in health care bills, they spent their savings, spent their child's college fund, lost their home, went bankrupt, and then finally got on State aid so they had health care again because they had so little income.

It seems ridiculous, in the richest country on earth, to have to go bankrupt, or be foreclosed, or get a lower income in order to have a path for health care. We believe, as all of the speakers said, if we are going to solve today and tomorrow's economic crises for working people and for our country, it is time right now to fix the health care system. Whether it is the economic impact of medical debt—and we should all appreciate as we deal with this debt crisis, there are now 72 million Americans struggling with medical debt, many of them who thought they had insurance that protected them.

Another study says that medical debt will be the cause of half of the future bankruptcies in this country. But more importantly, if people do not have a sense of health care security, they are not going to begin to purchase at the levels we need to revive consumer spending, and when we look at what happened in retail where it dropped an astounding 2.8 percent in sales just last month, we need people to be secure and feel like they can spend.

With these kinds of choices facing working people today, it is hard to argue that health care is not tied to the immediate economic crisis. If we do nothing, health care will only continue to fuel the economic crisis for years to come. We know, as you said, that the typical employer-based family health insurance plan will rise 84 percent, to more than \$24,000, in 2016. That will collapse businesses, health care plans, as well as employees' budgets.

If we do nothing, we know, as you said, that we will double, from \$2 trillion to \$4 trillion, national expenditures on health care, which is unsustainable. As you said, Federal spending on Medicare and Medicaid, now 4 percent of our economy, will grow to 6 percent by 2030, and 12 percent by 2050. This cannot continue.

The single most important way to dramatically improve our economic and fiscal outlook is to take steps now to put health care spending on a growth rate more closely aligned with the overall economic growth.

Now, here is the good news. As opposed to, as Senator Rockefeller said, in 1993, I think there is a unique window of opportunity here. The voters have spoken clearly about the need for change. Businesses, consumers, unions, the insurance and pharmaceutical industries, I think, are all ready to participate in a process of real change.

I think everyone now understands this is not a Democratic problem or a Republican problem, this is an American problem, for families and for our businesses. Just like GM, if we fail to live up to our responsibilities and see the problems and deal with them quickly and responsibly, we will see the collapse of our health care system as well.

We have begun to participate, as Ivan Seidenberg said, in many coalitions with many people we do not usually agree with, but on this issue we totally agree. Whether it is the Business Roundtable, NFIB, Wal-Mart, Intel, Manpower, or the pharmaceutical industry, we believe the time has come to solve this health care crisis.

That is why, Mr. Chairman, your call to action last week was so timely, so bold, and such an important step to move this forward. We were especially pleased to see strong support for accessing coverage, including a public option; strategies for cost containment; payment and delivery system reform; transparency; and more options for long-term care. The only way to fix this problem is not incremental, but fundamental, focusing on access, quality, and cost all at one time.

Senator Grassley, we appreciate your long record of supporting policies that ensure coverage for all Americans. I am proud to work with you on transparency and long-term care. Senators Rockefeller and Hatch have shown great commitment to these issues. Senator Wyden has obviously been a leader as well. President Obama has promised us all that he will reach across the aisle. Now is the time to solve this problem. It is within our reach and can be done, we believe, in the first 100 days.

Finally, let me just say, when it comes to the health care crisis, we have to take a lesson from the economic crisis: the longer we wait, the less we do, the worse it gets. There are those who will say we cannot afford to reform our health care system, but I say we cannot afford not to.

Thank you very much.

The CHAIRMAN. Thank you very much, Mr. Stern. I deeply appreciate that.

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

The CHAIRMAN. Dr. Reinhardt?

**STATEMENT OF UWE E. REINHARDT, Ph.D., JAMES MADISON
PROFESSOR OF POLITICAL ECONOMY, WOODROW WILSON
SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS, PRINCETON
UNIVERSITY, PRINCETON, NJ**

Dr. REINHARDT. Mr. Chairman, Senator Grassley, members of the committee, thank you very much for inviting me to this important meeting. I would also like to congratulate you, Senator Baucus, for this fine document. As I mentioned, I will use it in my course on health policy as an opening and say the aim is that you should be able to write a document this good. [Laughter.] So, you have made a contribution to Princeton University.

The CHAIRMAN. Thank you very much.

Dr. REINHARDT. It is indeed a window of opportunity at the moment. My wife and I were part of a group of foreigners who went to Taiwan in the early 1990s to help them move to universal coverage, and they did it in 1995, as we failed. They had all the ingre-

dients: a demand for it among the populace, among the business community; there was a legislature enlightened to be receptive; and there was strong presidential leadership. This president was passionately committed to the cause, as I hope and believe President-elect Obama will be. So, this is a great window of opportunity.

My statement falls into four sections. The first one is a reaction specifically to the proposal you have, and it may seem like pandering when I say I wholeheartedly support the design parameters, but I had a proposal I had sketched out 15 years ago, and I had very similar ideas. I called it the All-American Plan, because this plan does not undo what there is; whatever you have, you can keep it. It is not a government take-over, it is just filling in the gaps with intelligent additions.

I like the mandate. I do believe you cannot have community rating and guaranteed issue, and then allow people to go without insurance when they are healthy and throw themselves on the mercy of a community rate when they are sick. If you belong to a club of people who look after each other when they are sick, you have to pay your dues into the club. So, I obviously favor a mandate.

The insurance exchange is often decried as a government take-over—and you will hear that again—of health care. But Governor Romney put one in in Massachusetts. The way I would look at it is, a big business like General Motors has an employee benefit department that organizes the market for insurance. Small businesses do not have that, and the exchange is a substitute for their personnel department. So, it is a private sector thing; it is not a government take-over.

The point I would say, in your testimony, that needs a little more work would be the subsidies for small businesses. To an economist, the issue is not small; the issue is the size of the wage base, the donkey that has to carry this load. So, if you had a small firm of architects or lawyers with 20 people, they might not have trouble paying for health insurance, but if you had a larger firm, 200 employees, all with a very low wage base, they would have a problem. So size is not the issue, but wage base.

Which brings me to the second section of my testimony. We are sailing into a perfect storm. While on the one hand the gross wage base that has to pay for all the fringes—whether a check is written by the employer or employee—for all the take-home pay and for health insurance, that wage base is growing at 3 percent per year, if we are lucky.

If you look at the Milliman Index, it now costs \$15,000 for a typical family of four, if you include health insurance premiums and out-of-pocket spending, and that will be \$35,000 10 years from now, while the wage base—I use an example of a family with a \$60,000 wage base that will be \$80,000 in 2016. So in 2018, 47 percent of the wage base of this family will be chewed up just by health care. So, that will not happen, and they will be uninsured.

That puts us—or you—into a nasty situation: either higher-income people have to pay more taxes to subsidize, to be their brothers' and sisters' keepers in the bottom third of the income distribution, or we have to run a multi-tier health system where the health care experience varies by the income of the people.

I have a long section on cost containment. It is imperative that we do cost control. You have a beautiful section on it, starting with the Wennberg variation. I will not have time to go into it, but the one point I do address is, in years past we have always said, let us do cost control first and then we can afford to cover more people.

That puts the cart before the horse. I think we need to have universal coverage first and then, parallel, do cost containment. But that takes much longer. It is a big, big wrestling match. Of course, there is Alfred E. Newman's cosmic equation which says every dollar of health care spending is someone's health care income, including fraud, waste, and abuse. So when you get at that, you are cutting into people's income, and there could be very powerful opponents. So that will take a little longer, that battle, to fight, but the insurance can be done more quickly.

Just some additional points. I applaud you for addressing, at least for discussion, the tax preference accorded employer-provided health insurance. I think Republicans and Democrats alike realize that this is an inequitable and inefficient subsidy that could be harvested. We are talking \$300 billion. There are ways—you sketched them out yourself—that, instead of taking it away right away, you could cap it or limit it by income. For example, if you make more than \$200,000, all employer-provided premiums will be added to the W-4, but if you make \$40,000, none would. There are easy, imaginative ways to do it. Technology assessment—I think we will have it sooner or later, because we are the only country that really does not.

Then I thought, in the Medicare Modernization Act, you missed a great opportunity. You gave the private insurance industry a tip, 12 percent, on top of what regular Medicare costs, but you asked nothing in return. Usually when I tip, I ask for something. What you could have asked for is what the Germans did. They told the insurers, we will pay you extra but you have to come to us with a fully specced-out disease management program, with a network of doctors.

Everything has to be in there. You do that. I think you hint at it in your report. I would go that way. If you want the subsidy, then you have to manage care, which probably would, for a lot of these plans, mean they either lose it or they have to get busy really addressing the issue of disease management.

Thank you very much.

The CHAIRMAN. Thank you very much, Professor. I might say on the small business, we attempt to deal with the question you raised, namely not just the size and number of employees, but also the income. For example, the difference between Jiffy Lube and a law firm, for example.

Dr. REINHARDT. Yes.

The CHAIRMAN. We tried to address that in this paper. But I must say, too, in listening to you, you sound like a professor grading this white paper. [Laughter.] It kind of sounds like you gave us a pretty decent grade, and I deeply appreciate that.

Dr. REINHARDT. You should see it. [Laughter.]

The CHAIRMAN. Thank you very much. It is like a tutorial here. Thank you very much.

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

The CHAIRMAN. Dr. Chandra?

STATEMENT OF AMITABH CHANDRA, Ph.D., ASSISTANT PROFESSOR OF PUBLIC POLICY, JOHN F. KENNEDY SCHOOL OF GOVERNMENT, HARVARD UNIVERSITY, CAMBRIDGE, MA

Dr. CHANDRA. Senator Baucus, Senator Grassley, members of the committee, thank you for inviting me to Washington today.

My first point this morning is to note that cost growth in health care has reduced wages and increased the numbers of the uninsured. My second point is that the Medicare program encourages the adoption of new medical technologies, some of dubious marginal value. It also rewards the full utilization of existing capacity. Yet, because physicians treat their over-65 and under-65 patients similarly, Medicare's incentives encourage the intensive treatment of the under-65, which raises their premiums. My third goal is to elaborate on reform options.

Let me start by discussing the effects of cost growth in health care on labor markets. Despite what is commonly believed, workers who receive health insurance benefits are paying for them in the form of lower wages, and that means less money for gasoline, food, and holiday presents. Recognizing this trade-off, some workers decline health insurance.

But firms have limited ability to offset increases in the price of health insurance through lower wages. They certainly cannot do it for workers who are retired. For employees whose compensation cannot be reduced, firms will reduce employment or move workers into part-time jobs without health benefits.

Dr. Katherine Baicker and I estimate that a 20-percent increase in health insurance premiums, which is less than a third of what they have grown since 2000, has resulted in an employment loss of 3.5 million workers, and an additional 3 to 4 million workers have been moved from full-time to part-time jobs without benefits. Firms may also respond by moving to the areas of the United States where there is less cost growth. For workers in other areas, there will be no jobs and no health insurance.

Because of our peculiar choice of tying health benefits to employment, Americans lose insurance when they lose their jobs. Some respond by being more reluctant to switch jobs because they do not want to lose their insurance and be exposed to the threat of a medical bankruptcy, but such switching is key to revitalizing our economy.

All this said, there is no reason to believe that, simply because something is expensive, it is not worth it. But we now know that 30 percent of medical spending in the United States confers no medical or therapeutic benefit. The United States spends over \$2.1 trillion a year on health care, and 30 percent of that is \$700 billion. This is a number that has particular significance today. It is surely possible to offer more affordable health insurance policies that do not cover this 30 percent of wasteful spending.

So what can we do? In the short run, Congress may consider increasing the portability of insurance and the expansion of existing programs. I urge you to do so, but these will be very costly. Perma-

ment, large-scale insurance expansions will increase providers' incentives to expand capacity, which will then be fully utilized in other Americans, driving up their premiums further.

Expansions will also encourage some employers to drop coverage, thereby increasing costs and reducing the realized coverage gains. Permanent expansions will also weaken the Federal budget situation. Reforming the individual health insurance market through regulatory reform is another coverage option and one that will eventually pave the way for decoupling insurance from employment. I will be happy to share my thoughts on such reforms with you later.

We should acknowledge that efforts to insure the uninsured will not check subsequent premium growth. Moreover, insuring the uninsured will give them access to the sort of care that everyone else receives, which is a combination of valuable care, the over-use of costly care with unproven benefit, and the under-use of some vitally important therapies.

Chairman Baucus, as you have noted, fundamental health care reform will have many, many components. The more challenging idea to simultaneously consider is to address cost growth in health care. This is not a uniquely American phenomenon, but our Medicare program's perverse incentives aggravate the situation by encouraging the adoption of innovations that are beneficial in some patients, but offer tremendous scope for over-use in others.

Physicians do not practice medicine in a vacuum. Because of malpractice and practice norms, how they treat Medicare patients is how they will treat non-Medicare patients. Medicare reforms that promote value-based reimbursement will spill onto everyone, thereby extending the reach of both public and private dollars.

Private insurers will be able to offer more affordable policies if they know that they do not have to cover the 30 percent of useless spending that Medicare currently covers. Indeed, cost savings from Medicare reform could be used to finance other health reform efforts.

How exactly to reform Medicare is a topic for another hearing, but I have many ideas that I would be delighted to share with you at that time. The key to Medicare reform is the realization that we must measure all costs and not only costs at the level of discrete episodes of illness. We must reimburse for value and ensure that the care that patients receive is congruent with their preferences. The accountable care organizations championed by the Dartmouth Institute offer the greatest promise, but they need to be more rigorously tested.

In summary, addressing cost growth in health care will increase wage growth and consumption, reduce the number of the uninsured and unemployment in general, and encourage voluntary turnover. It might revitalize our economy. It will prevent Medicare from taking over the entire Federal budget, and it will have the bonus effect of improving the Nation's health. There is no better time to initiate such reform.

Thank you.

The CHAIRMAN. Thank you, Dr. Chandra, very much.

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

The CHAIRMAN. What strikes me, as Senator Rockefeller has said, and so many others have said, is that the time has come. So many groups, people, stakeholders, providers, and consumers want to work together to find a solution now. It really has risen to the next level above partisanship. As you said, Mr. Stern, it is truly an American phenomenon, and clearly the time has come. I think the stars are aligned where we can get this all put together in a very meaningful way.

One question we are going to face, though, is, you have done a good job, all of you, of explaining the costs of inaction. Inaction is just intolerable. But the question we are going to face is, how much will the up-front investments be to accomplish our objective, whether it is health IT, comparative effectiveness, and on down the line.

We run into this difficult question in the Congress of pay-fors, that is, the degree to which the costs initially are going to be a hindrance as we try to realize the benefits from those costs. That is, the costs are really investments, but we have this archaic budget system here that is going to make that a bit difficult.

So I would like you to address the importance of these initial investments and what you think the consequence of the failure of making those investments might be as we try to achieve meaningful reform here. I will just go down the line here and start with you, Mr. Seidenberg.

Mr. SEIDENBERG. All right. Senator, there is no magic answer to that. You have mentioned before, we sit in meetings. I know in our company and at the Business Roundtable, we listen to experts on this all the time. So the short answer to your question is, you should look at the categories where we could make the system more efficient—evidence-based treatment, disease management, health IT, transparency of data, and wellness practices. In my company this is nothing more than looking at a return on investment of some initial dollars.

So, if we can create accountability around these areas, and we can get this system to pay for itself over a 3-, 4-, or 5-year period, cash in/cash out that looks pretty stable, there should not be any reason why the Congress could not provide the seed money to get it going. But every time I hear this debate, what we talk about is all this money on the front end and there is never any discussion about what the accountability is on the back end.

The CHAIRMAN. Right.

Mr. SEIDENBERG. So my view is, it is what it is. But, if we can create the accountability around these well-established ideas for efficiency and savings, then the economy should step up and seed the program necessarily, and make sure this gets back into accountability.

The CHAIRMAN. Thank you.

Mr. Stern?

Mr. STERN. I just think we all appreciate what is going to happen, if we do not do this, to the Federal budget, I think, as someone said earlier. I think there are questions of our willingness to try to, in some ways, legislate a cap on Federal expenditures over some time that starts to cut the cost of growth in out-years, because, if we do make an investment, there should be a return. I do not know legislatively how one would do that, but we have to cut this cost

curve. I think, if the investment does not do that, it is a bad investment. The good news is, this is an investment that has paid off in many other places around the world. Businesses have shown treating chronic disease, doing things early in terms of prevention, actually saves money. I think the question is, how do we build that into the legislative thinking?

The CHAIRMAN. Right.

Dr. Reinhardt?

Dr. REINHARDT. If you look at page 10 of my testimony, I show there a table which I had asked for as chair of the Commission on New Jersey Health Care that shows in one hospital area, in the last 3 years of life, Medicare spends 3 times as much as in another hospital area in the same State of New Jersey. I asked the hospital executives to justify this to me, and they said, well, we are just open workshops. Doctors come in here and tell us what to spend and we have to spend it, and we have no control over them.

So I proposed in this commission report there exists software that can track every order entry of every doctor, for every patient, by every input. It already runs. I think it has been used in Albuquerque, at Lovelace, where that was tried. So that allows you to build profiles of what doctors spend to do certain procedures.

As a first step, it would be good to get the doctors in a hospital in a room and have them justify, what gives? This is how Wennberg's variation could be addressed. We also can link that to output data. That software is cheap because it basically exists. It is easy to run. It would be the first investment, because most allocation decisions in health care flow over the pen of a doctor, and that is where you would have to start: justify what you do.

The other thing is leverage. If you do sharing—say business, the Congress, and providers share in IT on the condition that it is interoperable, that it meets certain specs—you could get a lot of dollars where everyone benefits, and yet you get the commonality that it is interoperable. Those things are not all that expensive, I think, but that is where you would start.

The CHAIRMAN. Well, I appreciate that. Those points are recognized in the white paper. We are going to have to move to dot some i's and cross some t's as we go down the road here. My thought is, as with e-prescribing, there have to be some incentives and rewards for providers that implement IT. We have to develop those standards. I think those standards, interoperable standards, can be, and must be, addressed.

I also think, to your other point, Dr. Wennberg's study, we could get at that problem—Dr. Chandra, you alluded to it in your testimony—with delivery reform and with transparency, which also is addressed in the white paper, so that people can compare. It makes no sense, the disparity you talk about in New Jersey, and the Wennberg findings make no sense. Clearly, there are areas there, I think, for great savings with more transparency and disclosure, which will, I think, root out a lot of the waste that otherwise occurs.

My time is up. Senator Grassley had to briefly step out.

Senator Rockefeller, you are next.

Senator ROCKEFELLER. Dr. Reinhardt, you made many presentations over the years to the Alliance for Health Reform. In one of

those you referred to the cover story of the September 25, 2006 issue of *Business Week* magazine. The cover story was entitled, "What Is the Real Propping Up of the Economy?" Now, this precedes the disaster of recent months, which has gone on a long time. The byline read, "Since 2001, the health care industry has added 1.7 million jobs; the rest of the private sector, none."

Now, obviously I am trying to set up economic recovery and what health care can do. The article goes on to say that health care has become the main American job program for the 21st century, replacing, at least for the moment, all the industries that are vanishing from the landscape. Health care is highly labor-intensive, so therefore most of the \$2 trillion in health care spending ends up in the pockets of workers.

My question to you: there is an undeniable link, obviously. Can you talk about the importance of the health care sector to job creation, and hopefully verify what I am trying to say and will ask you in another question, and what comprehensive reform could mean, therefore, for our economy?

Dr. REINHARDT. This was an editorial which, alas, the *Washington Post* chose not to print, where I compared universal coverage versus tax cuts. The problem with a tax cut is, you do not know how the people who get it will spend it. Will they put it into offshore mutual funds? Will they buy a Ferrari? You have no control. But, if you put it into health care, it will, in fact, create American jobs, because we do not import health care.

Now, I would not advocate putting it in anywhere where it is wasted, but my theory is, and I think the facts show that, if you spend more on the uninsured, you are actually buying high-value health care. You will insure a child and, therefore, if the child gets asthma treatment and will not be hospitalized, that is high-value output. So I am not arguing digging ditches and filling them in, but it is a fact that the health sector is the American locomotive in the economy.

So, if you were to move to universal coverage, that, incidentally, would also be a good part of the stimulus package. It just simply works out that way. I think, therefore, I did not put that into my testimony in the statement, but it is a fact. You saw in *Business Week*, Michael Mandel took that further and looked at the numbers. It turns out health care is the job machine in the U.S. In particular, if you target it on under-served areas, I think you will get high value for the dollar.

Senator ROCKEFELLER. Does anybody else want to comment?

Mr. STERN. I think it is an enormous opportunity, not just for universal health care, but I think one of our untapped industries continues to be our pharmaceutical, life science, and bio science opportunities to develop jobs. I just would say that, as we think about this, we need to think about workforce development. We do not have enough family physicians, we do not have enough nurse practitioners. I know that Pfizer and others have talked about this. I think there is both a training/upgrading as well as job creation opportunity that will be really good for America.

Senator ROCKEFELLER. But, if we do all of what you suggest, the money is all going into the pockets of American workers. I mean, that is the point I am trying to make.

Mr. STERN. It is all American workers, and it is all American jobs. It could not be much better than that.

Senator ROCKEFELLER. Yes.

Thank you, Mr. Chairman.

The CHAIRMAN. Thanks.

Senator Hatch is next. Dr. Reinhardt, one point. You mentioned that health care is a locomotive. It is interesting to note that the only two sectors where there was job growth in October were in the mining industry and in the health care industry.

Senator Hatch?

Senator HATCH. Well, thank you, Mr. Chairman. I appreciate you holding this hearing, and I particularly appreciate this very eminent panel of witnesses that we have here today.

Mr. Seidenberg, you mentioned there were some ideas in Chairman Baucus's proposal that may need to have further discussion about the costs and impact on the workforce. Could you just elaborate a little bit more on what some of those ideas are?

Mr. SEIDENBERG. I think, Senator, the places that we are working through the issue, not to use sort of forbidden Washington words, but the Business Roundtable believes that we have reached a point where universal participation is a good idea, so getting people into the system early in life, through their lives, and practicing good health care mechanisms are good. So, how you incent and pay for that is one of the things that we need to work through.

Now, the health IT exchange is a good thing. The thing we want to make certain is that it is equitable, there is personal responsibility in there so that people have to buy insurance, they have to shop for it, they have to drive appropriate behaviors. We also have to make sure on the back end of that that insurance companies can construct new products that incent wellness, and that incent disease management.

So I think, Senator, we are more focused now on the debate as to how we sort of blend in good, sound business practice with the idea that we want everybody to participate in the system, and then we want to make sure we do not come up with simple answers, because sometimes a simple answer has a lot of unintended consequences. So those are just two examples, sir, of what we are talking about.

Senator HATCH. Well, thanks. We would appreciate more, if you can write to us.

Mr. SEIDENBERG. Yes. We have a whole group of expert staff people here who love to talk about this who will do that.

Senator HATCH. All right.

Mr. Stern, I appreciate your interest in this area, very much. You have been one of the prescient labor leaders in this country, as far as I am concerned. Now, with health care costs rising at more than twice the rate of GDP, everybody knows we are a Nation on the road to fiscal insolvency if we cannot solve that. Within the next decade, health care costs alone are going to take 20 percent of GDP unless we can find some way around that. An important step in ensuring that all Americans have access to quality and affordable health care is some way of bringing down these unaffordable costs or out-of-control costs.

Now, in your testimony you mentioned that we need to take steps to “put health care spending on a growth rate more closely in line with overall economic growth.” Could you elaborate on that, how you propose to help us to get there?

Mr. SEIDENBERG. We have a couple of thoughts, and I think Dr. Reinhardt mentioned a couple. I would just take a couple of big categories. So, as a businessman, I cannot figure out every line item of every single one of these bills, but there are two or three major categories that we have focused on. So we know that in Medicare, no matter what study you look at, 30 percent of the costs go to the last year of life. We need to get disease management. In Medicare, we have all sorts of programs geared to paying for activity rather than output, so we need to get after that.

Health IT is a no-brainer to us. There is not an industry in this country where, if you put a healthy dose of IT into it that, over the course of 3 years, you are going to get 20 to 25 percent savings. You can look at almost any industry. So these are some examples of how you can bring down that 11 percent premium rate that we have been paying, on average, down closer to GDP rate, and maybe even lower it for a couple of years. But from a business standpoint, it is just inconceivable that we cannot apply health IT and sound business practice and create accountability that will arrest the curve of these costs.

Senator HATCH. Mr. Stern, the same question.

Mr. STERN. I just do not know, Senator, because I am not skilled in this area, how you would actually begin to place a cap on the overall Federal expenditures.

Senator HATCH. I do not know that you can place a cap.

Mr. STERN. And I do not know either. But I think that is what you have to, conceptually, at least, deal with: how are we going to drive disease management and all these changes into the system? I think we know lots of answers now. We just seem unable to drive the change into the system. We have lots of anecdotal experience, as we like to point out, that this company or this hospital did it. But a lot of them can be scaled up, I believe. I do not know how to drive it in, but I think we know the answers. Now where is the financial incentives and the political will to get them done?

Senator HATCH. Well, thank you.

One last question to you, Dr. Reinhardt. In your testimony, you identify that allowing small businesses to join larger risk pools will help alleviate the pressures that discourage them from offering coverage. Bipartisan small business health plan legislation allowed small businesses to pool across State lines to form larger risk pools. According to the nonpartisan Congressional Budget Office, nearly 750,000 more Americans would have private health insurance and three out of four small business employees would pay lower premiums. So, give us your thoughts on that approach as well.

Dr. REINHARDT. Yes. Whatever works is fine. The problem I identified is that, when you have a small business firm and that pool of employees becomes the experience rated pool and one of them has cancer or some serious illness, it immediately drives up premiums. That is why, when you meet small business people, they say my premium went up 30 percent. It could have been one employee who caused that. So whatever large risk pool you can con-

figure. And what is important is that it remain stable so businesses do not go in and out depending on the premium. It has to be stable over time. Whatever works is fine, as long as it is large.

Senator HATCH. Thank you.

The CHAIRMAN. Next, Senator Bingaman.

Senator BINGAMAN. Thank you very much for having the hearing. Thank you all for being here.

My impression is, the overall subject of the hearing is health care reform, and we are all impressed with the proposal that has been put forward by the chairman which provides a critical framework for the Nation to undertake comprehensive reform.

Dr. Chandra's testimony, a lot of it, focuses on Medicare reform, not just health care reform, but more specifically how can we reform Medicare and, through that device, get to some significant reform of the overall health care system. I gather from what you said, Dr. Reinhardt, that you see serious problems with Medicare as well.

I guess I would start with you, Dr. Reinhardt. How do we interface these two attempts: overall health care reform with more specific Medicare reform, particularly in light of your testimony regarding Alfred E. Newman's cosmic health care equation? You point out correctly that bringing greater cost-effectiveness to health care is a monumental challenge, and we know that, and I agree with that.

It seems as though, if we take on the job that Dr. Chandra is recommending we take on, we are doing just that, we are bringing this cost-effectiveness to health care. How do you see the two interfacing? Do you just go full speed ahead on both or do you try to do some of the reforms of Medicare that Dr. Chandra is recommending as a prelude?

Dr. REINHARDT. Well, the first thing is that almost no economist will talk about cost control or expenditure control, but cost-effectiveness, by which we mean spending per unit of output, whether it is lowering blood pressure or quality-adjusted life gained, or the flip side, which is value for the dollar. We feel we are not getting value for the dollar in Medicare, and that needs to be addressed.

But it also has the dimension—and that needs to be said—in general we spend about twice as much for elderly in the Sun Belt than in the Wheat Belt. If you were to bring them all to Mayo Clinic standards, that would have a tremendous income impact on the southern area.

So one has to proceed slowly, not with a meat-axe overnight approach. But as Dr. Chandra says, we need to calibrate where, over time, the growth in the high-cost areas is slower. In your Call for Action paper, you have some ideas of having blended rates that would, over time, gradually get you there. This, I think, would be a 10-, 15-year program before you could actually do it. If you look at Dade County in Florida, if overnight you said you are not going to get more than Minnesota, you would devastate their medical community.

In almost all areas in health care, Medicare policy has become, in part, an incomes policy, because people rely on that as a mainstay. One has to withdraw that very carefully. But to not do any-

thing—we have talked about this when I was on the Physician Payment Review Commission in the early 1990s. Let us start now gradually ratcheting down the growth of health spending in the Sun Belt areas and let the other States come up. But that never had political traction. At some point, it must.

Senator BINGAMAN. Dr. Chandra, how do you see the timing of bringing about the reforms in Medicare that you are advocating? Do you agree this is a 10- or 15-year effort we need to involve ourselves in?

Dr. CHANDRA. Absolutely. I think that private health insurance does not operate in isolation of Medicare, so, when a new cost-effectiveness study comes out and says that a particular procedure generates no clinical value, no improvement in patient satisfaction, as long as Medicare continues to support it, as long as Medicare continues to cover it, private insurance has to do the same thing. So I do not think we should think about two separate sets of reforms.

We have to think about cost growth more generally, because what is happening in Medicare does spill over into the insurance products that private insurers are offering their beneficiaries, which is something that is then strengthened by the fact that doctors do not treat differently insured patients differently. If you go back to the variations that Dr. Reinhardt put up, you can look at bypass rates for Medicare patients in a hospital and correlate that with bypass rates for non-Medicare patients in a particular hospital, and they line up beautifully.

When doctors have extra capacity lying around, they become aggressive. So when we think about Medicare reform, I do not think we should just think of it as a means to put the long-term Federal budget situation problem in order. I think we have a real opportunity here to reform health care for the rest of us. But it will take time. I do think that we need to spend more money, as Dr. Baucus suggested in his Call to Action.

The CHAIRMAN. Is that a promotion? [Laughter.]

Dr. CHANDRA. Sorry, Senator. Well, I thought you did very well. [Laughter.]

We need to understand. We are learning a lot from the physician group practice demonstrations. We are learning a lot from accountable care organizations and bundled payments. Even though I am a champion of these institutions, I am still not willing to say that we know all the answers. We need a few more demonstration projects. But demonstration projects are cheap, and we learn the answers from demonstration projects in 4 to 5 years.

Senator BINGAMAN. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman. First, Mr. Chairman, let me say I do not think the Finance Committee has ever gotten out of the gate faster on this health reform issue and been more committed to getting to the finish line, and I just want to commend you for that white paper last week.

The CHAIRMAN. Thank you. Thank you.

Senator WYDEN. For the witnesses, my own view is that one of America's biggest hurdles in these tough economic times is that

much of our health care system comes from the 1940s, when America was under wage and price controls. Nineteen forties health care was pretty much all right then because workers stayed at their jobs for decades and employers competed against people down the street.

But now the typical worker changes their job 11 times by the time they are 40, and the workers want coverage that is portable, and the employers need cost relief or they are not going to be able to offer coverage, or they are just going to have to keep cutting back benefits.

Now, the fact is, there is nobody outside this building driving around in an automobile from the 1940s, and I think we have to modernize the system. That is where I want to start with you, Mr. Stern, and you, Mr. Seidenberg. Largely at the request of Mr. Seidenberg and business groups, we now have 17 U.S. Senators on an actual piece of legislation that says that employers can continue to keep doing exactly what they are doing, but we are also going to have more choices for workers. We are going to have more cost containment because workers get to share in their savings, and coverage will be portable.

My question to you is, divorced from any bill, Mr. Stern—the Healthy Americans Act, Senator Baucus has a lot of the same ideas in his proposal—how important is it to you that the system be modernized, that the employer/employee system be modernized and at least brought into the relevant century rather than be a creature of 60 years ago?

Mr. STERN. First of all, I constantly say that America has not come to grips with the fact that we are living through the third economic revolution. And where the agricultural revolution took 3,000 years, the industrial took 300 years, this is taking only 30 years. I think many of our systems, including our health care and employment, have not been modernized up until where we are. My son, who is 22, will have 9 to 12 jobs by the time he is 35. It is not a one-job-in-a-lifetime economy. So, I clearly believe in pension plans that are employer-sponsored. They are just going to be very complicated to maintain in a globally competitive world.

So I think the question is, as Dr. Reinhardt was saying, we sort of need to figure out where we want to go and figure out what are the steps to get there. We cannot do certain dramatic things about health care in Miami, FL because they have unintended consequences. So I would say we absolutely need to modernize how we think about health care, pensions, jobs, training completely. I think where we are on health care is what Senator Baucus has proposed and is a huge step forward that allows us to keep having that discussion about where we want to go. But in the end, we cannot stay where we are.

Senator WYDEN. Let me ask you about this kind of situation, Mr. Seidenberg. This is something I want to work with the Roundtable on. You are 57 or 58 years old and you are laid off in Oregon or Michigan where there is tremendous hurt. You are going to just go out into a marketplace where you cannot afford this COBRA program. You are going to get your head handed to you in the individual market because there is discrimination if you have had any kind of illness.

I think that is one of the real textbook cases why we have to have portability in our health care system. That person has to have portable coverage. They have to have it in a group so that they have bargaining power. We have, in the Healthy Americans Act, an actual, concrete, budget-neutral solution for that person who is 57 or 58 who gets laid off next week in this tough economy. What is the thinking at the Business Roundtable and large business organizations about how—again, divorced from any bill—you would modernize the system so that coverage would be portable for people who get laid off in this tough economy?

Mr. SEIDENBERG. Well, it is a difficult question, as you know. But I think that, first of all, we believe that, when a worker still of working age is laid off from a job because of technology, competition, or something else, the issue is a bridge to finding a new job. It is not a bridge to have permanent coverage from the government for the rest of your life.

Senator WYDEN. We are talking about private sector coverage where there is personal responsibility for the individual and the individual is a part of a group where they can get their value for their dollar.

Mr. SEIDENBERG. Yes. So when we say “portability of health care”—I mean, today we talk about portability of pensions. That is a different question. But when you talk about portability of health care, I am not so sure that what we are talking about is taking the Verizon plan to our competitor. I do not think it works that way. I think what we are talking about is that we are not locking in our employees to 30 years of work because all the actuarial assumptions based on our pricing of health care is based on staying with us that long.

So I think what we have to say is, portability needs to be there because the employee cannot assume that all businesses have some sort of health care program, and where the businesses do not have it, there is some sort of default case where they can purchase some insurance. So I guess portability, in the case of health care insurance, is a different question than when people talk about it in the case of pensions. It is a different issue. We do not price our health care to make it portable.

The CHAIRMAN. Thank you, Senator.

Senator Stabenow, you are next.

Senator STABENOW. Thank you, Mr. Chairman. Thank you very much for the work that you have done in putting out an excellent white paper, and I look forward to working with Senator Rockefeller, who has such long-term passion and has been such a leader on this, as well as Senator Wyden, who has been spending a tremendous amount of time on this issue.

I wanted to talk, just as a follow-up to Senator Wyden, more specifically about options, but first I do want to make a note that, coming from Michigan, we have been able to see direct job loss as it relates to health care costs going up. You can literally look across the Detroit River into Canada and see plants that have been built with the same wages, auto worker wages, the same environmental standards or greater. The plant was moved because of health care. So, we are the poster child, I think, for looking at what has hap-

pened, and certainly there are many, many other stories about that.

When we look at health care reform, I am struck by the fact that, first of all, about 45 percent of health care is already paid for by the public sector in some way—Medicare, Medicaid, providing public health insurance through employers, and so on.

But then we also have this piece that we do not talk about, which is taxpayer subsidies for private employers. We essentially are paying for, in some way, all of health care, whether it is through tax preferences or directly through Medicare and Medicaid.

Speak about your thoughts—I would welcome anyone on the panel—about changing that tax preference or about using the dollars that are there in a different way to provide universal coverage—which certainly is part of Senator Wyden’s plan—as we struggle, and certainly coming from a State where many people currently have insurance through their employer and those who have insurance have relatively good insurance, although it is going down and the premiums are going up every year.

But speak about how people can keep their insurance, while at the same time we address what is a publicly funded part of this which goes to the employer. We as taxpayers publicly subsidize the tax preferences for employers right now. So how would you change that, or would you change that? Would you just build on the current system or take the dollars right now and restructure it?

Mr. SEIDENBERG. I think your question is great. I do not want to sound like I am hostile to these ideas, because I am not, but I want to respond to a couple of things. Your first point—and this goes to the question before about Medicare—government is the largest purchaser of health care, so, if you do not tackle Medicare, it does not matter what you do in the private marketplace, because you are not going to get the efficiencies out of it. So in my view, one of the things we need to do is engage the government, as the purchaser, to get a lot more efficient.

Now, your question about taxpayer subsidies. Theoretically, you are correct. If I take a health care dollar I spend in wages and take it as a deduction, to some extent, that is a tax issue. But it is working. We are covering 132 million people. They are not complaining. They are not writing you letters. I think to throw them in a pool because of the people not covered, to me is not the right thing to do at this time.

So my answer to your question is, we need more options so those who do not have coverage can get it. The insurance market today is providing State plans; they are not providing new national plans, so we need a vehicle similar to some of the items discussed in not just Senator Baucus’s plan, but in other ideas. Give incentives and create a structure for the insurance companies to provide new plans. For example, a catastrophic plan that covers the whole Southeast, or a plan that has certain standards built into it that covers the Midwest. Of course, you would still have the States license the plans.

Now, I would make one point. Our health care costs are exactly the same as for General Motors, and we have managed them down over the course of time because we have closed old plants down and

we have created new businesses. So, it can be done. But I think the issue we need is a transition to help businesses and industries that are trapped to get to a new place.

But in the long term, our view is, if the consumer is not part of the decision-making process, we will never get the efficiency in it. So I am very concerned that throwing all the money back into a tax pool is going to recreate what we have in a slightly different form, and we are going to be back here talking about the same thing in the future. Unfortunately, that is where we are.

Senator STABENOW. Anyone else? Yes, Dr. Reinhardt?

Dr. REINHARDT. This tax subsidy that you talk about, or preference, has been a thorn in the eyes of economists for 20 years, because it is regressive. I am fortunate to be a high-income American. I benefit a lot more from that than a janitor at Princeton. That is highly regressive.

Now, there has always been opposition to removing this subsidy, which is now \$300 billion, and it came from the National Association of Manufacturers, the Business Council, and the unions, and therefore, it became something you did not touch. But I am glad that we are at least raising the possibility of harvesting some of it. Again, as I proposed, if you are earning more than \$200,000, perhaps you just should not get that at all. If you make \$40,000, we will leave it in place for you.

So I think you should be able to get \$100 billion from that. If you ask any group of health policy analysts, they will say, if we had to do it over again, we would never have the employment-based system that we have now. We might have something like the Wyden-Bennett bill where business contributes, but you would have portable insurance.

But I think, Senator Baucus, this proposal is really not antithetical to yours. Yours is more a long-run vision, where we could end up. What I like about your proposal is that there is a parallel system into which people who lose employer-provided coverage can tumble, this public plan or any private plan so, at some point way down the pike, these plans could merge.

The Committee of Economic Development also posted a plan last November, Alain Enthoven designed that, and theirs is somewhat similar. So those are options. I think what is good about this plan is it can be done fast. This, and President-elect Obama's ideas, can be put in place very fast. Your proposal is really quite revolutionary, and God knows what that would trigger. That is how I see it.

The CHAIRMAN. Thank you, Senator.
Senator Snowe?

Senator SNOWE. Thank you, Mr. Chairman. Thank you for your leadership on this critical question that is certainly long overdue for addressing by Congress and the President.

There are obviously a lot of disparities in the health care system, and we have had a series of hearings before the Finance Committee regarding cost, and getting more value for our health care dollars, and duplicative practices, comparative practices.

I am wondering, as we tackle health care in general and providing particularly for the uninsured, should we not, in conjunction with that, be required to address health care costs and reducing

the burdens on the system where we know that there are some serious inequities and disparities? For example, we talked about comparative practices. There are protocols and best practices that have yet to be adopted by doctors and hospitals across this country that have been in place for the better part of a decade, for example.

Is there a way of addressing that, and should there be a prerequisite to be part of it? Obviously what we can do in Medicare might have an impact on the private system as well.

Dr. Chandra?

Dr. CHANDRA. I just wanted to say that I agree with the spirit of your comments completely. What is really interesting to note is that the plans that are more likely to comply with the best quality indicators that we have are actually cheaper plans. So to get providers to be in compliance with HEDIS quality measures, or whatever quality measures, does not actually require us to spend any more money. We also have the technology to measure provider compliance on a host of different dimensions today. It is software that is already up and running.

The people up at the Dartmouth Institute are certainly able to do that. So I am very optimistic that, through the initiatives that CMS has begun to take, we can kind of do more. But there are two caveats. First is, we need to do a better job of communicating that information to the public, because I think we should not underestimate the ability of embarrassment in the marketplace to get providers to do better.

The second problem that I have with how we are measuring things right now is that we are measuring things at the level of technical process of care measures, which are things like, did you give someone a flu shot, did you do the beta-blockers for someone who had a heart attack? This is a wonderful first step. Ultimately we have to go to the next level, where we actually ask: did this patient survive for 5 years after their heart attack? It is not enough to know that they just got their beta-blockers at the time of discharge.

Senator SNOWE. Thank you.

Dr. Reinhardt?

Dr. REINHARDT. Yes. In your Call to Action, Senator Baucus, you mentioned bundling. Payment reform is really at the heart of a lot of this. The idea of bundling is an old idea. Most policy people would support it. The idea there is that all the services going into a standard treatment like coronary bypass will be bundled and there will be one bundled payment.

The Robert Wood Johnson Foundation granted \$6 million to a company called Prometheus Payment, Inc. They are, in fact, experimenting and having doctors and hospitals work together to do coordinated care and charge one price for that. That should be based on evidence-based medicine, in other words, not just what they want, but the price will be pegged on cost-effective care. That is really the hope. That will take a while, but I believe, as I look 10 years down the pike, we will reimburse a substantial fraction of American health care that way, and that will get at the issue of cost.

The problem is, as I think we all agree, it needs to be done, and we should start now. Victory there will take a lot longer than victory on universal coverage, which could be had first.

Senator SNOWE. Any other comments? Yes?

Mr. STERN. I want to say two things. One is, I want to subscribe to the “tip” theory that Dr. Reinhardt mentioned. If you think that the tax subsidy is a tip, and Medicare Advantage is a tip, and we have 40 percent of our money being spent by the Federal Government, the question is: what do we get for that?

I just think if we have best practices—and I think that goes to the whole question of whether Congress is in the best position to make all those decisions or there should be someone else—but once we decide, I think the question really becomes, if you are giving people something, do you demand that they use the best practices, whether they are in the private sector or the public sector, when we know things work? If we do not drive the cost savings into the system, we can invent them all we want but it will not do us any good.

Mr. SEIDENBERG. Senator, just very quickly, I am in agreement with where you are. I guess if I had some sage advice, which probably is not worth anything, it is this: when Congress finishes changing this, this should not just apply to the insiders, the medical industry, the corporations. Every household has to know something changed: either you now have access to something you never had access to or you have to sit down and shop and learn more about your health care.

So I think the answer to your question is, if you do not attack the quality and the efficiency and the personal involvement, you can make all the changes you want, and the average person is not going to behave differently. So I am in favor of wholesale focus on the issue of efficiency, quality, and all those kinds of things, because it gets the household in the game.

Senator SNOWE. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Grassley?

Senator GRASSLEY. Thank you. I also thank Mr. Stern for bringing up our working together with your organization on the Kerry bill on the one hand, and the Kohl bill on the other. If you had not brought it up, I was prepared to thank you anyway. I had a chance to thank the members of your staff yesterday. I really appreciate that.

Dr. Chandra, we need to have you give us a bottom line here. Would it be good for the economy to add up to \$1 trillion or more on long-term unfunded health care spending to the Federal deficit?

Dr. CHANDRA. Are you going to reform Medicare at the same time?

Senator GRASSLEY. That has to be a part of this issue of our total overall health care reform.

Dr. CHANDRA. Senator Grassley, I am not opposed to adding more money to the Federal deficit. What I worry about is, what is the value that we get for the trillion dollars that we added to it, because that is a trillion dollars that our children are going to have to pay back in the form of higher taxes.

So, if we can convince ourselves that the value that we got in terms of the reductions in uninsurance, the reductions in medical bankruptcies, the improvements in health were more than enough to offset the trillion dollars, then I think it is a trillion dollars well spent.

Senator GRASSLEY. In your testimony, Dr. Chandra, you say “now is a good time to deal with health care costs.” Question: If you had to say which would give us the biggest bang for the buck, which would it be—bending the cost growth curve or getting everyone insurance? In your opinion, can we do both?

Dr. CHANDRA. I think we can absolutely do both. If the question is framed in terms of what is going to change, then going after costs will bend the cost growth curve more than dealing with the uninsurance problem. But I do not see any tension between insuring the uninsured and reducing cost growth, because I believe that the reason people are uninsured is because insurance is currently unaffordable. So, if we made it more affordable, we would be spending less on health care and we would be insuring more Americans.

Senator GRASSLEY. Also, Dr. Chandra, in your testimony you say that some health reforms may help so long as they are not “fiscally expansive.” Would you explain what you mean by that and tell us a little more about what reforms would weaken and which would not weaken, or might even strengthen, the economy?

Dr. CHANDRA. What I worry about, Senator Grassley, is that, if we take our current insurance programs and expand them without any other interventions to inject accountability and improve value, I do not think that it is good value for the dollar because I think that we have many problems in health care that go beyond the problem of the uninsured. The uninsured would not necessarily, with few exceptions, get very high quality health care. So that is what I worry about a lot.

I also worry that people think of the fact that we have 47 million uninsured and, if we brought them into a pool, what is it going to cost us? It is going to cost us \$5,000 a person or more. That is the way that this calculation is usually done. They forget what happens when you bring that many people into the pool of insured. One of the first things that happens is that providers respond by expanding capacity. The minute they expand capacity, they increase or change the threshold at which they readmit. So a lot more gets done not only to those uninsured people, but to everybody else in the economy.

So I am definitely—and I have been in my testimony—in favor of expanding insurance as long as we are thinking long and hard about these broader problems about how to deal with capacity and how to deal with the effectiveness of the health insurance that is being offered to the uninsured. I do not know if that answered all the components of your question.

Senator GRASSLEY. It touches every point. If we have a follow-up, we will ask for answer in writing.

The last question that I would have for you, Dr. Chandra, is, some have suggested that Congress must act quickly to resolve our health care crisis. You have suggested an incremental reform, as we know from the law of medicine, “First Do No Harm.”

Question: When presented with a problem with the complexity of the health care system in America, and in an effort to do no harm to those millions of Americans who want to keep the health insurance they have, what economic risks do we assume by undertaking immediate and comprehensive change in our health care system?

Dr. CHANDRA. Senator, this is the reason why I believe that we should not, overnight, jettison the employer-provided health insurance system, even though I am not a fan of the system at all. I believe that we need to first reform the individual insurance market, and only—only—when that is absolutely functioning well can we think about reforms in the employer-provided health insurance market. So I think we have to do this in steps, but I think the opportunity to undertake those steps is now.

Similarly, when we are talking about Medicare reform, I am not in favor of capitation at all. I am in favor of designing accountable care organizations where providers are rewarded on the basis of the value that they created. That is not something that we are going to be able to do in 6 months or 1 year. My most optimistic guess is that we will be able to do this 5 to 10 years from now.

Senator GRASSLEY. Thank you.

Dr. CHANDRA. Thank you.

Senator GRASSLEY. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

The employer-based tax exclusion has come up here. I think there is a lot of agreement that that has to be addressed. Dr. Reinhardt, you have mentioned it. Senator Wyden has mentioned it often. I think there is some agreement, if we were to finance our health care system all over again, it would be different than what we now have. But we have what we have. We are where we are. My view is, and I know you agree, Mr. Seidenberg, to eliminate the current tax provisions. I think we have to address it in some way because it is regressive, and it has to be a part of the solution here.

Second, I do believe that another part of that same issue on the question of portability can be solved various ways. The way we attempt to solve it in our white paper is to make sure that adequate, good, solid, meaningful health insurance is available for everybody. So keeping health insurance at your current place of employment is not a disincentive for taking a different job someplace else. Job lock is a bit of an issue today. There is no doubt about it. But our goal here is to eliminate job lock by making sure that health insurance is available for all Americans.

Add to that, too, there clearly is an individual's responsibility here. Individual Americans have to step up as well in various ways. I believe that that is a critical part of the equation here, and we will try to find a way to help accomplish that.

I am also struck that there is a lot of agreement here at the witness table—in fact, much more agreement than disagreement. I am just urging all of us in the country to keep an open mind, suspend judgment, do not knee-jerk Republican reactions, or Democratic reactions, or business, or consumer, or whatnot. The issue is so important and we are in such a crisis today, it is imperative that we work together.

Sometimes I think Congress really does not do much unless there are two conditions. One is, we are in a national crisis. Sputnik, put

a man on the man, Depression, Pearl Harbor. The other condition is there is extraordinary political leadership. Frankly, I think we are at a time in American history where we are in a crisis in health care reform, and I do think we are in a time where, with the election of Barack Obama, and with the Congress working with him—I will not say extraordinary political leadership—but I will say there is a tremendous commitment to go the extra mile to put this together in a very meaningful way.

I know I speak for everybody on the committee, and I say that, and other groups I talk with have been saying that. It is my goal just to keep us all working together, keep us all having an open mind, because we all know what the problems are. We tend to know what the solutions are. It is now in the execution, it is dotting the i's and crossing the t's, and we just have to keep that positive attitude, and we are going to go a long way. So, I just want to thank all of you very much for adding so much to the equation here.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman. I would heartily agree with that, but expand on it just a bit. I think that President-elect Obama is profoundly committed to this, and not to do it incrementally, but to do it all within a measurable and responsible period of time. I do not mean to make that seem too long.

Words are important. Dr. Chandra, you said two things using two sets of words which gave entirely different reactions. One was that, I am not in favor of raising debt levels with respect to what the effect would be on our children and grandchildren. But then you turned around and said, well, in response to a Medicare question, yes, I would be willing to see Medicare increased in the size of its amount, provided that quality and efficiency and other matters were being addressed at the same time.

Well, if you say it one way, people get one impression, if you say it the other way, where you mean exactly the same thing in both cases but you say it differently, it is very, very important. I think it is part of what our chairman is talking about, that this really is a time for us to do it. Therefore, we have to in some sense step back from our traditional roles and be highly flexible. Now, that was not my question.

Mr. Seidenberg, the Business Roundtable proposal for health care reform mentions coverage and assistance to low-income uninsured individuals and families. That is something that, if you come from the State of West Virginia or from the State of Montana—in the State of West Virginia, 50 percent of our babies are born under Medicaid, paid for by Medicaid, so we tend to think about that fairly clearly.

But the only suggestion on the Business Roundtable's proposal is that low-income folks be allowed to go out on the individual market. Even going back to the 1993–1994 argument is a fatally flawed argument, in that there is no possible way. I mean, back then we used to talk about \$5,000, and now we are talking about \$16,000 if you include premiums and all the rest of it, up to \$16,000. There is no way they could possibly do that.

So I strongly believe that health care reform should be based, in part, upon our current system. It seems to me that the Business

Roundtable supports that viewpoint in the area of employer coverage, but noticeably absent from your proposal is a discussion of public program expansions. It is a huge, huge point. I believe Medicare, Medicaid, and CHIP should be improved and expanded as part of health care reform, even as we might be doing what Dr. Chandra is talking about, and that is making them work better, cutting out inefficiencies. But you fail to mention that in the Business Roundtable model, and I am sort of curious as to why.

Mr. SEIDENBERG. Yes. First of all, I agree with you. But here is the thing we are trying to avoid. If we get down to the number of people who need public assistance, I think you will find the Business Roundtable will be very cooperative in figuring out whatever the public mechanisms are to do that. When we talk about 47 million—we did not get into it today—a large number of those people are opting out because of structural problems in the system, not because they cannot afford it.

Our testimony was not as specific about how to deliver the health care to the groups that need it, but we are open to make sure that works. Our belief is pretty simple, that, if we take the inefficiencies out of the system, it will more than pay for the 10 to 15 million American households that need the assistance.

Senator ROCKEFELLER. But in the report—not your testimony but in the report—it did not mention that.

Mr. SEIDENBERG. Yes.

Senator ROCKEFELLER. When you put out a report, you have to assume that it is a fairly formal document. So you are revising the report right here before us?

Mr. SEIDENBERG. I do not think I am revising it, but we will make sure that we address the point that you just raised.

Senator ROCKEFELLER. I thank you.

Mr. SEIDENBERG. All right.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman.

Mr. Chairman, let me echo your admonition there a couple of minutes ago. This is going to be critically important to stay flexible and be open. I just want you to know that, as a sponsor of a bill with 17 sponsors, it is my desire to do exactly what you just described, which is to be open and to work with all concerned.

I just have a couple of additional questions. I am going to start with you, Dr. Reinhardt, of course, known as a champ on reform for so many of us for many years. I want to get your sense about a theory that Dr. Ezekiel Emanuel has offered up, and it is one that I largely subscribe to. That is that bold reform actually generates more cost savings than going at this incrementally. I think we saw that with the Congressional Budget Office report on our legislation on the Healthy Americans Act.

But Dr. Emanuel essentially says, well, if you do all these things that are largely supported individually—electronic medical records, comparative effectiveness, prevention—you are going to have to spend some money to get some savings. But, if you go at this boldly, as Senator Baucus talks about in his white paper, as we are trying to do in the Healthy Americans Act, that that actually generates more savings more quickly. It is kind of contrarian that

doing more and being bold actually saves money. But what are your thoughts on that?

Dr. REINHARDT. Well, unfortunately it is true. I just was up in Canada. If you chart health spending in Canada until 1970, the U.S. and Canada were on almost identical tracks in spending. Then you could see us keep going and the Canadians taper off. I wish my wife were here, because she is an expert on the Taiwan health system. I think, Ms. Fowler, you have seen her work. There, too, when they introduced overnight national health insurance, there was 1 year of a big bump in health spending, but thereafter they have actually kept health spending as a percent of GDP at 6 percent, and before it was something like 5.7. That is true.

These countries, however, have parliamentary systems where bold things are very easily done because there is party discipline, et cetera. We have a more complex system of government. I think those of us who are a little bit timid on this have been impressed over time with how hard it is and what political entrepreneurship it takes to get anything done.

Most of us, in fact, at the level of theory would completely agree with that, that if you put a new system in place, you could control costs better. If you really ask yourself, why do we spend so much more than other nations, one of them is, we spend infinitely more on administration. I personally believe it is just inexcusable, how much we blow on administration.

But in addition, we have so fragmented the demand side that it is weak. It is chronically weak relative to the supply side. In all other countries that manage to control costs, the demand side is stronger, they can bargain over rates as they do in Germany. So those are issues that really involve political structure. You have political scientists here that could explain to you why these bold things are so difficult to do. Unless you are in a real calamity—Ezekiel's co-author, Victor Fuchs, says, you can do bold things in a depression and war, and some others say a pandemic, if we had it. Well, I hope not.

Senator WYDEN. Let me see if I can ask you one other question. Dr. Orszag was here recently, the CBO director, now the head of OMB. I asked him the following. He has been talking about the inefficiencies in the system, and they are so pervasive. He has essentially said in response to my question that only two things will actually bend the cost curve downward. I mean, that was his response. One, making sure workers see what they are losing out on in terms of take-home pay. Two, giving them a financial incentive for making a cost-effective purchase. Would you largely agree with that?

Dr. REINHARDT. I think, first of all, to inform workers of the well-known economic theory that it is really they who pay out of lower take-home pay. Traditionally, workers thought this was a free lunch. They thought it came from shareholders. But every economist and every business executive knows it actually gets shifted back, certainly over the long run, into the wages, telling workers that—I quote Douglas Frazier, the leader of the UAW, and he understood it, absolutely fully understood that it really came under take-home pay. That would be the first thing.

Now, the business executives have never seen any reason why they should inform workers of this. It is much easier to tell workers we are giving you something for nothing. So that is a teaching job. The other one is to give people an incentive to choose prudently as long as that ultimately does not turn into a rationing by income class, unless you want that, of course.

Senator WYDEN. No. No, of course not.

Dr. REINHARDT. I am just an economist.

Senator WYDEN. I am with you.

Dr. REINHARDT. If you do not want to ration by income class, then the incentives have to be modulated so that you do not get poor people just getting bare bones and generics and never a specialty drug, and rich people get plans that offer that. But definitely even just telling people—the Employee Benefit Research Institute puts out a beautiful graph that shows total compensation and take-home pay, and the gap is basically health insurance.

Senator WYDEN. Thank you.

The CHAIRMAN. I would like to ask a different point here. That is—and you touched on it, Dr. Reinhardt, and Mr. Seidenberg, you may have a little different point of view—the administrative costs in the U.S. system, which are 18, 19 percent, something like that, 3 or 4 times higher than the next most expensive country.

One reason may be because of the complexity of plans. Medicare is supposed to have much lower administrative costs. But you, Mr. Seidenberg, suggested, if I heard you correctly—implied, at least—more options, that the health insurance industry be able to tailor more. I just wonder the degree to which that makes sense, because in the white paper we have essentially delegated to the exchange, and also to—it is not an institute, but the outfit, the Board of Governors over the exchange, to begin to look at ways to simplify insurance applications and to also begin to boost benefits, to have a minimum benefit package. Also, to some degree, to start to make it easier for people to choose apples from apples, that is, trying to reduce some of the complexity rather than to increase some of the complexity. I just do not know if I heard you say different things or not there.

Mr. SEIDENBERG. May I answer that? Actually, if I can address both your points, one of the reasons that I am spending so much of my time on health care is that we have been down the road of doing exactly what some of you might want us to do. We have explained to our employees what they are missing out in terms of why their wages are going up at a slower level than the benefits that we are paying in health care. We publish this information. They can look it up in their own accounts and they can see the effects.

We have created an enormous number of financial incentives working with the insurance carriers to see if we can drive costs down around what we can control. But what I have found is that employees then say, so, Ivan, what you are doing is you are putting all the burden on us, when the fact is, you should be down in Washington helping to change the structure of this process. So now you get into your question of, what is bold?

I think the modern employee gets on the Internet and they do not see more plans as being more complex. They say, I am smart

enough to figure out which products and services I want to buy. These are the same people who go out and look at 275 different versions of cell phones. They do that pretty well.

So I think we need to fix the structure, which is creating a lot of the things that both of our economists here on the panel have explained so well. I do not think more plans means more complexity. I think it simplifies the delivery of product, and I think each person is very capable of making those choices. We need more product to make sure that people are not trapped in either a job because their employer provides a plan, or, if they leave it, they cannot get some sort of assistance. So I do think it is inconsistent.

The CHAIRMAN. Dr. Reinhardt?

Dr. REINHARDT. Yes, if I may respond to that. You have to look at the other side of it. Recently we had a conference at Johns Hopkins, and Bill Brody, the president, said Hopkins' health system deals with 700 distinct managed-care contracts, each with its own rules on drugs and payment. I serve on the board of the Duke Health System, and we consolidated all our billing. We had 900 clerks, and we have 900 beds. I am sure we have a nurse per bed, but we have a billing clerk per bed. I think we have probably worked this down maybe a little, so do not hold me to that number. But that borders on the obscene.

Mr. SEIDENBERG. No, I agree with that.

Dr. REINHARDT. It clearly does.

Mr. SEIDENBERG. But what happens is, you will end up reducing all the State plans.

Dr. REINHARDT. But there is this notion that we have, and we economists are guilty in propagating it: the more choice, the better. Well, mortgages are much simpler than health insurance, and we saw how beautifully the average American picked mortgages. So, if you like the way we do mortgages and you like the complexity there, you will like complexity in health insurance.

I remember when you simplified the Medigap policies.

The CHAIRMAN. That is right.

Dr. REINHARDT. It was chaos before.

The CHAIRMAN. It was.

Dr. REINHARDT. Now, it is a much, much better thing.

The CHAIRMAN. Yes.

Dr. REINHARDT. That is exactly what we need.

The CHAIRMAN. Thank you very, very much. This has been a very good hearing, and I thank you all for participating. This is exciting. We are going to go places here. Thank you.

The hearing is adjourned.

[Whereupon, at 12:02 p.m., the hearing was concluded.]

A P P E N D I X

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD



Harvard University

Harvard Kennedy School of Government • 79 JFK Street • Cambridge • Massachusetts

Testimony to the United States Senate
Senate Finance Committee, Hearing on *Health Care Reform: An Economic Perspective*
November 19th, 2008

Amitabh Chandra, PhD
Harvard University

My name is Amitabh Chandra, and I am an economist and an assistant professor of public-policy at the John F. Kennedy School of Government at Harvard University. I am also a research fellow of the National Bureau of Economic Research (NBER) and affiliated with the Dartmouth Institute for Health Policy at Dartmouth College. My testimony does not reflect the opinions of the institutions that I am affiliated with.

In a jaundiced economic environment where a growing federal budget deficit has just consumed another 700 billion dollars, advocating the case for health care reform may seem imprudent. This view pitches healthcare reform, which may have some costly components, against the reality of a deficit that will grow even larger as entitlement programs and automatic stabilizers expand with slowing economic activity. But not all reforms confront this tradeoff equally. A few can actually improve American healthcare while reducing the pressures on the Federal deficit. I will focus on these reforms today. At the same time, today's economic environment offers great scope for the advancement of well-intentioned but simplistic panaceas for reform— it is tempting to collapse the entire reform debate into one about insuring the uninsured, adopting information-technology, rewriting malpractice laws, or proposing that supplemental healthcare spending should constitute stimulus spending. We must recognize that genuine healthcare reform requires doing substantially more. Senator Baucus, I congratulate you on for recognizing these complexities, and providing great vision for comprehensive reform in your Call to Action for Health Reform 2009.

My argument today is that reforms that target cost-growth in healthcare will improve the efficiency of our healthcare system while strengthening the functioning of America's labor markets, and consequently, the well being of millions of workers. Cost-growth in healthcare has reduced the wages of workers, decreased their ability to be consumers, increased non-employment, swollen the ranks of the uninsured, discouraged job-search and voluntary turnover, and crippled the competitiveness of American corporations who offer retiree health benefits. Depending on the nature of reforms that confront this problem, they may even catalyze the economy's ability to emerge from a recession.

Cost-growth in healthcare is not a uniquely American phenomenon, but the incentives underlying our Medicare program aggravate this situation by encouraging the adoption of technologically intensive innovations of dubious clinical and therapeutic value. While beneficial in some patients, these new innovations also offer great scope for overuse in others. Regrettably, despite thirty years of academic research on this topic, warnings from the Congressional Budget Office (CBO) and legions of concerned MedPAC Commissioners, the program is also on the eve of bankrupting the United States. But today's strained budgetary environment may give us the stick needed to domesticate the Medicare monster by finally enacting payment reform that promotes accountability and rewards outcomes. Because of spillovers from the practice of medicine in the Medicare to non-Medicare sectors, both public and private dollars will go further if such reforms are adopted. Indeed, cost savings from Medicare reform could be used to pursue other health reform efforts, some of which will certainly cost money. But it is also my view that in the absence of checking the growth of healthcare spending, or accepting limits to what therapies are covered by insurance, other reform efforts will ultimately fail.

I. Rising Health Insurance Premiums and Labor Markets

Let me first explain the effects of cost-growth in healthcare on labor markets. The smooth operation of labor markets requires fewer headlines than capital markets, but they're equally vital—155 million Americans who are in the civilian labor force are affected by what happens in them. According to a national survey conducted by the Kaiser Family Foundation, since 2000 health-insurance premiums for employer provided health insurance have grown three times more than the corresponding increase in wages. Health insurance premiums for workers do not come out of a unlimited reservoir of firm-profits—they come out of wages, and the extent to which that happens depends on workers valuation of the benefits (amongst other things). As the price of health insurance increases, firms lower the wage portion of compensation. The adjustment towards lower wages is not instantaneous, nor is it dollar for dollar, and is therefore often obscured. But as many academic studies have noted, it is clearly at work. Lower wages means lower consumption and less money for gasoline, food, and retail purchases. Recognizing this tradeoff, some healthy workers may be tempted to decline health insurance. Their departure increases premiums for those remaining in the pool. In economics we call their withdrawal the 'adverse selection death spiral.' It decimates health insurance markets.

There is an important caveat to this discussion: while the uncomfortable arithmetic of the wage-fringe tradeoff applies to employees, it cannot apply to retired workers for whom there are no wages to reduce. Increasing costs of retiree health benefits is forcing firms to lose market share to foreign competitors, or respond by slashing these benefits.

There are many reasons, however, to believe that firms have limited ability to offset increases in the price of health insurance premiums through lower wages. Institutional constraints, such as the minimum wage, union rules, and other provisions of labor and tax law that prohibit different demographic groups from being paid differently, limit a firms ability to reduce compensation. For such employees, firms cannot reduce wages but they can move them into part-time jobs without health benefits, or simply lay them

off. And this is exactly what has been happening: Dr. Katherine Baicker and I estimate that a 20% increase in health insurance premiums (which is less than a third of what premiums have grown nationally) results in an employment loss of approximately 3.5 million workers. A similar number of workers would move from full-time jobs to part-time work. Because of the tremendous geographic variation in the way medicine is practiced, employers may avoid locating in the areas of the United States where this is large cost growth cannot be passed on to workers. For workers in these areas, there will be no jobs and no health insurance.

Recessions create painful job-losses and income uncertainty. Even worse, Americans lose their health-insurance when they lose their jobs. They respond by being more reluctant to switch jobs. My colleague Brigitte Madrian estimates that the turnover rate for those with employer-provided health-insurance is 25 percent lower than for those without. But such switching is key to revitalizing our economy, as workers should leave failing firms and move to more exciting opportunities. The health of the economy is vitally tied to the speed and precision with which this matching process is accomplished. Job-lock, induced by the lack of portability of health-insurance, is making the most energetic labor market in the world increasingly sclerotic. The worst news has yet to come—the historical record on the relationship between unemployment and the business cycle suggests that peak unemployment rates are usually seen over a year after the economy starts to grow. Many if not most of these families will lose access to affordable health insurance.

Employers often respond to these pressures by capping insurance benefits. Doing so is short-sighted: we now have evidence that such caps result in adverse clinical outcomes, worse adherence, and increased hospital and ER costs. Worse, the presence of caps means that patients are not insured against catastrophic costs—exactly what insurance is supposed to protect against. The capping of benefits combined with the fact that many workers are not only losing jobs but also their health insurance implies that Americans are a substantially higher risk for a medical bankruptcy (between 20 and 50 percent of all personal bankruptcies are medically related).

All this cost-growth in health may have been palatable if the increase in costs meant greater quality or higher patient satisfaction. But neither is true. Katherine Baicker and I have shown that the association between spending and quality is actually negative. My colleagues at the Dartmouth Institute have demonstrated that 30 percent of medical spending has been shown to confer no medical or therapeutic benefit. The United States spends over 2.1 trillion dollars a year on healthcare. 30 percent of that is 700 billion dollars. We're spending a financial bailout every year, with the difference that this one rescues no one. The growing price of health insurance is creating two Americas—one with Americans who lack health insurance and are subject to great uncertainty about medical expenses, and another whose members carry expensive health insurance policies which promise great hope. But relative to the price of this insurance, this group second receives little when outcomes and patient satisfaction are actually measured. We can do better for both groups.

II. Incremental Reform

What are we to do about this situation? In the short-run, we should allow workers to retain access to health insurance benefits. Extending COBRA coverage remains a reform lever, but this gives workers who're unemployed access to expensive healthcare.

Reforming the individual health insurance market through regulatory reform offers promise. But it poses several challenges. Reforming the individual market will require us to address variation across states in the extent to which insurance is 'community rated'. Otherwise, insurers will charge sick people more in states without these provisions. Forbidding such behavior and forcing firms to charge sick patients the premium for healthy patients will put insurers out of business; an outcome that helps no one. Arguing that poor-sick and rich-healthy persons should be charged the same premiums reflects a normative preference for redistribution (from the healthy to the sick) and we should not be surprised if voters object to such a system. Defining the extent to which such redistribution or 'social insurance' operates in insurance markets is only vaguely guided by economics—politics and voter opinion ultimately determine such things. Geographic variation in how medicine is practiced will mean that premiums for Hanover, New Hampshire will be substantially higher than those in McAllen, Texas. Simply deregulating insurance markets will do nothing to address these concerns. And, at the end of the day, none of these reforms ensure that premium growth reflects growth in valuable services.

People who have already purchased insurance and then fall sick pose a particular policy problem: insurance is not just about protecting against unexpected high expenses this year, but is also about protecting against the risk of persistently higher future expenses in the case of chronic illness. With this kind of protection, enrollees' premiums would not rise just because they got sick, but this is not always the case today. In fact, insurers have an incentive to shed their sickest enrollees, which suggests a strong role for regulation in protecting such enrollees. Nor are insurers held responsible when inadequate coverage raises the costs for a future insurer, such as Medicare for those over age sixty-five. These problems highlight the limited availability of true long-run insurance offerings. But these are the reform issues that Congress can turn to even in times of great fiscal pressure.

One reform idea that we hear more of in coming months is that that large-scale expansions in insurance are most necessary in terms of economic crisis. I agree with the spirit of this comment, but want to highlight an important caveat to how it is best accomplished. Reforms that are permanently expansive will weaken the Federal budget situation even more and compromise America's long-term economic prospects by raising capital costs and forcing future generations of Americans to pay higher taxes. While it may be tempting to view some of this spending as part of a stimulus package, my colleague and former U.S. Treasury Secretary, Lawrence Summers, has noted that wise stimulus spending has the hallmark of being able to be shut off in a year or two, and be linked to a concrete deficit reducing action in the future. Permanent expansions in government healthcare spending are unlikely to meet either criterion. A compromise position at this point may be to offer vouchers, or authorize temporary expansions of Federal and State health insurance policies to American families.

Regardless of the chosen option, we should not delude ourselves into thinking that insuring the uninsured assures them access to high-quality healthcare. The focus on the uninsured is predicated on the view that the insured are receiving high-quality care, equating higher spending and higher quality. The frequent failure of the use of best practices and the tremendous geographic variation in the use of costly care of uncertain medical benefit are often obscured in the focus on the uninsured. Insuring the uninsured will give them access to the sort of health care that everyone else receives: a combination of valuable care, overuse of some costly interventions with little proven benefit, and underuse of some vitally important therapies— care that is sometimes coordinated but often fragmented. This is better than no care, but it highlights the problem of collapsing the entire debate about U.S. health care reform down to the issue of uninsurance: health insurance does not guarantee good health care.

III. Structural Reform

A deeper, more challenging reform proposal would be to think about the fundamental causes for cost-growth in healthcare. The aging of the population has very little to do with this trend. We have a malpractice system that encourages physicians to use every imaging and diagnostic test in the healthcare armamentarium. However, my research shows it's wrong to argue that malpractice is the principal driver of increases in healthcare spending. Rather, cost-growth in healthcare stems from the adoption of new medical technologies that while offering great hope to some patients also offer tremendous scope for overuse in others. The biggest monster under the bed is the gluttonous Medicare program whose perverse incentive structure rewards the adoption of these technologies, encourages financial entrepreneurship by providers, motivates improper physician-industry associations and undesirable forms of physician self-referral. It penalizes prevention and jettisons accountability by reducing healthcare to thousands of discrete billing codes.

Because the same providers treat Medicare and non-Medicare patients in an environment of shared practice norms, what happens in Medicare spills over into the care of non-Medicare population. If a new cardiac catheterization laboratory is set up to treat heart-attacks in the elderly, it can surely be used to perform angioplasty for stable coronary disease in a 45 year old? Even though the former intervention has been shown to be life-saving, the latter procedure has been shown to generate zero benefit as an initial management strategy. Zero Benefit. Not small benefit. Zero Benefit. These insights are probably quite familiar to members of this Committee and to the Commissioners of MedPAC, both of whom have been prescient in recognizing the disincentive effects of Medicare. But it is these very spillovers that offer us an opportunity for reform. Introducing value based reimbursement in Medicare will spillover onto non-Medicare patients. Profiling physicians in the Medicare program on quality will information that will be used by insurers who cover the non-Medicare program to negotiate better prices. Information about quality and resource use is a public good, and is consequently underprovided. Government has a unique role in subsidizing the production of such public-goods.

Reforming Medicare will require enormous Congressional courage, as the beneficiaries of the status quo will launch a bitter fear-campaign against attempts to inject accountability. But, as I stated earlier, it is my view that today's strained budgetary environment may give us the stick needed to domesticate this monster by finally enacting payment reform that promotes accountability and rewards outcomes. For real reform we have to provide these reforms not only for acute care, but also for ambulatory care. At the Dartmouth Institute, Dr. Elliott Fisher, and Dr. Julie Bynum have made great progress in our understanding how to measure, monitor, and benchmark the longitudinal efficiency of physicians in such settings. But we do not claim to know all the answers.

Reform efforts that target cost-growth require more than the adoption of cost-effectiveness analysis (CEA)—they will require us to measure and reward outcomes for services that are not easily brought under traditional approaches to cost effectiveness analysis because they are not provided to treat specific abnormalities. These range from variations in the intensity of management of chronic disease to different approaches in diagnosing patients with new symptoms or concerns. The remarkable variations in per-patient spending observed across academic medical centers with similar outcomes are largely due to differences in use of largely discretionary services such as the frequency of physician office visits or specialist consultation, differences in the relative intensity of imaging services, and how much time similar patients spend in institutional settings. There is evidence that suggests the growth of these services, as opposed to treatments that are administered in an inpatient setting (and amenable to evaluation by CEA), account for the lion's share of cost growth in U.S. healthcare.

IV. Conclusion

I liken the recent financial-crisis and accompanying bailout to a heart-attack—swift, costly, therapy with rescue angioplasty is the only way to restore blood flow and preserve life. But two vital measures of the economy's long-term health—the state of its labor markets and the size of long-term federal budget are ailing. Ignoring these ailments is like a healthcare plan that treats acute events, but ignores prevention and chronic disease management. Ironically, we have great expertise in setting up such plans.

Healthcare reform that addresses cost-growth will enhance the productivity of labor markets, and have effects on the wages, consumption, employment and insurance of millions. It can energize our ability to emerge from recession. If such reform is engineered by reforming the Medicare program, we would also have improved the long-term budget situation. Doing so would help us cope better with the next economic challenge that America will surely face.



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December 19, 2008

Senator Max Baucus
Committee on Finance, United States Senate
Washington DC 20515

Dear Senator Baucus:

Thank you for giving me the opportunity to respond to Senator Stabenow's question that was submitted for the record. There are two parts to the inquiry and I shall respond to each in turn.

Question 1: Could anyone on the panel discuss how the economy will impact our nation's children?

Given the hearing's focus on healthcare, I've focused my response on how the economy's condition will affect health of children-- there are other important outcomes such as educational performance that I have not discussed.

Economists have shown that when the fathers of children in the bottom 25 percent of the income distribution, are displaced, the *children* are more likely to receive unemployment and social assistance, and have lower earnings themselves when they become adults. So what happens to people in childhood affects not only their outcomes as children, but also as adults. As such, for the most disadvantaged children, the effects of a deep recession may be felt decades into the future. There is something about job-displacements, and the attendant stressors of income uncertainty and residential instability that is extremely disruptive for children. These stressors create mental health problems which affect educational attainment, and through this channel, longevity and lifelong economic circumstance.

As I said in my oral testimony, when Americans lose their jobs they also lose their health insurance-- this loss may greatly affect infants and expectant mothers. We know that babies who were exposed to high disease burden in childhood experience much higher

rates of adult mortality. Similarly, low birth weight children have been shown to have lower test-scores, educational attainment, wages and employment. These facts highlight the potential for great value in expanding insurance. I elaborate on this point in my response to your second question.

Finally, I would like to add an important caveat to discussions about the state of the economy and the well-being of children. It is certainly true that poorer children, and those of lower socio-economic status (SES), are more likely to experience adverse health events such as asthma, mental health problems, or a hospitalization). It is tempting to observe this fact and conclude that slowing economic activity will reduce the resources of families and consequently an increase adverse health events for children. But we must be careful here: simply because poorer children have worse health outcomes does imply that lower socio-economic status (SES) causes worse child health. It is possible that a third factor, such as lower parental education, causes both lower SES and worse child outcomes. In such a world, policies that attempt to improve child health by affecting their parents SES will ultimately fail, and we should not let our efforts to help vulnerable children justify the adoption of well-intentioned, but ineffective policies. I raise this caveat because several welfare-to-work experiments increased family incomes and maternal employment. Yet, the National Research Council and the Institute of Medicine evaluations of welfare to work programs found no effects (positive or negative) on children.

We would do well to start a conversation about how best to insulate children from the effects of job-displacement for health-insurance is unlikely to be a sufficient guarantee of their well-being. We will do well to think about strengthening the WIC program (the nutrition program that provides supplemental nutrition provides coupons for specific foods for women and children who're "nutritionally at risk"). We have systematic evidence that WIC improves child cognitive outcomes, and temperament. And in the midst of this conversation, we should avoid making it more difficult for plant closures to happen or for economic activity to reorganize itself-- this reorganization is central to America's ability emerge from recession, and consequently, affect the well-being of millions.

Question 2 How will the Bush administration's failure to reauthorize CHIP and to address the Medicaid regulations impact our nation's ability to ensure children have access to health care?

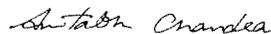
I disagreed with the President's decision to veto the compromise legislation that members of the Senate Finance Committee had taken the initiative in drafting. We will soon have to revisit the business of CHIP reform, and we will be able to increase the value from this social insurance program by recalling the experience of Medicaid expansions. Medicaid benefits children in families who are poorer than those covered by CHIP. So if we find small effects of Medicaid on child outcomes, then we will probably find even smaller effects from CHIP (CHIP starts coverage at a point in the income distribution where approximately 15 percent of children are uninsured). A large literature in economics has evaluated the effect of Medicaid expansions on children's wellbeing. Research has found that Medicaid expansions reduced low birth birth and infant mortality *in lower income populations*, where expansions were 'targeted' (as was the case until 1987). These expansions were also shown to be cost-effective. Later, "broad" expansions, to higher income families (but still disadvantaged) were not found to improve health in these populations. This is perhaps because such families were more likely to be covered by employer provided health insurance.

Second, arguments about 'crowdout' are not theoretical-- they are a harsh reality and we will serve our children better by acknowledging the challenge of ensuring that public insurance programs do not become a way for people to leave the non-public insurance market. The estimates of "crowd out" in this population imply that number of privately insured falls by 50% to 60% as the number of publicly insured rises.

As we think about reforming Medicaid and CHIP, we should focus on the neediest and most vulnerable groups first. It makes very little sense to think about expanding coverage to new demographic groups who have lower rates of uninsurance and in whom the program will generate less benefit, when there are 4 million children who are already eligible but do not take up the program because of stigma or lack of information. It is my view that the compromise legislation that that was initiated by the Senate was sensitive to these concerns. Adding anti-crowd out measures that have been shown to work, would extend the reach of public dollars even further.

I hope that you find my response useful. Please do not hesitate to contact me if I can be of more assistance to you.

Sincerely,



Amitabh Chandra.

SUBMITTED BY SENATOR GRASSLEY

United States Government Accountability Office

GAO

Statement for the Record
For the Committee on Finance,
U.S. Senate

For Release on Delivery
Expected at 10:00 a.m. EST
Wednesday, November 19, 2008

STATE AND LOCAL FISCAL CHALLENGES

Rising Health Care Costs Drive Long-term and Immediate Pressures

Statement of Stanley J. Czerwinski, Director
Strategic Issues



November 19, 2008

STATE AND LOCAL FISCAL CHALLENGES

Rising Health Care Costs Drive Long-term and Immediate Pressures



Highlights of GAO-09-210T, a Statement for the Record for the Committee on Finance, U.S. Senate

Why GAO Did This Study

GAO was asked to provide its views on projected trends in health care costs and their effect on the long-term outlook for state and local governments in the context of the current economic environment. This statement addresses three key points: (1) the state and local government sector's long-term fiscal challenges; (2) rapidly rising health care costs which drive the sector's long-term fiscal difficulties, and (3) the considerations involved in targeting supplemental funds to states through the Medicaid program during economic downturns.

To provide Congress and the public with a broader perspective on our nation's fiscal outlook, GAO previously developed a fiscal model of the state and local sector. This model enables GAO to simulate fiscal outcomes for the sector in the aggregate for several decades into the future. GAO first published the findings from the state and local fiscal model in 2007. This statement includes August 2008 data to update the simulations.

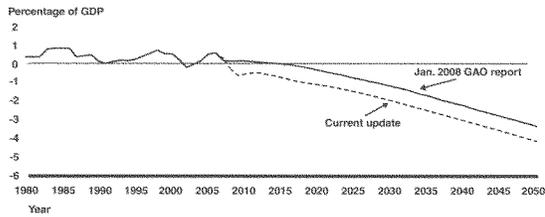
This Committee and others also asked GAO to analyze strategies to help states address increased Medicaid expenditures during economic downturns. GAO simulated the provision of such supplemental assistance to states. As we previously reported, the simulation model adjusts the amount of funding states would receive based on changes in unemployment and spending on Medicaid services.

To view the full product, including the scope and methodology, click on GAO-09-210T. For more information, contact Stanley J. Czerwinski, (202) 512-6806, Czerwinski@gao.gov.

What GAO Found

Rapidly rising health care costs are not simply a federal budget problem. Growth in health-related spending also drives the fiscal challenges facing state and local governments. The magnitude of these challenges presents long-term sustainability challenges for all levels of government. The current financial sector turmoil and broader economic conditions add to fiscal and budgetary challenges for these governments as they attempt to remain in balance. States and localities are facing increased demand for services during a period of declining revenues and reduced access to capital. In the midst of these challenges, the federal government continues to rely on this sector for delivery of services such as Medicaid, the joint federal-state health care financing program for certain categories of low-income individuals.

Our model shows that in the aggregate the state and local government sector faces growing fiscal challenges. Incorporation of August 2008 data shows that the position of the sector has worsened since our January 2008 report.



Source: Historical data from National Income and Product Accounts. Historical data from 1980 - 2007. GAO projections from 2008 - 2050 using many GAO projections and assumptions, particularly for the next 10 years. Jan. 2008 GAO Report is GAO-08-317.

The long-term outlook presented by our state and local model is exacerbated by current economic conditions. During economic downturns, states can experience difficulties financing programs such as Medicaid. Downturns result in rising unemployment, which can increase the number of individuals eligible for Medicaid, and declining tax revenues, which can decrease revenue available to fund coverage of additional enrollees. GAO's simulation model to help states respond to these circumstances is based on assumptions under which the existing Medicaid formula would remain unchanged and add a new, separate assistance formula that would operate only during times of economic downturn. Considerations involved in such a strategy could include:

- Timing assistance so that it is delivered as soon as it is needed,
- Targeting assistance according to the extent of each state's downturn,
- Temporarily increasing federal funding so that it turns off when states' economic circumstances sufficiently improve, and
- Triggering so the starting and ending points of assistance respond to indicators of economic distress.

Mr. Chairman and Members of the Committee:

I appreciate the opportunity to provide this statement for the record for today's hearing that discusses our observations on health care costs and their relationship to long-term state and local government fiscal conditions in the context of the current economic environment. Our economic perspective on health care costs draws on historical data, simulations, and analysis of policy options to reveal daunting challenges in need of intergovernmental solutions. As Acting Comptroller General Gene Dodaro testified before this committee in June, the nation's long-term fiscal outlook is driven primarily by rising health care costs and known demographic trends.¹

Rapidly rising health care costs are not simply a federal budget problem. Growth in health-related spending also drives the long-term fiscal challenges facing state and local governments. The magnitude of these pressures presents vexing long-term sustainability challenges for all levels of government. The current turmoil in the financial sector adds to the immediate fiscal and budgetary challenges for these governments as they attempt to remain in balance in a rapidly changing and uncertain budget environment. States and localities are facing increased demand for services during a period of declining revenues and reduced access to capital. In the midst of these challenges, the federal government continues to rely on this sector for delivery of services such as Medicaid, the joint federal-state health care financing program that covers medical costs for certain categories of low-income individuals.

This statement addresses a few key points:

- the state and local government sector's long-term fiscal challenges,
- the rapidly rising health care costs which drive the sector's long-term fiscal difficulties, and
- the immediate considerations involved in targeting supplemental funds to states through the Medicaid program during economic downturns.

This statement is based on our previous work on intergovernmental fiscal issues, including reports and testimony on state and local government fiscal challenges, our nation's long-term fiscal challenges, and approaches to providing federal fiscal assistance through Medicaid. We conducted this

¹GAO, *Long-Term Fiscal Outlook: Long-Term Federal Fiscal Challenge Driven Primarily by Health Care*. GAO-08-912T (Washington, D.C.: June 17, 2008)

performance audit in November 2008 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The State and Local Government Sector Faces Increasing Fiscal Challenges

Fiscal sustainability presents a national challenge shared by all levels of government. The federal government and state and local governments share in the responsibility of fulfilling important national goals, and these subnational governments rely on the federal government for a significant portion of their revenues. To provide Congress and the public with a broader perspective on our nation's fiscal outlook, we developed a fiscal model of the state and local sector. This model enables us to simulate fiscal outcomes for the entire state and local government sector in the aggregate for several decades into the future. Our state and local fiscal model projects the level of receipts and expenditures for the sector in future years based on current and historical spending and revenue patterns.² This model complements GAO's long-term fiscal simulations of federal deficits and debt levels under varying policy assumptions.³ We

²To develop the long-run state and local model simulations, we make projections for each major receipt and expenditure category of the state and local government sector. On the receipts side, key categories of receipts for state and local governments include several types of taxes (personal income, sales, property, and corporate), income on assets owned by the sector, and grants from the federal government. Categories of expenditures include wages and salaries of state and local employees, health insurance costs, pension costs, payment of social benefits (e.g., Medicaid and unemployment), depreciation expense on state and local capital stock, interest payments on state and local financial debt, and other expenditures of the sector. The primary data source for the model is the National Income and Product Accounts (NIPA). The timeframe for the simulations parallels that of our federal fiscal model—the simulations extend until 2050. The state and local model examines the aggregate fiscal outcomes for the sector and does not examine the condition of any individual state or local government.

³GAO, *The Nation's Long-Term Fiscal Outlook: September 2008 Update*, GAO-09-34R (Washington, D.C.: Nov. 2008).

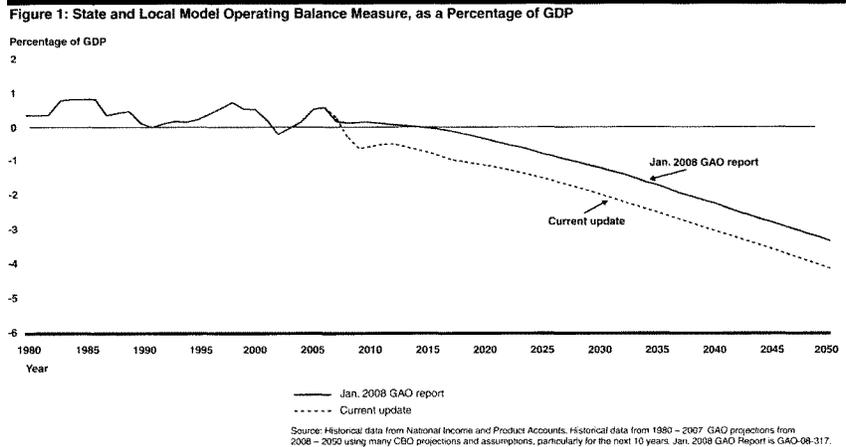
have published long-term federal fiscal simulations since 1992. We first published the findings from our state and local fiscal model in 2007.⁴

Our model shows that the state and local government sector faces growing fiscal challenges. The model includes a measure of fiscal balance for the state and local government sector for each year until 2050. The operating balance net of funds for capital expenditures is a measure of the ability of the sector to cover its current expenditures out of current receipts.⁵ The operating balance measure has historically been positive most of the time, ranging from about zero to about 1 percent of gross domestic product (GDP). Thus, the sector usually has been able to cover its current expenses with incoming receipts.

Our January 2008 report showed that this measure of fiscal balance was likely to remain within the historical range in the next few years, but would begin to decline thereafter and fall below the historical range within a decade. That is, the model suggested the state and local government sector would face increasing fiscal stress in just a few years. We recently updated the model to incorporate current data available as of August 2008. As shown in Figure 1, these more recent results show that the sector has begun to head out of balance.

⁴GAO, *State and Local Governments: Growing Fiscal Challenges Will Emerge during the Next 10 Years*, GAO-08-317 (Washington, D.C.: Jan. 22, 2008), and *State and Local Governments: Persistent Fiscal Challenges Will Likely Emerge within the Next Decade*, GAO-07-1080SP (Washington, D.C.: July 18, 2007).

⁵In developing this measure we subtract funds used to finance longer-term projects—such as investments in buildings and roads—from receipts since these funds would not be available to cover current expenses. Similarly, we excluded capital-related expenditures from spending.

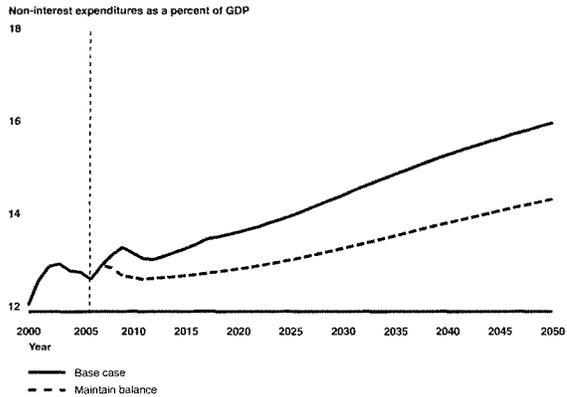


These results suggest that the sector is currently in an operating deficit. Our simulations show an operating balance measure well below the historical range and continuing to fall throughout the remainder of the simulation timeframe.

Since most state and local governments are required to balance their operating budgets, the declining fiscal conditions shown in our simulations suggest the fiscal pressures the sector faces and are a foreshadowing of the extent to which these governments will need to make substantial policy changes to avoid growing fiscal imbalances. That is, absent policy changes, state and local governments would face an increasing gap between receipts and expenditures in the coming years. One way of measuring the long-term challenges faced by the state and local sector is through a measure known as the “fiscal gap.” The fiscal gap is an estimate of the action needed today and maintained for each and every year to achieve fiscal balance over a certain period. We measured

the gap as the amount of spending reduction or tax increase needed to maintain debt as a share of GDP at or below today's ratio.⁶ As shown in figure 2, we calculated that closing the fiscal gap would require action today equal to a 7.6 percent reduction in state and local government current expenditures. Closing the fiscal gap through revenue increases would require action of the same magnitude to increase state and local tax receipts.

Figure 2: Extent of State and Local Action Required to Maintain Balance (State and Local Expenditures, as a Percentage of GDP)



Source: Historical data from National Income and Product Accounts.
 Note: Historical data are from 2000-2007. Projections are from 2008-2050. In the "base case" model we assume that the tax structure is not changed in the future and that the provision of real government services per capita remains roughly constant. That is, a basic assumption of our model is that the current set of policies in place across state and local government remains constant.

⁶Fiscal gap is calculated for the years 2008 to 2057.

Rapidly Rising Health Costs Drive Long-term State and Local Sector Fiscal Difficulties

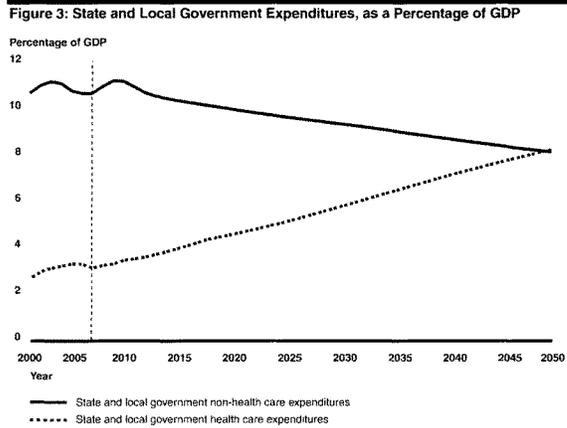
Growth in health-related costs serves as the primary driver of the fiscal challenges facing the state and local sector over the long term. Medicaid is a key component of their health-related costs. CBO's projections show federal Medicaid grants to states per recipient rising substantially more than GDP per capita in the coming years.⁷ Since Medicaid is a federal and state program with federal Medicaid grants based on a matching formula, these estimates indicate that expenditures for Medicaid by state governments will rise quickly as well. We also estimated future expenditures for health insurance for state and local employees and retirees. Specifically, we assumed that the excess cost factor—the growth in these health care costs per capita above GDP per capita—will average 2.0 percentage points per year through 2035 and then begin to decline, reaching 1.0 percent by 2050.⁸ The result is a rapidly growing burden from health-related activities in state and local budgets. Our simulations show that other types of state and local government expenditures—such as wages and salaries of state and local workers, pension contributions, and investments in infrastructure—are expected to grow slightly less than GDP. At the same time, most revenue growth is expected to be approximately flat as a percentage of GDP.⁹ The projected rise in health-related costs is the root of the long-term fiscal difficulties these simulations suggest will occur. Figure 3 shows our simulations for expenditure growth for state and local government health-related and other expenditures.¹⁰

⁷For Medicaid, our cost growth projections align with CBO's most recent budget baseline for the first 10 years. Thereafter, we project Medicaid grants by combining the Center for Medicare and Medicaid Services' 2008 excess cost growth assumption for national health expenditures with CBO's Dec. 2007 long-term projection for Medicaid assuming zero excess cost growth.

⁸We developed estimates of cost growth for health insurance based on research and discussions with experts.

⁹The exception to this is Medicaid grants from the federal government.

¹⁰Interest payments that these governments will need to pay on their outstanding debt will also likely be a rising expense for the sector in the future. Rising interest costs are a reflection of the sustained deficits the model predicts across future years.



Source: Historical data from National Income and Product Accounts. Historical data from 2000 – 2007, projections from 2008 – 2050.
 Note: Health care expenditures include health care benefits for employees and retirees and medical spending on behalf of other individuals, such as Medicaid and the State Children’s Health Insurance Program (SCHIP). Non-health care expenditures include all expenditures with the exception of health care and interest payments.

On the receipt side, our model suggests that most of these tax receipts will show modest growth in the future—and some are projected to experience a modest decline—relative to GDP.¹¹ We found that state personal income taxes show a small rise relative to GDP in coming years. This likely reflects that some state governments have a small degree of progressivity in their income tax structures. Sales taxes of the sector are expected to experience a slight decline as a percentage of GDP in the coming years, reflecting trends in the sector’s tax base. While historical data indicate that property taxes—which are mostly levied by local governments—could rise slightly as a share of GDP in the future, recent events in the housing market suggest that the long-term outlook for property tax revenue could

¹¹Percentages of each category of state and local tax receipts in 2007 were approximately: sales, 33; property, 30; personal income, 24; corporate, 5; and other, 9.

also shift downward. These differential tax growth projections indicate that any given jurisdiction's tax revenue prospects are uniquely tied to the composition of taxes it imposes.

The only source of revenue expected to grow rapidly under current policy is federal grants to state governments for Medicaid. That is, we assume that current policy remains in place and the shares of Medicaid expenditures borne by the federal government and the states remain unchanged.¹² Since Medicaid is a matching formula grant program, the projected escalation in federal Medicaid grants simply reflects expected increased Medicaid expenditures that will be shared by state governments. These long-term simulations do not attempt to assume how recent actions to stabilize the financial system and economy will be incorporated into the federal budget estimates in January 2009.

Considerations for Targeting Supplemental Funds to States through the Medicaid Program during Economic Downturns

The outlook presented by our state and local model is exacerbated by current economic conditions. During economic downturns, states can experience difficulties financing programs such as Medicaid. Economic downturns result in rising unemployment, which can lead to increases in the number of individuals who are eligible for Medicaid coverage, and in declining tax revenues, which can lead to less available revenue with which to fund coverage of additional enrollees. For example, during the most recent period of economic downturn prior to 2008, Medicaid enrollment rose 8.6 percent between 2001 and 2002, which was largely attributed to states' increases in unemployment. During this same time period, state tax revenues fell 7.5 percent. According to the Kaiser Commission on Medicaid and the Uninsured, in 2008, most states have made policy changes aimed at controlling Medicaid costs.¹³

Recognizing the complex combination of factors affecting states during economic downturns—increased unemployment, declining state revenues, and increased downturn-related Medicaid costs—this Committee and several others asked us to assist them as they considered a legislative

¹²Because CBO's baseline adjusts discretionary spending, such as non-Medicaid grants to state and local governments, only for inflation, our projections for these grants decline as a share of GDP over the next 10 years—the timeframe of CBO's projections. Beyond that, we grow these expenditures at the rate of population growth plus inflation.

¹³Kaiser Commission on Medicaid and the Uninsured. *Headed for a Crunch: An Update on Medicaid Spending, Coverage and Policy Heading into an Economic Downturn* (The Henry J. Kaiser Family Foundation, Sept. 2008).

response that would help states cope with Medicaid cost increases.¹⁴ In response to this request, our 2006 report on Medicaid and economic downturns explored the design considerations and possible effects of targeting supplemental assistance to states when they are most affected by a downturn.¹⁵ We constructed a simulation model that adjusts the amount of funding a state could receive on the basis of each state's percentage increase in unemployment and per person spending on Medicaid services. Such a supplemental assistance strategy would leave the existing Medicaid formula unchanged and add a new, separate assistance formula that would operate only during times of economic downturn and use variables and a distribution mechanism that differ from those used for calculating matching rates. This concept is embodied in the health reform plan released by Chairman Baucus last week.¹⁶

Using data from the past three recessions, we simulated the provision of such targeted supplemental assistance to states. To determine the amount of supplemental federal assistance needed to help states address increased Medicaid expenditures during a downturn, we relied on research that estimated a relationship between changes in unemployment and changes in Medicaid spending.¹⁷ Our model incorporated a retrospective assessment which involved assessing the increase in each state's unemployment rate for a particular quarter compared to the same quarter of the previous year. Our simulation included an economic trigger turned on when 23 or more states had an increase in the unemployment rate of 10 percent or more compared to the unemployment rate that existed for the same quarter 1 year earlier (such as a given state's unemployment rate

¹⁴The bipartisan group of Senators requesting this work included Senators Bingaman, Collins, Nelson, Rockefeller, and Smith.

¹⁵GAO, *Medicaid: Strategies to Help States Address Increased Expenditures during Economic Downturns*, GAO-07-97 (Washington, D.C.: Oct. 18, 2006).

¹⁶U.S. Senator Max Baucus, *Call to Action: Health Reform 2009* (Washington, D.C.: Nov. 12, 2008).

¹⁷Stan Dorn, Barbara Markham Smith, and Bowen Garrett, *Medicaid Responsiveness, Health Coverage, and Economic Resilience: A Preliminary Analysis*. Prepared for the Health Policy Institute of the Joint Center for Political and Economic Studies (Washington, D.C.: Joint Center for Political and Economic Studies, Sept. 27, 2005). For our model, we used Dorn et al.'s estimates to derive an average increase in Medicaid expenditures per additional unemployed person of \$300, which could be adjusted over time by inflation and changes in demographics of the Medicaid population.

increasing from 5 percent to 5.5 percent).¹⁸ We chose these two threshold values—23 or more states and increased unemployment of 10 percent or more—to work in tandem to ensure that the national economy had entered a downturn and that the majority of states were not yet in recovery from the downturn.¹⁹ These parameters were based on our quantitative analysis of prior recessions.²⁰ As shown in figure 4, for the 1990-1991 downturn, 6 quarters of assistance would have been provided beginning with the third quarter of 1991 and ending after the fourth quarter of 1992.²¹

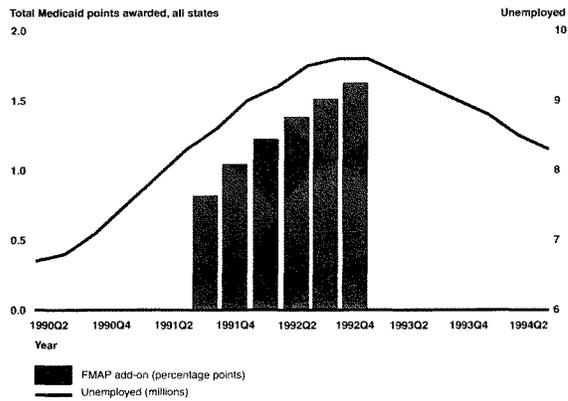
¹⁸This is an increase of 10 percent compared to the unemployment rate of the same quarter in the previous year and not a 10 percentage point change in unemployment rates (such as from 5 percent unemployment to 15 percent).

¹⁹We chose both numbers based on a review of states' unemployment rates over the past three recessions and determined that these levels would have provided considerable certainty that the economic slowdown was nationwide.

²⁰We chose these threshold values based on evidence which indicated that 23 states experiencing a 10 percent or more increase in unemployment provided considerable certainty that an economic slowdown had extended nationwide and that at least 23 states had not yet entered a recovery. These parameters could be adjusted up or down to tighten or loosen the threshold for providing supplemental assistance. The use of unemployment as an indicator also reflects research establishing a connection between increased unemployment and Medicaid enrollment.

²¹This reflects a slight variation from our 2006 report based on a reduction in the administrative lag to make payments.

Figure 4: Simulation Model's Supplemental Medicaid Assistance Compared to States' Unemployment Increases



Source: U.S. Dept. of Labor, Bureau of Labor Statistics and GAO-07-97.
 Note: Unemployment data are expressed in millions and represent a twelve-month rolling average calculated for each quarter. The Federal Medical Assistance Percentage (FMAP) add-on amount is the average of all states' percentage point increases in their FMAPs calculated using the prototype formula simulation described in Appendix II of GAO-07-97.

Analysis of recent unemployment data indicate that such a strategy would already be triggered based on changes in unemployment for 2007 and 2008. In other words, current data confirm the economic pressures currently facing the states.

Considerations involved in such a strategy include:

- Timing assistance so that it is delivered as soon as it is needed,
- Targeting assistance according to the extent of each state's downturn,
- Temporarily increasing federal funding so that it turns off when states' economic circumstances sufficiently improve, and
- Triggering so the starting and ending points of assistance respond to indicators of states' economic distress.

Any potential legislative response would need to be considered within the context of broader health care and fiscal challenges—including continually rising health care costs, a growing elderly population, and Medicare and Medicaid’s increasing share of the federal budget. Additional criteria could be established to accomplish other policy objectives, such as controlling federal spending by limiting the number of quarters of payments or stopping payments after predetermined spending caps are reached.

Conclusions

The federal government depends on states and localities to provide critical services including health care for low-income populations. States and localities depend on the federal government to help fund these services. As the largest share of federal grant funding and a large and growing share of state budgets, Medicaid is a critical component of this intergovernmental partnership. The long-term structural fiscal challenges facing the state and local sector further complicate the provision of Medicaid services. These challenges are exacerbated during periods of economic downturn when increased unemployment leads to increased eligibility for the Medicaid program. The current economic downturn presents additional challenges as states struggle to meet the needs of eligible residents in the midst of a credit crisis. Our work on the long-term fiscal outlook for state and local governments and strategies for providing Medicaid-related fiscal assistance is intended to offer the Committee a useful starting point for considering strategic evidence-based approaches to addressing these daunting intergovernmental fiscal issues.

GAO Contact and Staff Acknowledgments

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**THE IMPERATIVE OF ENACTING HEALTH REFORM NOW:
An Economic Perspective**

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**Statement presented to the
U.S. SENATE FINANCE COMMITTEE HEARING ON
“HEALTH CARE REFORM: AN ECONOMIC PERSPECTIVE”
November 19, 2008**

My name is Uwe Reinhardt. I am Professor of Economics and Public Affairs with a joint-appointment at the Woodrow Wilson School of Public and International Affairs and the Department of Economics of Princeton University. My research during the past several decades has focused mainly on health economics and policy, although I also teach courses in general economics and financial management.

I would like to thank you, Senator Baucus, for holding this important Hearing on the economics of health reform. It is an honor to sit at this table to contribute to that exploration.

I also would like to congratulate you, and thank you and your staff, for the vision and great effort that went into your recently released white paper *Call To Action*, which I have read.

The overarching theme of my presentation today is that the reform of our health system – especially the extension of reliable health insurance coverage to the currently uninsured – should indeed receive the highest priority in the Congress and the new Administration.

As I shall argue below, in the decade ahead our traditional employment-based health insurance system is likely to deteriorate drastically for low-wage employees. While the measures you propose to shore up that system can arrest the pace of this deterioration, you are to be applauded for proposing to put in place also a reliable parallel health-insurance system that can capture Americans displaced by the employment-based system and provide them with the financial security citizens in all other industrialized nations have long enjoyed.

Furthermore, this is one of those rare windows of opportunity in which several factors come together to make health-reform a real possibility, at long last:

- 1. a financially distressed and anxious electorate shell-shocked by the economic turmoil that the financial markets have visited on the real economy,**
- 2. a President-Elect deeply and personally committed to improving the health-care experience of Americans and thus likely to provide strong presidential leadership that is the *sine qua non* of successful health-reform, and**
- 3. a Congress whose working majority now is equally committed to making health reform a reality and agreeing with the President-Elect on the principles and major design parameters for the needed reforms.**

My formal written statement, which I have submitted to your Committee for inclusion in the official record of this Hearing, falls into several distinct parts, to wit:

- I. a few brief comments on the reform proposals put forth in your *Call for Action*;*

- II. a section on the economic imperative of moving towards universal health insurance coverage now;
- III. some thoughts on the imperative of attaining better cost-effectiveness for American health care;
- IV. a critical reaction to the argument, often made, that we must have better cost control for American health care before admitting millions more to the club of well insured people.

As an American *citizen* whose social ethic was forged in countries with health systems based on the *Principle of Social Solidarity* – Germany and Canada -- I naturally hold ingrained views on the *moral dimensions* of the issues before this Committee. In my role as an *economist*, however, I shall try not to dwell in this testimony on those moral dimensions, which in any event are well understood by the members of this Committee and their staff.

I. SOME BRIEF COMMENTS ON THE PROPOSALS IN *CALL FOR ACTION*

For starters, I would like to express my full support for the broad outlines of your health-reform proposals in *Call to Action*. Although that may come across as pandering, I can say this with a straight face, as I had published in the early 1990s a health reform proposal with similar building blocks. For the record, I have appended that paper hereto as Appendix A.

The basic Design Parameters: Specifically, I then had advocated the following features that were designed to build health reform on the existing American system, rather than to scrap it and replace it with an entirely new approach. Prominent among these features were:

1. a mandate on the individual to be insured administered to the extent possible through the tax system;
2. building on the present system, rather than scrapping it;
3. a reorganization of the market for individual health insurance through what then was generally called a "Health Insurance Purchasing Cooperative (HIPC)" and your proposal calls a "Health Insurance Exchange";
4. choice of insurance carriers and policies through either an employer or through the HIPC;
5. The inclusion in that choice of a government-run health insurance plan for Americans under age 65 (in my proposal simply by permitting a buy-in into Medicare or Medicaid);
6. Means-tested public subsidies for the purchase of health insurance.

In addition to these features, I had also advocated the elimination of the unseemly price discrimination that is rampant throughout the American health system – a

feature more commonly known as “cost shifting” among payers. I shall return to that issue later in this Statement.

In view of the similarity of these design parameters with those embedded in your *Call for Action* it should come as no surprise that I support wholeheartedly the proposal you have put before the Senate. That proposal can look to the already operating Massachusetts plan for empirical support. It is also fully compatible with the proposal put forth during the election campaign by President-Elect Obama, whose support and leadership on this issue will be crucial to successful health reform.

Yours is a pragmatic approach adapted to the unique history of health insurance of this country and solidly build on it. That should make it more acceptable, because it forces no one to give up what they currently have and yet gives Americans added choices in the market for health insurance. Harry and Louise need not be exercised at the prospect of it, other than being put on notice that freeloading in health care is not acceptable.

The Issue of Mandating Insurance: Although the proposal to mandate the purchase of health insurance on the individual is likely to be the most controversial design feature proposed in *Call to Action*, I have always favored it for a very simple reason: people who expect society to come to their rescue with possibly hundreds of thousands of dollars of health care in case they fall seriously ill should be required, when they are healthy, to make contributions based on their ability to pay into a health insurance fund that will then pay for such care. Simply to go uninsured when healthy is to freeload off others when sick. It violates the basic tenets of civic conduct and fairness.

Furthermore, from a strictly economic perspective, leaving the individual free to choose whether or not to be insured is incompatible with a reorganization of the insurance market that imposes *community rating* and *guaranteed issue* on health insurers. Such an approach would invite egregious adverse risk selection on the part of the insured, who could afford to go without insurance when healthy in the comfort of knowing that they are entitled to health insurance at a community-rated premium when sick. As every economist and actuary appreciates, this type of adverse risk selection ultimately leads to the so-called “death spiral” of the community-rated risk pools.

The only way to curb such adverse risk selection under voluntary insurance coverage would be to impose a long waiting period – say, 5 years or more – between an application for insurance and a community rated premium, and offering only medically-underwritten insurance with very high premiums in the meantime. One could even contemplate outright denial of certain kinds of care.

The Health Insurance Exchange: Another feature of your proposal may trigger accusations of a “government take-over” of health care or of a regulator coming between you and your health insurer” will be the Health Insurance Exchange you propose. Harry and Louise may come back from retirement.

Your proposal is nothing of the sort.

In effect, the Exchange you propose is merely the analogue of a farmer’s market for health insurance policies. These policies are so-called “contingent financial contracts” that pay benefits when certain contingencies – here illness – occur. When these

contingencies are defined by smart lawyers in pages of fine print, the contracts become very complex.

As the nation is learning belatedly, but to its great dismay, such complicated financial contracts should be supervised by someone to make sure the contract is sound and that there are adequate reserves to honor it. In large corporations the employee benefit divisions of the human resources department perform that monitoring function. For smaller business firms and for individuals, the Insurance Exchange is an efficient substitute for the employee-benefit department of large corporations. It should be seen as such and not at all described misleadingly as a "government take-over" of health care.

Subsidies to Small Businesses: Like President-Elect Obama's proposal advanced in the election campaign, your proposal provides for subsidies to small business firms to help them offer employment-based health insurance to their employees.

By virtue of their low number employees, small business firms have two strikes against them in the market for health insurance.

First, a relatively large part of their premium goes for marketing (including broker commissions) and other overhead costs of insurers. For them the so-called "loss ratio" of insurers – the fraction of the premium "lost" for the payment of health benefits – can be 70% or less.

Second, the premiums charged small business firms are experience-rated (medically underwritten) over the firm's small number of employees. If one or two have fallen seriously ill in one year, it can substantially drive up the premium for all employees in the following year.

These two factors, of course, could be reduced in importance if these firms could join larger risk pools offered through the Health Insurance Exchange. For that reason, the mere size of a small business firm may not be the proper benchmark for the granting of a public subsidy toward health insurance.

As I shall show in the next section, the proper criterion is not firm size but the size of the average wage base that financed employer-provided health insurance. A small law-, engineering-, architectural- or business-consulting firm paying mainly high average salaries is less in need of a public subsidy toward health insurance than a medium size firm with primarily low-paid workers.

Therefore, I urge the Committee to revisit the issue of subsidies to small business firms to make sure that public funds are targeted on actual need of support, rather than a convenient administrative definition.

II. SAILING INTO A PERFECT STORM: THE ECONOMIC IMPERATIVE OF MOVING TO UNIVERSAL COVERAGE NOW

One reason for putting in place now a health insurance system parallel to our traditional employment-based system is that the latter is now sailing into a perfect storm.

That storm will leave parts of the system in tatters, especially among low-wage employers.

Health Care and Competitiveness: Although it seems counterintuitive to many business executives, the storm whereof I speak is not that employer-paid health insurance makes American business *uncompetitive* in the global market place. Few economists buy into that story, for reasons I explain in more detail in Appendix B to this Statement.

The distinguished late leader of the United Auto Workers (UAW) Douglas Fraser understood economic theory in this regard when he remarked in a debate with an auto executive¹:

"Before you start weeping for the auto companies and all they pay for medical insurance, let me tell you how the system works. All company bargainers worth their salt keep their eye on the *total labor cost*, and when they pay an admittedly horrendous amount for health care, that's money that can't be spent for higher [cash] wages or higher pensions or other fringe benefits. So we directly, the union and its members, feel the costs of the health care system." (Italics added).

Regardless who actually writes the check for the insurance premium to the insurance company, or puts money into a firm's self-insurance pool, all of a family's health spending, including all other cost of living, must be covered out of what economists call the "gross wage base" or the "price of labor" in their analyses. Accountants would think of it as the sum of all the debits an employer makes for an employee to the account "Payroll Expense."

That sum includes all fringe benefits -- including health insurance-- whether officially paid by the employer or the employee. It includes all taxes taken out of the gross wage, whether withheld from employees or officially paid by the employer (e.g., the employer's share of payroll taxes). Finally, that sum includes the employee's cash take-come pay which, in turn, supports all of the spending on any item made by the employee and the family he or she supports.

Thus, the perfect storm into which more and more Americans are sailing in health care is fueled by the fact that the gross wage base that supports the living expenses of most American families tends to grow at an annual compound rate of less than half the rate at which total health spending per capita grows in this country. Simple arithmetic dictates that this differential growth will inexorably price more and more lower-income Americans out of health insurance. No mechanism is in sight now that could eliminate this divergence in growth rate over the next half decade or more.

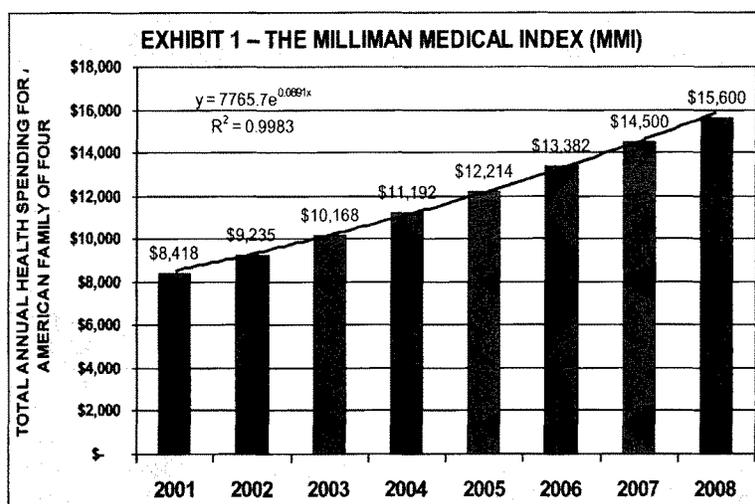
As is shown in Exhibit 1 below, according to the well-known *Milliman Medical Index* regularly published by the benefit-consulting firm Milliman, Inc. the total annual health care cost of a typical privately insured American family of four is now \$15,600². The exponent on the equation in Exhibit 1 indicates that the average annual compound growth rate of this index has been 8.9%. It has been closer to 8% since 2004.

¹ Douglas Fraser, "A National Health Policy Debate," *Dartmouth Medical School Alumni Magazine* (Summer, 1989): 10.

² <http://www.milliman.com/expertise/healthcare/products-tools/mmi/pdfs/milliman-medical-index-2008.pdf>

The total of \$15,600 for 2008 represents the sum of (1) the part of the health insurance premium paid by the employer, (2) the part of the premium paid by the employee and (3) the family's out-of-pocket spending for health care. In 2008, the total employment-based premium for family coverage averages about \$12,600, of which an average of 26% is contributed by the employee.³ Out-of-pocket spending therefore appears to average around \$3,000.

Regardless of the relative size of these three components, and regardless of who writes the check for it, the entire total health spending on 2008 of \$15,600 for the family must be supported by the family's 2008 gross wage base in the labor market, as I have defined that term.



Consider now a family of four with a current, 2008 total gross wage base of \$60,000. It could be a two-earner household with a take-home pay between \$35,000 and \$40,000. It would not be a destitute American family. Rather, it would be a family in the lower-middle income classes. The median money income of American households under age 65 currently is slightly more than \$55,000 which means that about half of all such households have a money income below that figure.

A household's money income is, of course, lower than the gross wage base that begets that income. Even so, it seems safe to say that roughly a quarter to a third of American households now derive their money income from a gross wage base of \$60,000 or less.

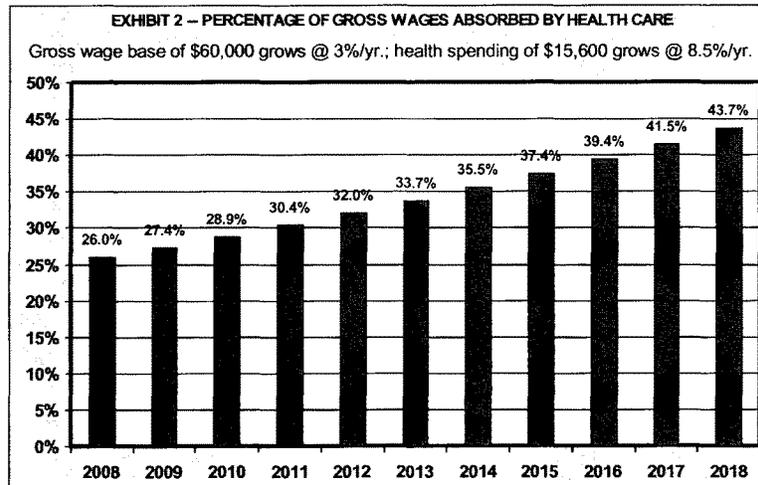
Assume now the skill levels of the family's breadwinners is such that their gross wage base will grow at an annual compound growth rate of 3%, roughly the annual

³ The Henry J. Kaiser Family Foundation and Health Education Research trust 2008 Survey of Employer Health Benefits; Exhibit 2 (<http://ehbs.kff.org/images/abstract/7814.pdf>).

compound rate at which average weekly nominal wages (not adjusted for inflation) have grown for the whole U.S. over the past two decades.⁴ At that rate, the wage base would have grown from \$60,000 in 2008 to \$80,600 by 2018.

But if health spending for the typical family continued to grow at an annual compound rate between 8% and 9% – say, 8.5% – then the total health spending for such a family ten years hence would be \$35,300. That would be as much as 44% of the family's projected gross wage base of \$80,600 in 2018.

Exhibit 2 below illustrates how the bite that health spending takes out of the gross wage base grows inexorably over time. For the many American families with a gross wage base of less than the \$60,000 gross wage base assumed for this numerical illustration, the picture would be correspondingly direr.



These economic trends – the disparate growth between health spending and the wage base that must support it – will confront American health policy makers in the decade ahead with two quite uncomfortable options.

Option A: One option would be to ask Americans in the upper half of the nation's distribution of income to step up to the cashier's window, there to support with higher taxes the traditional health care of families in the lower half of that distribution.

Option B: A second option would be to allow the American health system to evolve even more than it already has towards a two- or multi-tiered system, with bare-bones health care and substantial rationing of health care in the lower tiers

⁴ See the Economic Report of the President to the Congress 2008, Table B-47 (<http://www.gpoaccess.gov/eop/2008/B47.xls>).

and the luxurious, no-holds-barred health care most Americans have hitherto enjoyed for families in the upper tiers.

Americans generally believe that the rationing of health care is something countenanced only by other nations. In fact, however, we have already for some time been rationing timely health care for uninsured Americans through the price mechanism, in spite of the safety net provided by the emergency rooms of hospitals and whatever uncompensated care is rendered by physicians. As Hadley et al. have reported in a recent paper published in *Health Affairs*, health spending per capita for people under age 65 with private health insurance is about \$3,915 in 2008.⁵ The comparable number for uninsured Americans is \$1,686. Unless one assumes that the lower figure represents the right amount of care and the higher figure is driven mainly by waste, one is entitled to conclude that rationing health care by price and ability to pay has represented a time honored feature of our health system.

Through its inaction so far, Congress has tacitly ratified that approach to rationing. Is Congress prepared to make it official U.S. health policy? If not, then the plight of the uninsured must be addressed by Congress soon.

III. THE IMPERATIVE OF GREATER COST-EFFECTIVENESS

In their policy analyses, economists typically do not advocate just "cost control" or "spending control," which is always interpreted by providers as a legislated reduction in the quality of care.

Instead, economists advocate greater "cost-effectiveness." By this term is meant minimizing the total treatment cost of achieving a given clinical outcome (e.g., reducing blood pressure by a given number of points or wrestling one extra quality-adjusted life year (QALY) from nature through medical intervention.) The flip side of the term is getting better value for the health care dollar. It is heartening to see that this facet of health reform has been given so much attention in your white paper *Call to Action*, with many examples of questionable practices.

Inexplicable Variations in Medicare Spending Per Beneficiary: The exhibit below dramatizes the need for greater attention to cost-effectiveness.

This exhibit is taken directly from the final report of the New Jersey Governor's Commission on Rationalizing Health Care Resources (2008), which I had the privilege to chair last year. Shown in this table are the total payments Medicare made in the period 1999-2003 in the last two years of life of deceased Medicare beneficiaries who resided in the hospital market areas of the New Jersey hospitals shown in column 1. These payments are standardized so that they average 1 for the United States. These data were provided to the Commission by John H. Wennberg, M.D., the pioneering researcher who, along with his research associates at Dartmouth University Medical School has alerted the nation for over two decades now with large variations in the use of health care per capita over small geographic areas, such as New Jersey, and over the United States as a whole.⁶

⁵ Jack Hadley, John Holohan, Teresa Coughlin, and Dawn Miller, "Covering The Uninsured In 2008: Current Costs, Sources Of Payment, And Incremental Costs," *Health Affairs*, September/October 2008; 27(5): w399-w415; Exhibit 1..

⁶ See (<http://www.dartmouthatlas.org/>).

Table 6.1:
Medicare Payments for Inpatient Care During the Last Two Years of Life of Medicare Beneficiaries
(Ratio of New Jersey Hospital's Data to Comparable U.S. Average, 1999-2003)

	Inpatient Reimbursements	Hospital Days	Reimbursements per Day	CMS Technical Quality Score
St. Michaels Medical Center	3.21	2.34	1.37	0.91
Kimball Medical Center	2.32	1.26	1.83	0.95
Raritan Bay medical Center	1.86	1.85	1.01	0.81
Christ Hospital	1.83	1.83	1	0.59
St. Mary's Hospital Hoboken	1.75	1.72	1.02	0.74
Beth Israel Hospital	1.58	1.86	0.85	0.83
Overlook Hospital	1.27	1.36	0.94	0.90
Medical Center at Princeton	1.17	1.26	0.93	0.94
Atlantic Medical Center	1.11	1.12	0.97	0.89

Source: Data supplied to the Commission by John H. Wennberg, M.D., Director of the Dartmouth Atlas Project, December 2006.

The number 3.21 for St. Michaels Medical Center in the exhibit indicates that, on average, Medicare spent over three times as much per Medicare beneficiary residing in that hospital's market area than Medicare did on average for all deceased Medicare beneficiaries in the U.S. during the period 1999-2003. By contrast, Medicare spent only 1.11 times as much as the national average for similar Medicare beneficiaries in the Atlantic Medical Center hospital market area of New Jersey. Dr. Wennberg has found similarly large variations in Medicare spending across hospital market areas – for example, in California.⁷

Because these are averages over many patients, they cannot be written off with the protest so often lodged by physicians that "every patient is different," which makes such data meaningless. Furthermore, because Medicare fees are the same across hospitals in New Jersey, these data represent difference in the use of real health care resources, such as patient days in the hospital, days spent in the intensive care unit (ICU) and physician visits per patient.

If one asks hospital executives, as I have, to justify these enormous variations in resource use, they tend to shrug their shoulders with the argument that hospitals are the free workshops of the attending physicians over whose resource use hospital executives have no control. The variations, explain these executives, reflect the different medical practice styles of the attending physicians, who have the authority to conscript the hospital's resources at will. That there is something to the executives' arguments can be inferred also from the fact that quite substantial differences can be observed also in the cost per patient treated for a particular medical condition by different physicians affiliated with the same hospital.

⁷ Laurence C. Baker, Elliott S. Fisher, and John E. Wennberg, "Variations In Hospital Resource Use For Medicare And Privately Insured Populations in California," *Health Affairs*, March/April 2008; 27(2): w123-w134.

After a cocktail or two these executives will go on to explain that economic motives, in the face of the piece-rate (fee-for-service) payment system used for physician compensation, has much to do with the practice style physicians “prefer.” That circumstance has persuaded many health policy analysts that a comprehensive health reform must include a bold effort at reforming our payment system for providers.

The dominant thinking is that compensation for care should take the form of one bundled payment for all of the ambulatory and inpatient services and supplies going into the treatment of an episode of illness. I notice that, Mr. Chairman, you call for that reform as well in *Call to Action*. Unfortunately, that approach raises many conceptual and practical problems that must first be overcome through experimentation.

As you also note in your white paper, Mr. Chairman, Dr. Wennberg and his associates have found similarly wide, inexplicable variations in Medicare spending per beneficiary statistically adjusted to be similar across hospital market areas with the entire United States⁸. Broadly speaking, Medicare tends to spend twice as much per beneficiary in the Sun Belt than it does in the Wheat Belt, although there are variations within these broad categories as well.

Research by other associates of Dr. Wennberg – notably Elliot Fischer and colleagues – has failed to detect any correlation between these variations in spending and commensurate variations in either clinical practice processes, clinical outcomes or even patient satisfaction.⁹ One pair of researchers has even found a negative correlation between spending variations and the quality of care.¹⁰

Variations in Private Sector Payments: Lest it be said that Medicare is a sloppy purchaser of health care – a common accusation – let it be noted that similar variations in per-capita spending are found also in the private sector. The only difference between the sectors is that Medicare makes its spending data freely available to health services researchers while private insurers generally do not.

Upon my request as Chair of the previously cited Commission, two private insurers were kind enough to extract some data on payments to hospitals for the Commission. The next two exhibits, taken directly from the Commission’s final report, show truly stunning variations in the total payments an insurer pays to different hospitals across a state for the same standard treatment. These payment data, it must be emphasized, do not reflect hospital “charges,” that is, the list prices that no insurer ever pays. They are the actual payments made by the insurers to different hospitals in a state for the procedures listed in the table.

⁸ John E. Wennberg et al., *Dartmouth Atlas of Health Care 1999*, AHA Press, 1999 Chapter 1, Table, pp. 33-34 (<http://www.dartmouthatlas.org/>).

⁹ Fisher ES, Wennberg DE, Stoke TA, Gottlieb DJ, Lucas FL, Pander EL. The implications of regional variations in Medicare spending. Part 1: the content, quality, and accessibility of care. *Ann Intern Med* 2003; 138:273-87., and Fisher ES, Wennberg DE, Stoke TA, Gottlieb DJ, Lucas FL, Pander EL. The implications of regional variations in Medicare spending. Part 2: health outcomes

¹⁰ Katherine Baicker and Amitabh Chandra, “Medicare Spending, The Physician Workforce, And Beneficiaries’ Quality Of Care,” *Health Affairs Web Exclusive*, April 7, 2004

Table 6.5:
Payments by One California Insurer to Various Hospitals, 2007 (Wage Adjusted)

	Appendectomy ¹	CABG ²
Hospital A	\$1,800	\$33,000
Hospital B	\$2,900	\$54,600
Hospital C	\$4,700	\$64,500
Hospital D	\$9,500	\$72,300
Hospital E	\$13,700	\$99,800

¹ Cost per case (DRG 167)

² Coronary Bypass with Cardiac Catheterization (DRG 107); tertiary hospitals only.

Table 6.4:
Payments by a N.J. Insurer to Various Hospitals for Four Standards Services, 2007¹¹

	Normal Delivery ¹	CABG ²	Appendectomy ³	Hip Replacement ⁴
Hospital A	\$2,178	\$26,342	\$2,708	\$3,330
Hospital B	\$2,787	\$32,127	\$2,852	\$3,444
Hospital C	\$2,906	\$34,277	\$3,320	\$4,200
Hospital D	\$3,187	\$36,792	\$3,412	\$4,230
Hospital E	\$3,276	\$37,019	\$3,524	\$5,028
Hospital F	\$3,629	\$45,343	\$4,230	\$5,787

¹ Mother only, case rate.

² Coronary Bypass with Cardiac Catheterization (DRG 547), tertiary hospitals only.

³ Surgical per diem (DRG 167) with average length of stay of 2 days

⁴ Surgical per diem for Total Hip replacement, average length of stay 3 days.

Critics of the Medicare program decry that program as a "dumb price setter." But are the payments described in the two exhibits evidence of a smarter pricing system? What social benefits are actually achieved with this pervasive price discrimination? ¹¹

Without further research, based on additional data from the insurers, it is not exactly clear what drives these huge variations in payments by private insurers for the same health care services. Is it merely the relative bargaining strength of different hospitals, that is, differences in the negotiated *prices* for the particular services going

¹¹ For a fuller explanation of the bizarre ways in which American hospitals price their products, see Uwe E. Reinhardt, "The Pricing Of U.S. Hospital Services: Chaos Behind A Veil Of Secrecy," *Health Affairs*, January/February 2006; 25(1): 57-69.

into these standard procedures? Or are these payment variations also driven by underlying differences of the preferred practice styles of the physicians affiliated with these hospitals, which means differences in the *use of real resources* in performing the procedures listed in the two tables above.

Eliminating Price Discrimination: It would be one thing if the price discrimination typical of American health care were designed to achieve a higher social purpose – such as the old sliding fee schedules for physicians' services based on the patient's ability to pay. But the price discrimination we now observe in American health care appears to be related mainly to the relative bargaining strength of payers and providers. Indeed, under this system uninsured patients – the weakest payers – often are charged the highest prices for hospital care and prescription drugs.

In my health-reform appended as Appendix A, I had advocated a different payment system. Under that system all hospitals would be forced to base their prices for privately-insured and self-paying patients on the *relative values* inherent in the DRGs used by Medicare. Similarly all physicians would have to base their prices for such patients on the relative values inherent in the Medicare physician fee schedule. If price competition among providers were to be encouraged, each hospital and every doctor could then be free to set the monetary conversion factor that would convert the relative value points into that provider's dollar fees. It would base price competition among providers on a simple, easily understood number that could be posted electronically. A long run goal of this pricing system would be that a given provider of care would charge every patient the same fee for the same service, assuming universal health insurance coverage. The approach would vastly simplify the administration of our payment system and reduce its cost.

While, as noted, the ultimate goal of payment reform has long been thought to be more extensive bundling of the fees for the individual goods and services going into the treatment of standard episodes of illness into one large, bundled fee for the entire treatment, it will be years before current experiments with that approach¹² have progressed to the point where widespread bundling of payments becomes a reality in American health care. In the meantime, the more easily implemented payment reform I advocate may warrant consideration.

The Need for Greater Transparency and Accountability: At the moment, the American tax- and premium payer and patients have absolutely no idea why the cost of health care varies so much across their state and the United States. Nor can anyone explain to them what extra benefits they may or may not receive for an average health spending per capita which, as you note in a table in your white paper, is about twice as high in purchasing power parity dollars as the comparable figure in Canada and Europe.

In the face of the general economic distress now befalling many American families through no fault of their own, and the fact that ever more families are inexorably being priced out of health care by health spending that grows over twice as rapidly as the wage base that supports it, several questions come to mind.

¹² For a demonstration project aimed at bundled payments for health care, see Prometheus Payment, Inc. at website <http://www.prometheuspayers.org/>.

First, how is it that over some two decades during which Dr. Wennberg's studies have been well publicized, the providers of health care – and especially the medical profession – have never been challenged by either the Congress or by private payers to explain the hitherto unexplained large variations in per capita health spending across the United States?

Second, how is it that the allocation by public and private payers to operations research in health care (otherwise known as “health services research”) that could help drive the U.S. health sector towards greater cost-effectiveness has remained miniscule to this day? Specifically, why has Congress never allocated funds specifically to inquire further into the spending variations identified by Dr. Wennberg and his associates?

Finally, how is it that even without being challenged by the rest of society, the providers of health care – especially the medical profession, whose members are the central decision makers in health care – have never felt morally obligated to explain and justify the variations in resource use?

It is to be hoped that, as part of the health reforms now being contemplated by the new Administration and the Congress, the posture of “business as usual” in the health care sector will be abandoned in favor of a *serious*, concerted effort to harvest the economies every student of the American health sector agrees are there to be harvested.

Alas, a concerted drive to greater cost-effectiveness in American health care is a monumental challenge that must overcome both institutional inertia and what I have described for years as Alfred E. Neuman's Cosmic Health Care Equation:

Every Dollar Health Spending = Someone's Health-Care Income
(including fraud, waste and abuse)

It will take ingenuity, tenacity and, for legislators, *courage* to tackle this challenge, but tackling the challenge the nation must at long last.

III. BETTER COST-EFFECTIVENESS BEFORE UNIVERSAL COVERAGE?

Many commentators on health reforms in the past have demanded that we eliminate the pervasive waste in American health care first before letting even more Americans join the club of the well insured. This objection to health reform undoubtedly will be trotted out once again in the months ahead.

Those who argue that cost control must come before universal coverage may soothe their conscience with the thought that our hospitals' emergency rooms are a good enough substitute for regular health insurance. They are wrong.

First, that system, where it still works, does not deliver timely, cost-effective health care. Research has shown that many hospitalizations and, indeed, deaths could have been avoided through earlier medical intervention.

Second, only in America do we expect hospitals to serve large numbers of patients without being paid for that care at all or, in the case of Medicaid, getting paid

less than it actually costs to render the care. No other country in the industrialized world relies on such an approach, which begets the sometimes unseemly game of cost- and patient-shifting that absorbs an enormous amount of human effort and ingenuity in this country, but has no socially redeeming economic value. It is a game in which "nice guys finish last," meaning that hospitals that make heroic efforts to serve the poor and uninsured often end up in perpetual financial distress and with dilapidated facilities as society's reward for that effort.

Finally, the haphazard catastrophic insurance system for the uninsured, kept in place in part by an unfounded government mandate (EMTALA), is likely to fray at the edges as more and more Americans are squeezed out of the employment-based insurance system by the wage—health-spending squeeze described above.

Finally, I cannot resist noting here the irony that those who would make universal health insurance coverage take a backseat to cost control invariably are well protected by comprehensive health insurance coverage. It is a comfortable perch from which to make that argument.

APPENDIX A

An “All-American” Health Reform Proposal

Reforming the U.S. health care system is frequently thought of in absolutist terms: managed competition versus rate regulation; federal versus state administration; and business mandates versus individual insurance purchases. While these choices must be resolved over the long run, the transition to a new health care system will take several years and require more flexible solutions. The “All-American” Deal offers just that. It requires individual households to be insured and allows businesses to voluntarily offer health insurance; relies on the federal income tax system to collect income-based premiums and transfer funds to states through risk-adjusted payments; and lets states manage the disbursement of funds for uninsured residents.

By Uwe E. Reinhardt

The current debate on the reform of our health system tends to polarize the options. The either-or questions frequently presented include: Should we pursue regulated (managed) competition based chiefly on prepaid capitation, or a regulated, all-payer system based chiefly on fee-for-service payment to providers? Should ours be a federal- or a state-administered health system? Should we mandate business to provide health insurance for employed Americans and their families, or should that mandate be placed on individual households themselves?

These are pertinent questions for a long-run solution. In the short run, however, the choices are unlikely to be as neat. What's needed is a system to take us from where we are now to wherever we may choose to go. The strategy proposed here is designed as such a flexible transition.

This strategy does not commit the nation to either regulated managed

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competition or regulated, negotiated all-payer rates. It allows some room and time for experimentation with both approaches at the state level. Yet it provides universal health insurance coverage and various forms of cost control, including implicit budgeting. Because the media insist that every proposal have a catchy name, I dub it the “All-American Deal,” to signify that it is not just some foreign import. The specifics of the All-American Deal are as follows:

- It would not mandate business to procure health insurance for employees. Instead, it would mandate individual households to be insured, but allow business firms to offer their employees health insurance on a voluntary basis. That design feature should minimize the opposition of small business to health reform.

- It would rely on the federal income-tax or payroll-tax mechanism as a convenient vehicle for the collection of income-based premiums, (not to be confused with taxes!), but it would use the states to

manage the disbursement of these funds to the providers of health care. The federal government would transfer funds it has collected to the states through risk-adjusted capitation payments that could and, in many instances would, be supplemented by the states with their own levies. The size of the federal fund would implicitly act as a partial budget cap on the health system, although it would not be an air-tight global cap.

- States could manage the disbursement of their health fund for residents not otherwise insured in one of three ways: (1) buy these residents into the federal Medicare program; (2) buy these residents into a qualifying state-run Medicaid program; or (3) fold them into a genuine managed competition administered by a state-run or state-chartered Health Insurance Purchasing Cooperative (HIPC).

Defining the Terms

Here is a thumbnail sketch of how such an approach might work (See

Figure 1). A clear distinction is made between the task of collecting the funds in an insurance pool from that of disbursing the funds to the providers of health care. One should always treat these two facets separately when thinking about health care reform, because any financing system for health care could be coupled with any number of alternative disbursement systems. This is an important point often lost in the debate on health policy when, for example, "managed care" or "managed competition" is presented as a complete health insurance program that is an alternative to "pay-or-pay" financing. "Managed competition" per se is not a health insurance program at all; it is merely a particular form of cost control that could be attached to any mechanism of financing.

Figure 1 illustrates this point. The health insurance fund at the center could be a publicly administered insurance program, such as Medicare, or the health insurance purchasing cooperative (HIPC) called for by managed competition. The diagram

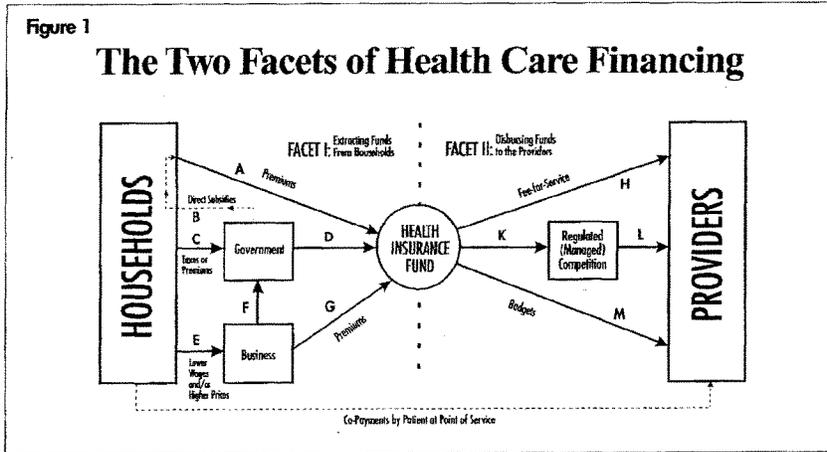
shows that any health insurance fund, privately or publicly administered, is fed solely by private households. Business firms and government merely function as pumping stations along the way, for ultimately they never pay anything for health care. Any outlays for health care they do make always will be recouped from private households in the form of taxes, if government is the pumping station, or in the form of higher prices or lower take-home pay for workers if private employers act as the pumping station.

Financing: Two Approaches

Under the All-American Plan, either the federal government or private employers, or both, could function as the chief pumping station. If government played that role, households would pay an income-based premium, probably along with their income tax, although the premium itself would not really be a tax and should certainly not be described as such in the political arena (Summers, 1988).

On the other hand, if business were selected as the chief pumping station, employers would collect an income-based premium from payroll and remit these premiums to the health insurance fund, such as a publicly administered health insurance program like Medicare, or a state-run HIPC. Our major foreign competitors, Japan and Germany, widely employ this mechanism to finance health care. Once again, however, health-insurance premiums collected at the nexus of the payroll ought not to be described to the public as an ordinary payroll tax.

If government were to be the chief conduit for financing health care, one would include among the income tax forms one strictly devoted to health insurance. On it the taxpayer would indicate either that the household has a private insurance policy at least as generous as a federally specified basic comprehensive package (and attach evidence of that coverage), or enter and pay an income-based premium for the basic package that would be then auto-



matically bestowed upon that taxpayer's household. I call this financing mechanism the "Fail Safe" policy. If written evidence of an adequate private policy were attached to the health insurance form, the household would, of course, be excused from the income-based premium.

As already noted, this payment would be collected in conjunction with the income tax, but it ought not to be confused with a bona fide tax. It is merely a mandated *premium* for which the households receive a well-defined and personal benefit — comprehensive, portable health insurance coverage. A skillful politician ought to be able to make this point clear to the general public.

The income-based premium rate "X" could be a flat percentage of adjusted gross income, or it could be made to increase progressively with income. For example, it might be set close to zero for very low-income households and might reach at its peak, for high-income households, a level equal to the percentage of the gross domestic product the nation spends on health care. The wealthiest households, therefore, might prefer to purchase private insurance policies, particularly if the industry figured out a way to make them available without the enormous administrative loading charges now added to premiums for individual policies. That tendency could be curbed if an upper limit were placed on a family's annual premium.

Additional Financing

Any system of income-based health insurance premiums requires some transfers of income from high- to low-income households, because the contributions made by the latter will not cover the full cost of their premiums. It is therefore desirable

to look at supplementary sources of financing for these required cross-subsidies.

Households above a certain minimum income might be asked to pay, on some line of the regular 1040 tax form, a small, progressive, earmarked indigent care tax (perhaps an average one percent or so of taxable income). I would call it "Membership Fee for the Club of Civilized Nations," so named since the 37 million uninsured Americans are an anomaly among industrialized nations. These funds would be needed to supplement the modest income-based premiums collected from low-income families.

Additional funds might be extracted from earmarked taxes on alcohol, tobacco and gasoline, products known to contribute directly to the nation's health bill. A case can be made for collecting directly from the manufacturers or importers of firearms a very stiff excise tax per gun, with near prohibitive taxes on sub-machine and machine guns. Distress over the mayhem caused by firearms may have progressed to the point at which a visionary politician could sell such taxes to the body politic.

As noted, many industrialized nations, notably Germany and Japan, collect premiums through the workplace, mainly because payrolls are managed by highly competent people who have little incentive to cheat on behalf of employees. By contrast, income tax forms typically are filled in by less competent individuals who have more powerful incentives to evade taxes.

Politicians frequently prefer health insurance mandates on business to income-based premiums because these premiums are so widely misunderstood as regular payroll taxes. In fact, however, mandated benefits typically are shifted backwards to

the employees' paychecks in any event. If an employer spends an average of, say, \$4,000 for an employee's health insurance, then the bulk of that amount will be shifted backwards to highly paid and poorly paid employees alike, which makes the mandate highly regressive. Income-based premiums taken out of workers' paychecks are not nearly as regressive.

Households above a certain minimum income could be asked to pay a small indigent care tax.

Some savings could probably be squeezed from the Medicare program. Ideally, one would fuse part A (hospital care) and Part B (physician care) into one program and collect from the elderly an *income-related* premium for the package, if only to eliminate the sizable federal subsidy toward health care the high-income elderly now receive. Unfortunately, the political power of that group may stand in the way of that approach, as was so vividly illustrated by the 1989 repeal of the Medicare Catastrophic Care Act.

A case can be made on grounds of both equity and economic efficiency to include in an employee's taxable income part or all of the health insurance premiums paid by an employer on behalf of that employee, at least for employees with an income of \$50,000 or more (Butler, 1992; Enthoven and Kronick, 1989). It has been estimated that the elimination of this tax exclusion would yield an estimated \$50-to-\$60 billion in additional federal taxes, and about \$20 billion in additional Social Security taxes. If one phased

out the exclusion, starting, say, at annual incomes of \$50,000, with a complete elimination of the exclusion at incomes of \$80,000 or more, the added tax yield would, of course, be commensurately less. But it may still be in excess of \$25 billion.

Whatever the source of the additional funds that would be required by universal coverage in the short run, Americans must at long last ask themselves whether nation with a \$6 trillion economy can really stare some 37 million mainly low-income Americans in the eyes and say: "Sorry folks, we are too poor a nation to extend to you the financial protection every other industrialized nation has been able to extend to its citizens." Among the millions of uninsured are many working mothers and their children. How can we stand by idly, letting these mothers toil on our behalf without health insurance?

Disbursing the Funds

Approaches to the cash-disbursement and cost-control facet of the Fail Safe system could fall into one of two major categories: purely federal programs and federal-state partnerships.

Under a purely federal program, the federal government could use its Fail Safe fund simply to enroll all Americans who are not privately insured in the federal Medicare program. One major advantage of that approach is its administrative simplicity. All of the requisite infrastructure has already been provided for and is fully operational. Furthermore, all health care providers are fully familiar with the operation of that system. Finally, the approach would provide government with considerable clout on the demand side of the health care market.

One major political disadvantage of the approach, however, is that it concentrates so much power in the federal government. Although Americans sometimes express a preference for that approach in opinion surveys, it is not clear how well an actual move in that direction would be received. Furthermore, while the Medicare program has been able to control the prices it pays for health care, it has had much more difficulty with controlling the volume of services under that fee-for-service system. It is true that other countries have been able to control costs better than has the U.S. with fee-for-service systems. But these countries also use other forms of cost control — capacity limitation and budgets — and they, too, now chafe under the problem of controlling the volume of services.

The federal route, however, is by no means the only cash-disbursement and cost-control option one could couple with the Fail Safe financing mechanism. An alternative would be for the federal government merely to collect funds into a Fail Safe pool and then to distribute that fund to the states in the form of capitation payments adjusted for age, sex, other measurable risk factors and regional cost variations. A mechanism for such risk-adjusted capitation payments already exists for the current Medicare program — the so-called average annual per capita cost (AAPCC), although this adjuster is far from perfect. The individual state could then disburse these capitations (possibly supplemented with state funds) to providers in a manner that suits local customs and preferences, and the existing delivery system.

There are several ways to do this:

1. Medicare Buy-In: Some states might prefer to buy their uninsured families into the federal Medicare

program. Under this opt-in strategy, a state choosing that option would return the capitation received from the federal Fail Safe program to the federal government and, possibly, be asked to add some funds. This gives states the option of transferring administrative responsibility for health care to the federal government.

2. Traditional State Insurance Program: Other states might prefer to run their own public health insurance program — for example, a modified Medicaid program that owns up to the federal standards spelled out for the Fail Safe program. This would still be a government-run disbursement system, albeit a decentralized one.

3. Managed Competition: States could also have their uninsured select from a roster of competing private insurance plans under the approach now widely known as managed competition or regulated competition. Under that concept, originally proposed by Princeton's Herman and Anne Somers (Somers and Somers, 1972) and further refined by Minnesota physician Paul Ellwood, MD, Stanford economist Alain C. Enthoven, and a group of analysts known as the Jackson Hole Group, rival networks of doctors and hospitals, such as health maintenance organizations, would be made to bid for enrollees on the basis of a pre-paid capitation payment for a specified, basic package of health benefits, all under the supervision of a HIPC.

The HIPC in a region could be the state's health department, or, alternatively, a semi-autonomous, not-for-profit organization chartered by the state. It would coordinate the premium bids submitted by the plans and also collect from each competing plan information on patient satisfaction and clinical outcomes (such

as mortality rates from surgery). That information would be conveyed to consumers, along with the premium bids. The states of California, Colorado, and Florida seem ready to move in that direction.

If the Fail Safe financing scheme outlined above were coupled with some form of managed competition, large parts of the current private insurance industry would survive health care reform. For the approach to work, however, the industry would have to use its extensive resources to enhance the value-to-cost ratio in health care through managed competition and managed care rather than using them to exclude sick Americans from insurance coverage through medical underwriting.

Whether managed competition actually will control costs, as its proponents insist, remains to be seen. The approach has been tried only in small, local experiments — for example, in the California Public Employees Retirement System (CalPERS) — with some encouraging early results. It is not clear, however, how dependent the cost savings of these relatively small, local experiments have been on the ability of providers to shift costs to other payers in the area, nor is it clear whether the savings registered early in the life of these experiments can be sustained over the long run. The cost savings under full-fledged national managed competition are still hypothetical estimates.

Global Budgets

It is virtually impossible to impose an air-tight national budget upon all types of health spending in a nation as geographically far-flung and as economically heterogeneous as is the United States, particular in a health system with multiple payers

and approaches to cost control. Absent a single-payer system (such as Canada's) for all health benefits and for the entire nation, attempts at top-down budgeting probably will have to be limited to controlling only segments of national health spending.

Doctors and hospitals should reveal their fees in terms patients can understand.

The federal Medicare program has achieved some apparent success with that approach by imposing on Part B of the Medicare program a so-called volume performance standard, which is really an expenditure target. That approach links updates in the fees paid by Medicare in one fiscal year to the degree of deviation from a predetermined expenditure target for the fiscal period two years earlier.

Under the Fail Safe system proposed here, the total funds collected by the federal government via income-based premiums and sundry additional outright taxes would constitute a powerful implicit national budget of sorts. The amount of money in that fund would limit the risk-adjusted capitation payments to the states and, thereby, inevitably the spending by the states on their residents without private health insurance. States still could, of course, spend more on health care if they want. The system would not directly impact that part of health spending which would occur outside the federal-state Fail Safe system. But the spending level of that presumably large system would undoubtedly provide highly visible benchmarks for private-sector spending, and would thereby indirectly exert budgetary

discipline upon the whole health system. It can be argued that this less powerful approach to top-down national budgeting would be an easier political sell than other alternatives now being contemplated.

Streamlining Fee-For-Service

It would probably take more than half a decade to fold the bulk of the American population into managed competition, even if most states chose to move in that direction. In the meantime, it would be helpful if doctors and hospitals were forced to reveal their fees more visibly in terms that patients and their insurers can easily understand.

Traditionally, American doctors and hospitals have billed their patients for each of thousands of distinct services and procedures. These fees, however, have not been based on common fee schedules, nor even common lists of procedures. This lack of uniformity has made it virtually impossible to compare the prices charged by different doctors and hospitals. The resulting lack of price transparency has made a mockery of the idea, so popular among economic theorists, that patients should "shop around" for low-cost doctors and hospitals.

Even a state embracing the concept of managed competition would presumably allow some fee-for-service carriers among the competing plans. In states not moving to managed competition, of course, fee-for-service payment would remain the dominant mode. To facilitate better price transparency in that environment, the government should impose at least common relative value scales, if not common fee schedules, upon all doctors and hospitals. A relative value scale expresses the fees for all procedures as a relative of the

fee for some base unit, for example, a routine, follow-up office visit or an appendectomy. A relative value scale becomes a fee schedule only if the dollar value for the base unit (the so-called "conversion factor") has been set.

***Common relative value
scales would greatly
reduce administrative
hassle.***

Relative value scales of this sort have already been developed by the federal Medicare program for both doctors and hospitals. For hospitals, the government introduced a system of flat fees for some 500 diagnostic-related groups (DRGs) of cases. These fees are based on average accounting costs per case and are based on a well-defined set of relative values that could be extended by law to all private payers as well. For physicians, the Medicare program has developed the so-called resource-based relative value scale, which is based on the estimated relative real resource costs of producing the 7,000 or so procedures in the catalog of physician services. That scale, too, should be extended by law to all private payers.

A policy of imposing common relative value scales upon all payers and providers in the health system would not, of course, be the same as outright price controls, if the government permitted physicians and hospitals to apply their own monetary conversion factors for private patients. In doing this, providers would be able to set the absolute monetary value of the base procedures and, thus, of all other procedures on the list. If these rates were set by each physician

and hospital at the beginning of the year, they could then be published in the local newspapers and made available via an 800 number.

Chances are that the publication of this simple price index would drive doctor and hospital fees towards more uniform levels, even without direct price regulation by the government. At least during a transition period towards government-mandated uniformity in fee schedules, this idea may be worth a try. One could, of course, couple the imposition of the federal relative value scales upon the private sector with a ceiling on the conversion factor set for private payers. That would be a partial move toward a true all-payer system based on common fee schedules adhered to by all private payers within a region.

Common relative value scales would greatly reduce the administrative hassle now bedeviling American health care, for they would facilitate the use of electronic billing based on common claims forms and common software. The chaos now reigning in the private fee-for-service sector makes electronic billing difficult and has added billions of dollars to annual health care costs.

Avoiding Adverse Risk Selection

In the absence of sanctions, the Fail Safe component of the dual-track health insurance system outlined above would be subject to adverse-risk selection. Business firms with relatively older or sicker or lower-wage employees probably would prefer to dump the latter into the federal Fail Safe system, while firms with younger or healthier or better-paid workers would prefer their own private coverage. Similarly, healthy people would tend to favor actuarially fairly priced private insurance;

chronically ill persons would gravitate toward the Fail Safe system, driving up its average cost. Such trends could destabilize the system.

Other nations that do operate dual-track insurance systems — for example, Germany — have dealt with that problem by making switches between the two systems cumbersome, slow, and expensive. A German family that opts out of the statutory, semi-private health insurance into the commercial, private system can return to the statutory system only under very rare circumstances, such as a lapse into extreme poverty, (Reinhardt, 1990).

In the dynamic American economy, where a family's economic fortunes can fluctuate substantially over time, it would be difficult to outlaw returns to the Fail Safe system. Even so, it would probably be possible to make the process of switching sufficiently cumbersome and risky to avoid the clever and highly destabilizing cream-skimming that has been the Achilles heel of any multiple-track insurance system, notably the current one.

Finally, business firms that already are offering their employees health insurance might be discouraged from dumping their employees into the Fail Safe pool by a mandate forcing them to increase their workers take-home pay by an amount equal to the health insurance premiums they have hitherto paid (and presumably taken out of their employees' take-home pay).

The Best vs. The Good

Could the plan outlined above — private insurance alongside the federal-state Fail Safe system — officially sanction a two- or multi-tiered health care system in the United States? It might. Some tiers are in-

herent in the very ideas of "choice", "managed competition" and "supplemental insurance." But the system proposed here would be so much better than the multiple-tier system now in place, which literally offers nothing or brutal rationing as its lowest tier.

Furthermore, Americans favor or at least tolerate a multi-tier approach in many other important human services sectors, notably in education and in jurisprudence. For example, Americans from the entire ideological spectrum, including those who profess belief in the concept of public education, send their children to the nation's better endowed and highly selective private schools, if they have the means to do so. The prospect of being able to impose a truly egalitarian health system upon

such a nation appears dim. One should not evaluate proposed health care reforms by highly exacting ideal standards that are unlikely ever to be reached in practice. As Senator Daniel Patrick Moynihan of New York has put it so aptly, in matters of social policy many well-meaning people too often have let the [hypothetical] best become the enemy of the [achievable] good. That approach may make well-meaning people feel good; but it usually ends up hurting the poor.

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APPENDIX B

WHO PAYS FOR EMPLOYER-PROVIDED HEALTH INSURANCE?

Currently, employment-based health insurance accounts for about one third of total national health spending. The premiums for the group policies that provide this insurance average \$12,600 for family coverage and \$4,704 for single coverage. Of those total premiums employees pay through withholds from their paychecks an average of 26% for family coverage and 15% for single coverage. For the remainder, the employer writes the check to the insurance company.¹³

The question is: who ultimately pays for the employer's part of the premium -- customers in the form of higher prices, owners in the form of lower returns to their investment in the company or employees in the form of lower take-home pay?

The Common Perception among Non-Economists: Most non-economists seem to believe firmly that when an employer pays X% of the health insurance premium for an employee and the latter contributes the balance, that X% is shifted by the employer either forward in the form of higher prices or backwards to the firm's owners in the form of lower return to owners' equity. Because financial capital is globally mobile, the argument goes, employers do not have the market power to shift much if anything of the employer-paid share of health insurance premiums to the firm's owners. Therefore, the argument continues, these costs necessarily must be shifted forward into higher output prices, which can render the firm uncompetitive in the global market for output. All told then, the argument concludes, employers find themselves increasingly desperate in the face of rapidly rising health care cost, especially in the midst of a global recession.

The Economist's Theory on Fringe Benefits: Economists do not quite buy this story line.¹⁴ Both economic theory and a considerable body of empirical research suggests to economists that over the longer run, the bulk of the employer-paid health insurance premiums actually is shifted back to employees in the form of lower cash take-home pay. It is an indirect hit on the employee's pocket book, in addition to the direct contributions to health insurance employees make by means of explicit withholds from the paycheck.

The formal theory underlying this argument is rather involved, but is available from the author upon request.¹⁵ Broadly speaking, the argument is as follows.

First, in the face of an exquisitely mobile global capital market, one firm's or one country's firms' ability to lower the rate of return to capital through backward-shifting

¹³ The Henry J. Kaiser Family Foundation and Health Education Research trust 2008 Survey of Employer Health Benefits; Exhibit 2 (<http://ehbs.kff.org/images/abstract/7814.pdf>).

¹⁴ See, for example, the author's "Health care spending and American competitiveness," *Health Affairs*, Winter 1989; 8(4): 5-21.

¹⁵ E-mail reinhard@princeton.edu with Subject: "Senate Testimony - EPHI."

employer-paid health insurance premiums is quite limited. Financial capital can too easily flow to the country in which it earns the highest expected rate of return.

Second, if a firm sells its output in a highly price-competitive global market for that output, then its ability to shift those costs forward in the form of higher prices is very limited as well. Customers around the world are selfish. No customer anywhere will pay more for a product just because it covers health insurance for employees.

Finally, however, labor is rooted locally and, for the most part, not very mobile among countries – certainly not as globally mobile as is capita or are global customers for output. Thus labor, being the least mobile factor, turns out to be the sitting duck to which the bulk of the cost of fringe benefits can be shifted in the form of lower cash take-home pay.

The precise degree to which the cost of fringe benefits can be shifted back to employees depends crucially on what economists call the “wage sensitivity of the supply of labor,” that is, the degree to which employees will actually reduce their supply of labor in response to wage cuts. While that elasticity may be high for individual firms – because workers can quit and work for other firms nearby – economists have found that for the economy as a whole the wage-sensitivity of the aggregate supply of labor to the economy is actually quite low. It means that the cost of fringe benefits can indeed be shifted back to employees in the form of lower cash take-home pay without reducing much the level of employment offered by workers. It means, however, that take-home pay can deteriorate quite a bit and workers will still show up for work.

There are some exceptions to the assumed backward shift.

The Short Run: First, the economic theory alluded to in the preceding discussion assumes adjustments over the longer run to increasing health insurance premiums paid by employers. Economists do recognize that, in the short run, take-home pay is “sticky downward,” as the jargon goes, which means that short run shocks in the health insurance premiums paid by employers may well be absorbed by owners in the form of lower retained earnings.

Retiree health Benefits: Second, the preceding discussion applies to health insurance for active workers, not to retiree health benefits. The cost of retiree health care does have to be shifted either to owners or to customers. If they are shifted to customers – either in the form of higher output prices or by cutting the quality of output at given prices – the firm will see its market shrink. If they are shifted to owners – through lower retained and reinvested earnings – then the firm will gradually strangle the capacity of the firm to innovate and replace capital equipment. The traditional American auto companies represent classic examples of this possibility. They literally have been suffocating under the weight of their retiree health benefits, which has absorbed the bulk of these firms’ net cash flow from operations in the past decade or so.

Monopoly in the Output Market: Third, if a firm enjoys a monopoly in its output market, then it can more easily shift the cost of fringe benefits into higher output prices, especially when the demand for output is relatively price-insensitive (“price inelastic”). Public utilities that produce basic necessities – such as water or power – have been classic examples of this possibility.

Labor Monopolies (Unions): Fourth, the late UAW leader Douglas Fraser’s theory notwithstanding, if a firm’s work force is organized into a union with very strong

bargaining power – which economists call a “labor monopoly” – then employees through their union representatives at the bargaining table may be able to resist any backward shift of the cost of fringe benefits into their cash take-home pay. Such a policy on the part of the union, however, is myopic and will be paid for by reduced employment. Indeed, unless the firm then enjoys a monopoly in the output market, such a bargaining posture can easily drive a firm, over time, to its gradual demise. This tendency, too, is illustrated by the traditional auto companies who now literally face bankruptcy.



Business Roundtable

**Testimony to
the Senate Finance Committee,
Hearing on “Health Care Reform: An Economic Perspective”**

**Ivan Seidenberg, CEO
Verizon, Inc**

**Chair,
Consumer Health and Retirement Initiative**

November 19, 2008

Introduction

I am pleased to present testimony on the financial crisis in our society and its impact on access to health care services for all Americans. Today, I am presenting this testimony on behalf of the Business Roundtable, an association of chief executive officers of leading U.S. companies with \$4.5 trillion in annual revenues and almost 10 million employees. Member companies comprise nearly a third of the total value of the U.S. stock markets and represent over 40 percent of all corporate income taxes paid to the federal government. Collectively, Business Roundtable companies returned \$114 billion in dividends to shareholders and the economy in 2006. Business Roundtable appreciates your leadership, Chairman Baucus, Senator Grassley and other Senators on this Committee, in holding this important hearing to explore ways to improve our health care system so that all Americans can have access to affordable health care.

With nearly a quarter of a million employees, plus dependents and retirees, Verizon Communications provides health insurance coverage to approximately 900,000 Americans at a cost of about \$4 billion a year.

As the provider of health coverage to almost 35 million Americans, Business Roundtable companies play a significant role in helping American workers and their families obtain medical care. Business Roundtable CEOs consistently cite health care as their number-one cost pressure. Rampant cost increases in the medical system mean we're paying *more* for *less* value. Health care costs are inhibiting job creation and damaging our ability to compete in global markets. They are also imposing a major strain on the household incomes of many Americans. In these times of financial insecurity, maintaining jobs and retaining the health care benefits is an enormous strain

on both employees and employers. We believe health care reform should be addressed now as we work our way through these difficult financial times.

Today, *all* employers make difficult economic decisions about whether to offer health insurance and face enormous increases year after year. Add to this, two alarming facts:

First, one-sixth of our economy is spent on health care. In 2007, total national health expenditures were expected to rise 6.9 percent — two times the rate of inflation. Total spending was \$2.3 trillion in 2007, or \$7600 per person. Total health care spending represented 16 percent of the gross domestic product (GDP). U.S. health care spending is expected to increase at similar levels for the next decade reaching \$4.2 trillion in 2016, or 20 percent of GDP.¹

Second, over 177 million American get health insurance coverage through their employer, yet we are facing an unemployment rate at a 14-year high of 6.5 percent. It is estimated that a single percentage-point increase in unemployment could increase the number of uninsured by 1.1 million. This means more uninsured, more who will qualify for public programs, and continued increase in premiums due to a cost-shift to those Americans who have health insurance. It is critical that we focus on ways to improve efficiencies to reduce costs just as much as we focus on expanding access to health insurance coverage. If we fail to do so, we risk being able to maintain *current* levels of health insurance coverage and we may find expanding coverage to be unattainable.

¹ Poisal, J.A. et al, Health Spending Projections Through 2016. Health Affairs (21 February 2007).

During these economic difficulties, we must commit to retain what is good about our health care system, yet find ways to improve the value and the costs, and provide affordable health insurance options for Americans.

Thank you, Chairman Baucus, for providing us with your views on how to improve health care coverage for all Americans. Your paper, "Call to Action, Health Reform 2009," contains many of the same suggestions that we, as CEOs joined at Business Roundtable, will make today. Thank you, Senator Grassley, for your leadership on health care reform. The work you have done, with Chairman Baucus, over the years has shown an extraordinary commitment by both of you to work together and find practical solutions to improving Medicare. To all the members of the Senate Finance Committee, I look forward to talking to you about our suggestions on how to improve our health care delivery system so that more Americans have affordable health insurance coverage.

Financial Situation

First, let me discuss our financial situation. As leaders of many of the largest American companies, Business Roundtable members know personally that the ongoing turmoil in global capital markets is placing great stress on businesses throughout the American economy — both financial and non-financial companies — as well as on workers and consumers. For non-financial businesses, the reduced access to credit markets is constraining the ability of American businesses to stock inventories, purchase new equipment, meet payroll and pay vendors. Left unchecked, this breakdown in lending may lead to a deep and sustained recession both at home and abroad, with significant job losses. Significant job losses mean that many more

Americans may lose their health insurance benefits. I appreciate your leadership in understanding that our economy needs help and that all Americans are depending on your leadership in finding the right solutions to address this crisis.

For the record, on behalf of Business Roundtable, I wish to express our strong support for new bipartisan legislation to address the severe financial credit disruptions in order to restore stability to the credit markets and the U.S. economy, which will help American workers, families and companies recover from the current economic downturn.

We applaud the actions of the Congress, the Administration and the Federal Reserve to date, that are intended to restore confidence in the banking system and additional efforts within the G-7 and G-20 countries to deal with this problem on a coordinated basis. However, the problems facing the credit markets are unprecedented, and additional legislative actions are required to assist the economy.

Recent events have demonstrated the close interrelationship between employer-paid health and retirement benefits and the economy as a whole. That connection is made clear by the current pension funding dilemma. The steep and sudden market declines have created immediate and significant pension contribution mandates. Unless prompt action is taken to allow those unexpected pension contributions to be smoothed over time, employers will not be able to retain as many workers, invest in job training, maintain the same robust health plans, or pursue capital improvements that are critical to the economic recovery. We know that the Members of this Committee have been examining the pension funding issues and we urge you to act quickly.²

² See attachment, Business Roundtable letter, November 14, 2008, to Congressional leaders.

Business Roundtable also believes that for broader economic legislation to be truly successful it must address two fundamental concerns.

First, policies must address the problems of liquidity confronting U.S. companies in order for the U.S. economy to return to growth.

Second, to promote a more rapid recovery, the economic stimulus package has to accelerate job creation and speed the return to work of unemployed workers.

Business Roundtable has made recommendations for addressing these issues and we offer our assistance to work with you to closely evaluate these and other proposals that Congress may consider to resolve the current credit crisis and bring about a quick and robust economic recovery for American workers, families and companies.³

Health Care Reform — Business Roundtable's Principles

Today, I want to share with you our principles for improving the health care marketplace for all Americans.⁴ Our suggestions are offered as ideas — we, as Business Roundtable CEOs, are prepared to work with you to improve the health care system and these principles are intended to begin the dialogue to find the right balance between preserving what is the best in our health care system and finding ways to expand affordable coverage to more Americans.

In September, we released a document entitled "Health Care Reform in America: A Business Roundtable Plan." This contains our principles to improve our system. We all recognize that the American health care system is among the best in the world. When it comes to scientific advances, medical technology and the quality of our doctors,

³ See attachment, Business Roundtable letter, October 30, 2008, to Congressional Leadership, Senators McCain and Obama, Federal Reserve Chairman Bernanke, and President Bush.

⁴ See attachment, Business Roundtable, "Health Care Reform in America," September 2008.

health care providers and hospitals, the United States is “the gold standard.” From our perspective, the problem with the health care market in this country is that it doesn’t really function as a market — it leaves major consumer needs unmet, costs unchecked by competition, and basic practices untouched by the productivity revolution that has transformed every other sector of the economy.

Contrast that to the communications industry, for example, where we’ve seen technology and competition invigorate our business and ignite innovation. Information technology has revolutionized the interface between customers and providers. The norms of the electronic marketplace — personalization, control, price and quality transparency, and 24-by-7 availability — have become part of the customers’ expectations in just about every aspect of life — except in our health care system.

Business Roundtable’s plan improves our health care system and contains four pillars:

1. Creating greater consumer value and efficiency in the health care marketplace;
2. Providing more affordable health insurance options for all Americans;
3. Placing an obligation on all Americans to have health insurance coverage and encouraging all Americans to participate in prevention and chronic care programs; and
4. Offering assistance to uninsured, low-income families to meet their obligation.

Business Roundtable strongly urges that any plan adopted by Congress reinforce the existing employer-based system through which Americans currently receive health benefits. The federal ERISA statute that governs these plans gives employers the flexibility to design and finance plans that meet their employees’ needs — a system that has proven successful in making coverage widely available to workers. Tampering with

this law at this time could cause massive dislocations for those 132 million Americans who have workplace coverage.

When it comes to health care reform, ERISA isn't broken and does not need fixing. What is broken is that there are 45 million Americans without insurance coverage — because their employers don't offer it, they don't elect it, they can't afford it, they don't enroll in programs where they are eligible, or they can't get it in the private marketplace. We must address this issue now. Let me provide more detail about our principles:

1. Creating Greater Consumer Value in the Health Care Marketplace

Today's health care system needs to use modern technology. Health care consumers find it difficult to obtain reliable information on the cost and effectiveness of care. Business Roundtable recommends several actions to empower consumers to take charge of their own health and use technology to make the system more efficient:

First, the most egregious flaw in the current health care delivery model is the woeful rate of adoption of information technology (IT). Health care has failed to capitalize on the productivity revolution that has transformed almost every other sector of the economy. A heavy dose of IT has been shown to improve efficiency by 25-percent over three years every time it's introduced and can and will demonstrate savings in health care.⁵ We believe the government should adopt uniform, interoperable health information technology standards so that all the systems can communicate with each other. This can be done through federal rulemaking or through

⁵ See attachment, Medco, A Prescription for National Healthcare Reform.

the government purchasing authority — so long as the Medicare program has the authority to require the use of health information technology systems.

Second, consumers need more transparency and wider distribution of information about the cost, quality and effectiveness of the health care services they purchase. This will make the market function better, create better health care consumers and improve the quality of medical care. We specifically support the dissemination of consumer information on the cost and quality of health care, comparison of the effectiveness of health care services and supplies, and the release of CMS data in an appropriate manner.

Third, the current Medicare reimbursement system pays for “activities,” not “outcomes.” The private marketplace generally does the same — we have tried to fix this through various partnerships and programs. To get meaningful change, all payers must be included in rewarding performance. We support changing payments by public and private payers, including Medicare, to reward the value of services provided, not the volume of the service.

2. Providing More Affordable Health Insurance Options for All Americans

Over 177 million Americans obtain health insurance coverage through their employers — almost 133 million through private employers. Almost all private employers offer plans that are governed under the federal Employee Retirement Income Security Act, or ERISA. This law establishes fiduciary requirements, administrative requirements, and procedures to resolve problems in the plans. We encourage the Senate Finance Committee to continue supporting this federal framework for those employers who offer their employees health care benefits.

However, for many Americans, who do not have access to employer-sponsored coverage, they must rely on the health insurance marketplace for their coverage. The structure of the market itself is state-by-state. This marketplace has become inflexible, is overly prescriptive, creates market segmentation, and is afflicted with dueling mandates, rules and regulations. In our vision, the current state-based system could be replaced by multi-state markets and there would be more people eligible for this new market. We believe that this expanded market should be covered by rules — state solvency requirements and consumer protections would apply. There should be greater consistency in applying other rules and rate setting and possible guaranteed issue requirements. Risk adjustments and reinsurance issues would need to be explored. We need a better marketplace for all Americans to get **affordable** and **portable** health insurance coverage. We have learned lessons about how to create good markets under the Medicare Modernization Act — and this Committee has an understanding of the right balance of rules between the federal, state and private marketplace. We would like to work with you on finding the right balance for individuals who do not have coverage through their employer.

3. Placing an Obligation on All Americans to Have Health Insurance Coverage

While many Americans do have health insurance coverage through their employer, millions of Americans do not have coverage at all. At Business Roundtable, we have been educated on who are those Americans who do not have health insurance coverage.⁶ Today, there are some 45 million Americans who do not have coverage.

⁶ See attachment, Aetna's "Covering the Uninsured: Who Are The Uninsured?"

- 4.7 million are college students;
- Just fewer than 10 million are non-citizens;
- About 11 million are currently eligible for public programs, such as Medicaid and SCHIP, but they have not enrolled; and
- More than 9 million have household incomes over \$75,000, yet they do not purchase or elect employer-sponsored coverage.

We believe a "one-size-fits-all" solution will not work because this group is far from monolithic. For many of these Americans, obtaining coverage isn't so much financial, as it is structural. We need to have a competitive system that provides Americans with affordable options that are suitable for their families. However, we believe that all Americans should have health insurance coverage — as an obligation through auto-enrollment or some other mechanism.

We also support encouraging all Americans to participate in employer- and community-based prevention and chronic care programs.⁷ Many Business Roundtable employers offer prevention and chronic care programs to their employees and there are many worthwhile efforts in which Americans can participate. More needs to be done to educate and encourage participation.

4. Offering Health Coverage and Assistance to Low-Income, Uninsured Individuals and Families

For some low-income uninsured families, health care coverage is unaffordable. We believe that the government should provide financial assistance so that low-income individuals and families can purchase coverage from the private market. These targeted subsidies would be funded from the cost efficiencies in improving the health

⁷ See attachment, Business Roundtable "Doing Well through Wellness," a 2006-07 Survey of Wellness Programs at Business Roundtable Member Companies.

care marketplace and by expanding the number of lives that are covered by the less fragmented health insurance marketplace. We want this assistance to be used either in the newly established health insurance marketplace or by paying the individual's portion of the premium if they are eligible for employer-sponsored health insurance coverage.

Medical Liability Reform

We also encourage Congress not to lose focus on medical liability reform. Chairman Baucus, we support S. 1481, the "Fair and Reliable Medicare Justice Act" that you have sponsored with Senator Enzi. We hope you will reintroduce this legislation next Congress. We believe Congress should authorize pilot projects to evaluate alternative ways to resolve medical liability claims and then enact measures that enhance the fair compensation of individuals who are actually harmed as a result of negligence by a provider of health care services.

In addition, we believe that evidence-based medicine that is developed through quality measures will make a difference. Dr. Rohack, the President-Elect of the American Medical Association, has said that the American Medical Association has already developed 261 clinical measures. The Business Roundtable believes that these types of measures should be followed and treated as a defense in medical liability actions. The AMA is working to ensure that evidence-based appropriate medical care is provided, health information technology will help this, and we need to get the right incentives in place to help physicians to have the resources to purchase HIT. Reducing the unwarranted variation in physician practice, building an evidence-based system, improving the "business model" of health care through investment in health information

technology, and moving toward reducing the impact of medical liability fears can do a lot to improve the cost and quality of health care.

Efforts to Reach Consensus and Real Examples to Achieve Reform

I want to highlight two important examples of how we can reach consensus on how to improve the health care system: one is through a "strange bedfellows" group of Washington-based organizations that are calling for reform. The other relates to efforts at Verizon, as part of our collective bargaining agreement, where we agreed with the Communication Workers of America (CWA) union and the International Brotherhood of Electrical Workers (IBEW) on specific health care principles for reform.

Divided We Fail

Let me start with Divided We Fail (DWF). Representing more than 53 million people, this organization includes Business Roundtable, AARP, the Service Employees International Union (SEIU) and the National Federation of Independent Business (NFIB). The group was launched almost two years ago to call on Congress to enact bipartisan health care reform and to improve the long-term financial security for all Americans. We have principles that we believe all Americans should have access to affordable health care; that wellness and prevention efforts should be priorities; and that a focus on long-term care is necessary.

On long-term financial security, we believe Social Security must be strengthened, there should be financial incentives to save, and we need to provide all Americans with the tool to help manage their finances. Divided We Fail provides constructive input on the changes that are needed on health care reform. Most Members of Congress have

joined in our pledge along with more than one million Americans. And, we have worked together in support of legislation.

Last year, we joined together to support passage of health information technology legislation. This year, it is our hope we can join together in support of positive reforms in our health care system.

Verizon, CWA, and IBEW National Health Care Reform Principles

As I stated earlier, Verizon, as part of our collective bargaining agreement, came to agreement with the CWA and IBEW on specific health care reform principles. Collectively, we are committed to working together to achieve meaningful health care reform that covers everyone; controls costs; shares the responsibility for coverage; and improves quality. We will work together to educate Verizon employees and the public about the health care crisis and options for solutions that meet our principles.

Conclusion

We want to work with you on finding solutions — and our plan is also to use the power of the market to drive down costs, drive up quality and improve access to health care for all Americans. Chairman Baucus, all ideas are good — you have captured some of the important issues we support. Some issues in your plan need to have further discussion about the costs and impact on the workforce. But, we want to work with you, and all Members of this Committee, to find realistic solutions to improve our current fragmented system. The challenge of reforming the health care system goes to the very heart of American competitiveness and innovation:

- When Americans are afraid to switch jobs or start their own business for fear of losing their health insurance;
- When American-made products carry a health-care premium that foreign-made goods do not;
- When Americans who currently have health insurance coverage must pay higher costs to subsidize those who do not have coverage;
- When America is not leading the world in technological innovation in health care delivery; and
- When year after year, we are spending more money and getting less value, then America's very place in the global economy and our ability to help those who are low-income are all at risk.

Our principles and ultimately your proposal must emerge from the uniquely American principles that drive our economy: competition, innovation, choice and a marketplace that serves everybody. We want to go to work with you to find solutions that are common sense and practical. Thank you for the opportunity to testify.

Attachments



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October 30, 2008

Individual letters to be sent to the following:

**Congressional Leadership
 Senators McCain and Obama
 Federal Reserve Chairman Bernanke
 President Bush**

Harold McGraw III
 The McGraw-Hill Companies
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Fenneth I. Chanaud
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 General Motors Corporation
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John J. Castellani
President

Larry D. Burton
Executive Director

Johanna J. Schneider
**Executive Director
 External Relations**

Re: Liquidity Crisis and Economic Stimulus

Dear _____:

On behalf of Business Roundtable, I am writing to express our strong support for new bipartisan legislation to address the severe financial credit disruptions in order to restore stability to the credit markets and the U.S. economy, which will help American workers, families and companies recover from the current economic downturn.

We applaud the actions of the Congress, the Administration and the Federal Reserve to date that are intended to restore confidence in the banking system and additional efforts within the G-7 countries to deal with this problem on a coordinated basis. However, the problems facing the credit markets are unprecedented, and additional legislative actions are required to assist the economy.

Business Roundtable believes that for legislation to be truly successful it must address two fundamental concerns.

First, policies must address the problems of liquidity confronting U.S. companies in order for the U.S. economy to return to growth.

Second, to promote a more rapid recovery, the economic stimulus package has to accelerate job creation and speed the return to work of unemployed workers.

The enclosed recommendations will assist in resolving the immediate liquidity problems and will support a more rapid recovery. These proposals will enable the U.S. economy to return to full strength

October 30, 2008
Page 2

more quickly and minimize job losses. Our recommendations are based on the front-line experience of our members. Business Roundtable is a CEO-led organization of over 160 leading corporations, with a combined workforce of more than 10 million employees and more than \$5 trillion in annual revenues. Business Roundtable's highest priority is to sustain growth of the U.S. economy in order to achieve higher living standards for all Americans.

As leaders of many of the largest American companies, Business Roundtable members know personally that the ongoing turmoil in global capital markets is placing great stress on business throughout the American economy – both financial and non-financial companies – as well as on workers and consumers. For non-financial businesses, the reduced access to credit markets is constraining the ability of American business to stock inventories, purchase new equipment, meet payroll and pay vendors. Left unchecked, this breakdown in lending may lead to a deep and sustained recession both at home and abroad, with significant job losses.

We are cognizant that additional measures will likely increase an already significant deficit in 2009. Business Roundtable has always placed a high priority on deficit reduction as a means to enhance sustained economic growth. However, in order to avoid a prolonged and potentially deeper recession than the country has experienced in recent times, we believe a short-term increase in the deficit is an acceptable, although unfortunate, outcome at this time. This does not mean that Congress can ignore deficits now, nor when the economy recovers. Measures to control future spending will be even more important given the increased debt this nation is now incurring.

Business Roundtable offers assistance to work with you to closely evaluate these and other proposals that you may consider to resolve the current credit crisis and bring about a quick and robust economic recovery for American workers, families and companies.

Sincerely,



Harold McGraw III

Enclosure: Business Roundtable Recommendations to Promote Liquidity and Economic Stimulus

**BUSINESS ROUNDTABLE RECOMMENDATIONS
TO PROMOTE LIQUIDITY AND ECONOMIC STIMULUS**

Accelerate Economic Recovery by Promoting Liquidity for Businesses

America's businesses fund their ongoing capital requirements through access to capital from equity markets, debt markets and retained earnings. To date, legislation passed by Congress and actions taken by the Administration and the Federal Reserve have resulted in a number of significant and historic steps to restore the functioning of debt markets, but these markets still remain in severe distress. As noted in a recent speech by Federal Reserve Bank President Janet Yellen, borrowing rates for most businesses are higher now than at the beginning of the crisis in August 2007 despite a 375 basis point reduction in the federal funds rate over this period.

Short-term Regulatory and Federal Reserve Actions to Promote Liquidity:

- Additional measured actions should be considered by the Federal Reserve and Treasury under existing authority to lower the cost of funds to business. One immediate step is for the Federal Reserve to expand its purchases of commercial paper through the Commercial Paper Funding Facility to all investment grade instruments ('A' and 'BBB' or higher securities) rather than just the most highly rated securities currently eligible and to extend the program to indirect issuers.
- Treasury should use some of the funds provided under the Emergency Economic Stabilization Act to provide direct infusions to auto finance and auto companies.

Short-term Legislative Stimulus Recommendations to Promote Liquidity for Business:

- Temporarily allow foreign subsidiary earnings of U.S. companies to be brought back to the United States. This will immediately provide more capital to U.S. companies for their capital needs. As a result of the current liquidity crisis, the importance of these funds is even greater at this time and, appropriately structured, this measure can bring about meaningful changes in liquidity and economic activity in the United States.
- Temporary relief from pension funding requirements. Stringent new funding rules adopted in the 2006 Pension Protection Act (PPA) are still being phased-in. Recent market declines and the shortage of available credit require a reevaluation of the transition to those new rules. The volatile and unexpected cash flow demands on plans caused by the recent economic downturn should be smoothed, with those plans prudently returned to full funding status over a reasonable period. Without temporary funding relief, the economic recovery will be slowed as available resources are diverted from job creation. Moreover, retirement security will be eroded as some employers will be forced to freeze or terminate their pension plans in order to meet the unanticipated and immediate increase in required plan funding.

- Temporarily extend the carry back period for net operating losses from 2 years to 5 years through 2009 and waive 90% limitation for AMT. Businesses with current losses may carry back these losses for 2 years, but if losses exceed profits in these years they must carry the losses forward to offset future income. Extending the carry back period from 2 years to 5 years and temporarily waiving the limitation on use of net operating losses against alternative minimum tax (AMT) (as was done in 2002) will enhance liquidity of businesses with current losses.
- Extend bonus depreciation and adopt a temporary investment tax credit. The 50-percent bonus depreciation provision enacted earlier this year is set to expire at the end of 2008. This provision should be extended, including the provision to monetize credits for companies in a loss position. Additionally, an investment tax credit should be considered for new investments. First adopted under President John F. Kennedy, an investment tax credit of 10 percent applied to most equipment purchases by businesses until 1986. This credit was frequently employed on a temporary basis throughout the 1960s to promote investment during economic downturns and was credited with having a significant investment response. Today, during this period of reduced liquidity, an investment tax credit can help stretch scarce capital by lowering the cost of undertaking new investment.
- Temporarily extend and expand the ability to "monetize" existing tax credits. Under the Housing and Economic Recovery Act of 2008, enacted on July 30, 2008, companies can accelerate a portion of their unused pre-2006 research credits and alternative minimum credits in lieu of claiming the temporary 50-percent bonus depreciation allowance. Expanding the provision to provide immediate monetization regardless of investment amount, cover all general business credits, as well as increasing the amount of unused credits that may be claimed or refunded through this provision or similar mechanism, will enhance liquidity of businesses with current losses or otherwise unable to claim these credits. Companies in a loss position are an important component of the companies that need access to capital and allowing for utilization of their already existing credits will help increase their liquidity and ability to fund new investments. These companies should be allowed to immediately monetize all of their prepaid AMT credits and earned but unused general business credits.
- Loosen restrictions on capital losses for corporations. Currently, corporations can deduct capital losses only to the extent of their capital gains, and excess capital losses can be carried back three years and carried forward five years. Easing the restrictions on capital losses by, for example, allowing corporations to treat losses on the sale of stock or debt securities as ordinary would be an effective way to bolster liquidity in difficult economic times, when losses of all types tend to increase.

- Allow financial services companies to accelerate bad debt deductions. Until 1986, companies generally could deduct reasonable additions to bad debt reserves rather than postpone the deduction until such time the debt was written off. After 1986, the so-called reserve method is available only to small banks. Expanding the reserve method to the broader financial services sector including large banks would be an effective means of improving liquidity for companies that have been particularly hard hit in the current economic downturn.
- Temporary reduction in required estimated tax payments of corporations to 90% of current liability. A temporary reduction in estimated tax payments can provide companies with additional short-term liquidity without creating any revenue loss to the federal government over the 5-year or 10-year budget periods.
- Temporarily exclude debt repurchases from cancellation of indebtedness income. The current credit crisis has depressed the value of debt issued by many companies with sound balance sheets. Companies that issued such debt may wish to repurchase their own debt to strengthen their own balance sheets and, since some of this debt is also held by financial institutions, such repurchases would also strengthen bank balance sheets in a manner similar to that intended under the Troubled Asset Repurchase Program. Companies can be encouraged to re-purchase this debt by temporarily relieving such repurchases by issuers (and parties treated as related to the issuer) from rules treating these repurchases as giving rise to discharge from indebtedness income.

Accelerate Economic Recovery by Supporting Workers, Promoting Employment and Moving toward a More Efficient and Sustainable Energy Future

Jobs are the source of strength in the American economy. Job creation, as well as maintaining employment during a declining economy, is vital for economic growth. The cost of job dislocation can be reduced by getting dislocated workers back to work more quickly. Helpful policies include reducing employment-based taxes on a temporary basis, offering job training for employees and dislocated workers, and maintaining incentives for workers to regain employment.

Our economy also is facing unprecedented energy challenges and the need to address these challenges through use of clean and efficient energy strategies. Measures aimed at creating green jobs motivate creation of capacity in an area vital to both our short-term economic health and our longer term energy security.

Short-term Legislative Stimulus Recommendations to Support Workers, Promote Employment and Move toward a More Efficient and Sustainable Energy Future

- Expand energy efficiency initiatives. Expansion of the labor intensive Weatherization Assistance Program to retrofit homes with additional insulation (currently about 70,000 homes) would not only create additional jobs, but also save consumers on their utility bills. Energy efficiency block grants to states

would enable states and localities to upgrade building efficiency requirements and/or match current state programs to finance efficiency retrofits of existing buildings.

- Fund green technology job training programs. The Energy Independence and Security Act of 2007 included training for green jobs, but nothing was appropriated for FY 2008. Labor shortages exist right now and demand for workers with these skills is growing.
- Temporarily extend unemployment benefits for workers who exhaust standard unemployment benefits. Consider also offering personal re-employment accounts that provide unemployed workers with funds for training, child care, transportation, moving costs, or other expenses associated with finding a new job. Recipients who take a new job within a defined period would be allowed to keep the funds remaining in the account as a re-employment bonus. Studies of experimental programs find these accounts help workers regain employment faster and at wages similar to those ultimately attained by unemployed workers without such accounts.
- Focus infrastructure investments. Infrastructure spending should focus on projects that can be undertaken quickly to repair critical infrastructure as well as build a more efficient, sustainable energy future. In addition, funding currently approved, but unfunded federal laboratory and university research infrastructure modernization and major research instrumentation procurement through existing federal programs would rapidly stimulate new construction and equipment purchases.
- Temporarily reduce the Social Security tax rate by one percentage point for both employees and employers. This enhances labor market incentives by reducing labor costs for employers and providing increased after-tax wages for employees. A worker earning \$50,000 would receive tax savings of \$500 over a year, with the employer receiving similar savings. The Social Security trust fund would be made whole by a transfer of funds from general revenues to cover the temporary reduction in payroll taxes.
- Provide a worker training tax credit for employers. During an economic downturn, there is an increased need for workers to find new employment in areas for which they may be poorly trained. A tax credit for employers can increase the ability of employers in growing sectors of the economy to take on workers displaced from contracting sectors and help these workers quickly regain productive employment.



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November 14, 2008

The Honorable Max Baucus
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Dear Chairman Baucus:

Last week, Business Roundtable shared some ideas on possible ways to improve the current economic situation. This letter provides additional information on the pension funding issues that we raised and urges you to take immediate action to address the problems that have been created for pension plans by recent economic conditions.

The sudden decline in the value of pension plan assets, when coupled with the current credit crunch, places defined benefit plan sponsors in a very difficult position. Plan sponsors are confronting unexpected funding obligations that greatly exceed even the most conservative forecasts and budgets. Resources that must be devoted to meet the unexpected new funding mandates will have to be diverted from maintaining payrolls and will delay the business investments necessary to preserve jobs and ultimately spur the recovery.

Let me emphasize, this is much more than a cash flow issue. It is a jobs issue and a broader economic issue that directly affects every American. Dramatically larger pension contribution requirements during an economic downturn reduce capital spending and exaggerate economic cycles. "Procyclical" pension funding rules result in an economy that overheats more during upturns and has deeper recessions during downturns. That is precisely the economic threat we face today — large and unexpected pension contribution requirements will dampen the economic recovery and lead directly to greater job loss from the current recession.

Dr. Robert F. Wescott, former Chief Economist at the Council of Economic Advisors, and a distinguished team of academic reviewers have reached the same conclusion. They examined the interaction of

November 14, 2008

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the pension funding rules and economic cycles and concluded that procyclical funding requirements result in greater job loss during recessions.

Business Roundtable member companies currently sponsor retirement plans benefiting millions of workers and retirees. We believe that pension plans must be prudently funded. Pension promises that are made must be kept because the retirement security of millions of Americans is dependent on it. Predictable and steady funding rules are important because they allow employers to make the long-term financial plans and commitments that are required when taking on pension obligations.

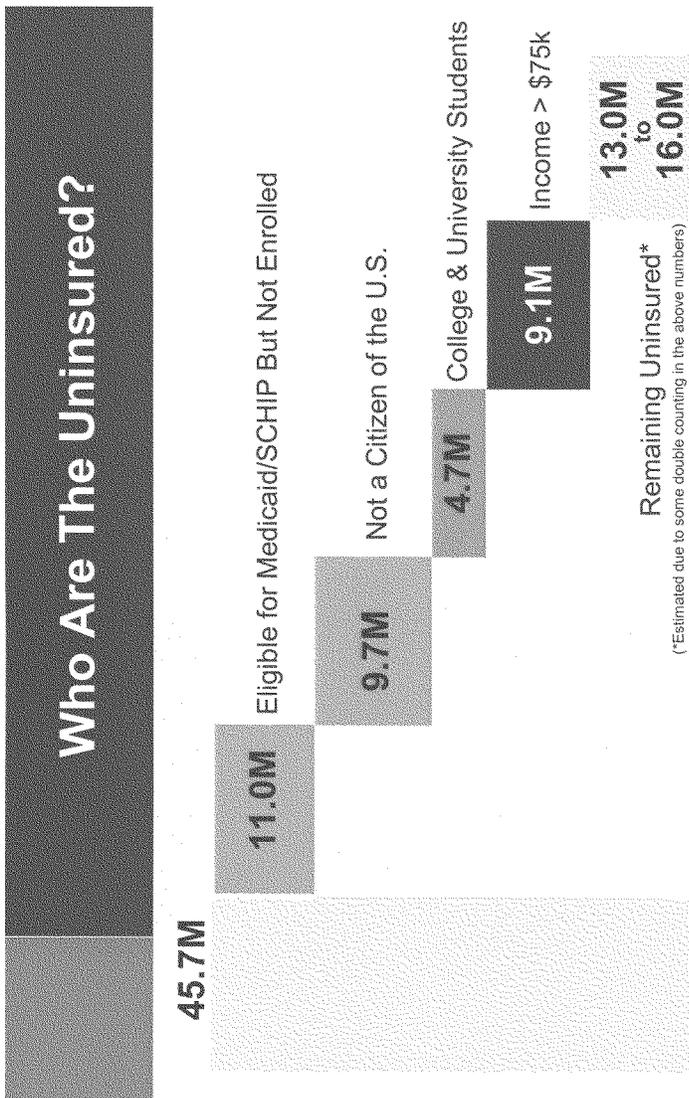
We urge immediate action to address this crisis. Specific steps you should consider are:

- **Smoothing.** Congress should enact the provision already passed by the House and Senate as part of PPA technical corrections legislation that makes clear that smoothing of asset gains and losses over 24 months is permitted under PPA. In order to make the asset smoothing change effective in this period of sharp market declines, Congress should temporarily remove the "corridor" that limits the benefits of the smoothing rule.
- **Transition to New Funding Rules.** The transition to new funding targets that was created in 2006 should be modified to reflect the new economic reality. The funding target for 2009 should remain 92% and the transition funding regime should apply not only to those at or above the phased-in funding target but also to those below these targets.
- **Permit New Funding Elections.** Congress should permit defined benefit plan sponsors to change their funding elections for 2009 and 2010.

Sincerely,



John J. Castellani



Covering the Uninsured

Sources: Total Uninsured, Not a Citizen and Income >\$75k, U.S. Census; "Income, Poverty, and Health Insurance Coverage in the United States: 2007," issued August 2008; Eligible, But Not Enrolled: Kaiser Commission on Medicare and the Uninsured; "Characteristics of the Uninsured: Who is Eligible for Public Coverage and Who Needs Help Affording Coverage?," February 2007; College & University Students: GAO, "Most College Students are Covered through Employer-Sponsored Plans, and Some Colleges and States Are Taking Steps to Increase Coverage," March 2006. Estimator number of college students is made up of traditional college students (age 18-23) of ~1.7M and non-traditional aged college students of ~3.0M. Note: Non-citizens encompass undocumented persons and others, including lawful permanent residents and refugee/asylum seekers.



This document is confidential. Any prospective information that may be contained herein should not be construed as a prediction by Aetna of future events. Updated September 16, 2008



Business Roundtable™

Health Care Reform in America

A Business Roundtable Plan

September 2008

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I. Introduction

Business Roundtable members provide coverage to more than 35 million employees and their families and are deeply committed to public policy changes that will improve our nation's health care system. To further this urgent priority, Business Roundtable has developed a health care plan aimed at creating a more competitive private health insurance marketplace while maintaining a strong, stable public safety net. This plan contains four elements to meet these goals:

- ▶ Creating greater consumer value in the health care marketplace;
- ▶ Providing more affordable health insurance options for all Americans;
- ▶ Placing an obligation on all Americans to have health insurance coverage;
and
- ▶ Offering health coverage and assistance to low-income, uninsured individuals and families.

II. Creating Greater Consumer Value in the Health Care Marketplace

The high cost of health care imposes an enormous burden on all Americans — raising the cost of health insurance coverage for those who have coverage and those who do not have coverage. Business Roundtable supports policies that will provide greater accountability, enhance efficiency and create value for all consumers of health care services.

Today's health care system needs to use modern technology. Health care consumers find it difficult to obtain reliable information on the cost and effectiveness of care. In addition, the health care payment structure emphasizes volume over quality. Building on Business Roundtable's existing principles to promote greater efficiencies, the Roundtable supports reform based on the following principles to create greater consumer value in the health care marketplace.

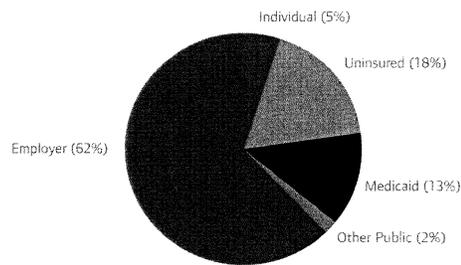
Specific principles:

- ▶ Adoption of uniform, interoperable health information technology standards;
- ▶ Dissemination of consumer information on the cost and quality of health care and comparison of the effectiveness of health care services and supplies; and
- ▶ Promotion of changing payments by public and private payers, including Medicare, to reward value of services provided, not volume.

III. Providing More Affordable Health Insurance Options for All Americans

Most Americans — a total of 177 million — obtain health insurance coverage through their employers. Approximately 133 million of these are covered under plans regulated by the Employee Retirement Income Security Act, or ERISA, which provides the framework for employer-sponsored coverage. This law has fiduciary requirements, administrative requirements and remedies. Business Roundtable supports continuation of employer-sponsored health insurance and the existing legal framework.

Health Insurance Coverage of Nonelderly, 2006



Source: Kaiser Family Foundation

To create greater health insurance options for all Americans, including insurance offered by large and small employers, Business Roundtable supports creating a more competitive marketplace in which health insurers could offer health coverage across state lines in regions, thereby expanding the numbers of people who could participate in the plans.

Specific principles:

- ▶ The Department of Health and Human Services (HHS) would establish regions, similar to those established under Medicare, to allow licensed insurance companies to compete in multistate areas where they hold at least one state license.
- ▶ Multistate plans would have the flexibility to offer plans to individuals and small and large employers throughout the states included in the area. These plans would not have to comply with mandated state benefit laws but would have to offer a minimum actuarial value plan.
- ▶ Low-income individuals who qualify for financial assistance would select coverage in these multistate markets.

An Open/All-Inclusive Market To Replace Segmented Insurance Markets

Current health insurance markets are segmented into two markets: (1) the self-insured/national plan market and (2) the insured market. Many health reform proposals would establish standardized benefit designs or further segment insurance markets to help certain purchasers through special rules. This proposal suggests taking the opposite approach — opening the market to all purchasers to increase access to competitive plans and allow additional choices for consumers.

Creating a Competitive, Multistate Marketplace without Disrupting Existing Business Opportunities

A framework could be used to govern new, multistate insurance market products, allowing insurers to offer health coverage across state lines within regions. Because of the wide geographic variation in health care spending, regions would combine similar markets. As variation decreases over time, regions could expand to potentially create a national market. Medicare Advantage, Medicare Part D and TRICARE all use multistate markets to improve access to benefits.

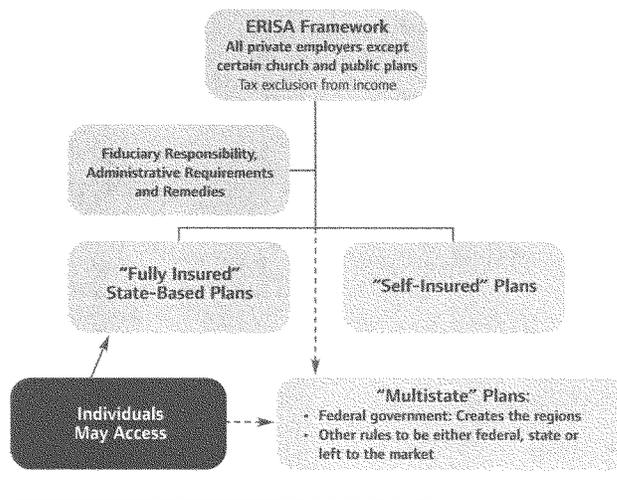
How Could Multistate Markets Be Established?

Establish Regions: HHS could establish regions, similar to those recently created under Medicare, to allow licensed insurance companies to compete in multistate areas where they hold at least one state license.

Create Framework Rules: HHS could establish, through the rule-making process, the regulations required for multistate markets. Regional plans would not have the benefit mandates; rather, they would have the flexibility to offer actuarially equivalent options driven by the market. The following issues would need to be addressed: benefit design, solvency requirements, rate setting, marketing regulations and possibly guaranteed issue requirements, risk adjustment, and reinsurance.

Create Interest in Multistate Markets: The multistate insurance market could be enlarged by encouraging participation through reinsurance adjustments that could help spread the cost of catastrophic cases across the multistate market or across the nation.

Policy Concept: Competitive Multistate Health Plans



The Benefits of Multistate Plans

- ▶ Individuals and small- and medium-sized businesses would all benefit from greater access to additional health insurance coverage options.
- ▶ Insurers and health plans would strive to become more competitive on cost and quality.
- ▶ Overall, multistate markets would improve competition, choice and access, which would result in better value for health care spending.

IV. Placing an Obligation on All Americans To Have Health Insurance Coverage

Although a majority of Americans do have health insurance coverage, there are others who do not. Some do not elect coverage from their employer or purchase coverage on their own because they cannot afford it. For those Americans, subsidies should be provided. Some Americans do not enroll in programs for which they are eligible, such as the State Children's Health Insurance Program, and Business Roundtable believes it is important to enhance education and enrollment opportunities. For all other Americans, it is an obligation that they elect health insurance coverage through their employers or purchase health insurance coverage. Through greater insurance coverage plans and bringing greater value to our health care system, the Roundtable believes the marketplace will provide employers and Americans more affordable options.

Specific principles:

- ▶ Impose an obligation on all Americans to obtain health insurance coverage that, at a minimum, offers catastrophic benefits; and
- ▶ Encourage all Americans to participate in employer- and community-based prevention and chronic care programs.

V. Offering Health Coverage and Assistance to Low-Income, Uninsured Individuals and Families

To ensure that all Americans can purchase health insurance coverage, the government would provide financial assistance to low-income, uninsured individuals and families.

Specific principles:

- ▶ Permit the individual or family to purchase private health insurance coverage with financial assistance through the private multistate marketplace; or
- ▶ For low-income Americans who have access to employer-sponsored health insurance, permit the individual or family to receive financial assistance for their portion of the premium.

Financing Health Insurance Coverage as a Safety Net for Low-Income Individuals and Families

Adopting reforms that would reorient our health care system toward consumer value would generate significant savings — savings that could be used to enhance the health insurance safety net for low-income Americans. For example, Medicare now is implementing e-prescribing, which is estimated to save \$2.1 billion over 10 years. Business Roundtable believes additional efforts to enhance efficiency and reward value rather than volume can produce additional savings, providing sufficient resources for the government to finance coverage for many individuals and families who cannot afford health insurance today.

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Perspectives

David B. Snow, Jr.
Medco Chairman and Chief Executive Officer
A Prescription for National Healthcare Reform



David B. Snow, Jr.
Chairman and Chief Executive Officer
Medco Health Solutions, Inc.

David B. Snow, Jr., Medco Chairman and Chief Executive Officer, is a healthcare industry veteran and innovator who has created and implemented solutions to manage the rising costs of health care for more than 30 years.

The following material is based on a presentation delivered by Mr. Snow to attendees at the National Press Club on September 9, 2008.

“The fact of the matter is that the United States is in serious need of major healthcare reform.”

Medicare is drifting toward disaster.

Those aren't my words. That's a thought expressed recently by U.S. Health and Human Services Secretary Michael Leavitt.

But that's only the tip of the iceberg. Beyond Medicare, it is apparent that the entire American healthcare system is on life support – suffocating under the unsustainable weight of \$2.1 trillion a year in spending.

For more than 30 years, first running hospitals and later health plans and managed health organizations, my passion has been to ensure that healthcare is accessible to as many people as possible. That's simply not possible unless healthcare is also affordable.

The fact of the matter is that the United States is in serious need of major healthcare reform.

The United States spends nearly \$7,000 per year, per person, on healthcare – two times the per capita healthcare spending of most other developed countries. However, the life expectancy, the perceived quality of care, and the healthcare inflation rate in each country are roughly equivalent to those of the United States.

In short, we're paying twice as much, but receiving little incremental value. It's a fundamental problem – and if the public and private sectors don't work together now to fix it, as a society we will be left with no choice other than to socialize healthcare under the federal government – eliminating choice, rationing care, and extinguishing innovation.

To restore balance, we need to reduce our cost base so that it's relatively consistent with that of other developed countries – and that means reducing costs by about \$1 trillion a year, nearly 50 percent.

*“First, keep it simple –
in business, complex
solutions always fail.”*

Although it won't be easy, it's not impossible. What follows are my guidelines for healthcare reform, followed by specific steps we can take to trim the \$1 trillion in waste. In addition to rebalancing our healthcare budget, we can create an investment fund for stimulating innovation and extending coverage for those who are currently uninsured.

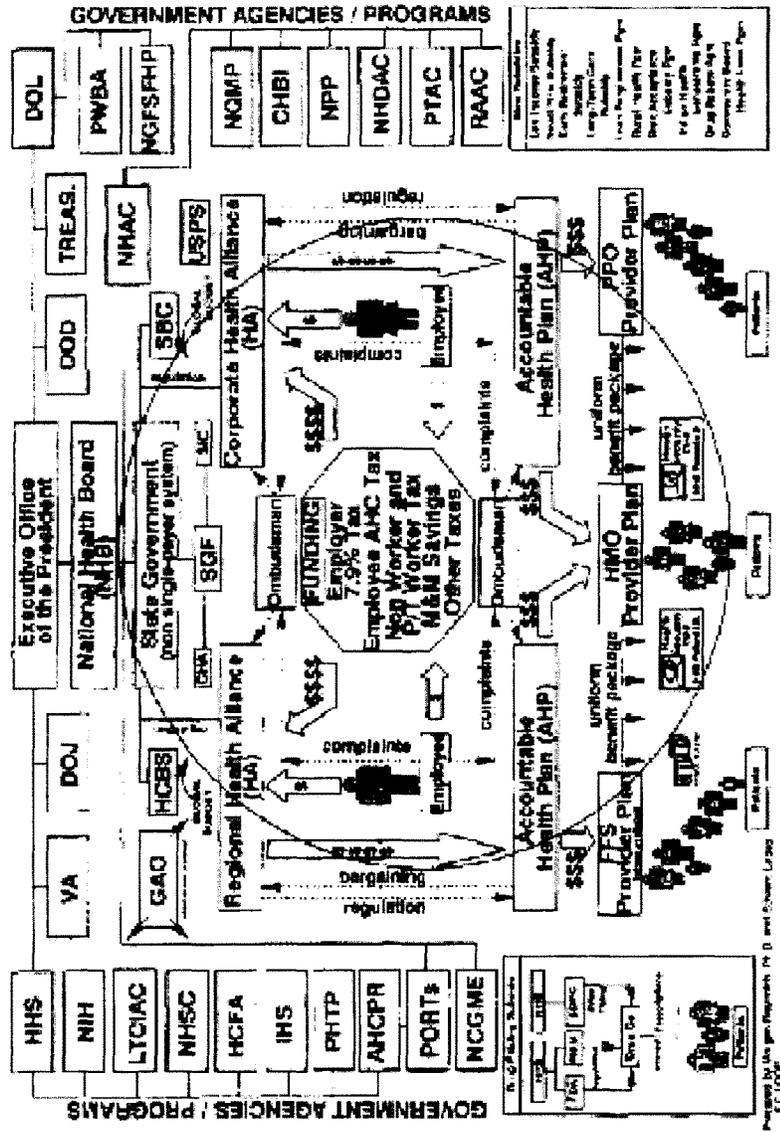
Three Rules for Reform:

- First, keep it simple – in business, complex solutions always fail.
 - Second, revolutionary reform is rejected by our society; instead, we need incremental, evolutionary change with a deliberate and phased approach.
 - Finally, and most importantly, we must define the roles of the private sector and the government. Each has an important but distinctly different responsibility and every time we cross those lines it results in failure – without exception.
- The government's function is to promulgate and regulate.
 - The private sector's function is to operate and innovate.

In the early 1990s, several examples underscored the perils of violating one or several of these guiding principles.

You may recall that a plan was unleashed in Washington that purported to revolutionize healthcare in America by creating the largest, most complex government bureaucracy ever proposed. Depicted to the right, it advocated creation of no fewer than 200 government agencies.

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*“The reality is that
our culture does not
trust private sector
entities to make these
determinations.”*

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The revolution failed and it was relegated to a footnote in the history of healthcare, serving now as little more than a poster child for well-intended but grossly misguided madness.

During that time, I was managing an HMO which, through a series of management techniques, was becoming increasingly effective at taming what had become runaway healthcare inflation. However, payors pressured HMOs to explore even more aggressive means of lowering costs and, without established public policy, the organizations became the de facto arbiter for setting new rules around healthcare protocols and standards of medicine.

The reality is that our culture does not trust private sector entities to make these determinations. Setting policy around life-and-death decisions is, and should remain, the province of the public sector, resulting from open discussion and public scrutiny.

So what happened? Despite the fact that HMOs successfully reversed healthcare inflation rates, the private sector was demonized in the press as politicians vilified HMOs for political gain. “Anti-managed care” regulations were promulgated and HMOs were rendered less effective. Costs again began to rise.

It is clear that rules of engagement should have been developed by government for the private sector to operate within. I liken these rules to guardrails on a highway.

What, then, should we do?

I have five suggestions. Each is simple and leverages the appropriate roles of the public and private sectors in a manner that, taken as a whole and aggressively pursued in a phased approach, creates an opportunity to reduce current healthcare expenditures by as much as \$1 trillion. They include:

- Wiring Healthcare
- Fixing Medicare's Financial Fundamentals
- Eliminating Medical Liability and Defensive Medicine
- Increasing Compliance and Reducing Errors
- Promoting Healthy Lifestyles

“Today, only about 20 percent of hospitals and 15 percent of physicians have access to electronic medical systems.”

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Wire Healthcare

By some independent estimates, we could save \$162 billion a year by wiring healthcare – which improves efficiency and accuracy and enables us for the first time to begin measuring everything from the quality of hospitals to the individual performance of care-givers.

Today, only about 20 percent of hospitals and 15 percent of physicians have access to electronic medical systems.

In an era when preschoolers use the Internet to chat with friends half a world away, it is inexcusable that doctors write paper prescriptions – in Latin – that patients need to take to another professional in a process fraught with countless opportunities for error.

“It’s estimated that e-prescribing would help avert more than 2 million adverse drug events each year.”

E-prescribing alone saves more than \$2 per prescription by eliminating errors – and allows prescribers to help consumers find the highest-value medicines for their course of treatment. It’s estimated that e-prescribing would help avert more than 2 million adverse drug events each year.

The technology for wiring healthcare is already in place. A Rand Corporation study estimates the return on investment is 20 times per year – in the private sector, that investment would be categorized as “a no-brainer.”

This is an area where government leadership through policy could become a catalyst for an immediate positive response by the private market. It’s happened once before.

In the 1970s, hospitals billed Medicare using a paper-based system that in its best day was inefficient and expensive. To stimulate change, the government promulgated payment rules whereby hospitals would be reimbursed only for claims that were submitted electronically. The private sector stepped in with technology solutions and, virtually overnight, electronic claims clearinghouses sprang up and all hospitals began billing electronically. Problem solved.

Fix Medicare

Medicare is considered “the third rail of politics” and suggesting revolutionary change is, politically, a nonstarter – even though the Medicare Trust Fund is expected to go bankrupt by 2019. That would become a crisis for the country and a tragedy for America’s seniors. We must confront difficult issues head-on.

When Medicare was conceived, relatively few workers reached retirement age. Today, thanks largely to modern medicine, we’re living much longer and, with the baby

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boomers retiring in large numbers and fewer workers to support each retiree, the system is buckling under the financial strain.

Although the financial fundamentals underpinning Medicare require intense review, few realize that 30 percent of Medicare spending today, roughly \$130 billion, relates to healthcare costs incurred by patients in their last year of life – often where there is no hope for recovery or improvement in quality of life.

Culturally, we are conditioned to expect and implement heroic methods, even in cases where treatment is futile, and often resulting in unintended negative and painful consequences for the patients and devastating financial consequences for Medicare.

This inherently uncomfortable issue forces us to confront our own mortality and requires strong leadership with candid conversation – it can't be left to doctors, hospitals, or insurers. Government needs to set policy and establish rational rules for the level of care based on medical science – it's not the private sector's role to pass judgment on hope.

“Government needs to set policy and establish rational rules for the level of care based on medical science – it's not the private sector's role to pass judgment on hope.”

Protocols based on scientific standards would ease the burden on families, physicians and, yes, patients. This is not withholding or rationing essential healthcare – it's stepping up to the important and necessary reality so that resources are available to those who can be helped.

Address Litigation and Defensive Medicine

Tort reform eliminates ridiculous litigation, averts the waste related to physicians performing unnecessary tests as they practice “defensive” medicine, and could reduce healthcare costs by another \$200 billion a year.

“Research shows that it currently takes 17 years from the time a medical protocol is proven effective to the time that it becomes a widely used standard of practice by physicians.”

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This is challenging given the density of law degrees within the Beltway. Wiring healthcare would enable us to establish measurable and scientifically sound protocols for practicing medicine. Physicians who follow these documented protocols should be held harmless from liability. In this day and age, medical protocols are appropriate and reliable – medicine is a science, not an art. Culturally, we must move beyond the belief that every negative health outcome must be “somebody’s fault.”

Encourage Compliance and Reduce Errors

It has been independently documented that we could save another \$177 billion related to improving compliance and reducing errors.

The fact of the matter is that doctors are well paid to offer their advice, but all too often, patients simply don’t follow the instructions. In the case of diabetes, which currently afflicts 5 percent of the population and whose treatment accounts for 15 percent of all drug spending, only 7 percent of diabetic patients are controlling the three primary factors that could mitigate the effects of their disease and allow them to live a healthy and productive life.

As a result, this noncompliance may lead to blindness, renal failure, amputations, increased hospitalization, and other complications that magnify the suffering and the expense related to diabetes.

The burden is not the patients’ alone. Research shows that it currently takes 17 years from the time a medical protocol is proven effective to the time that it becomes a widely used standard of practice by physicians.

The chart below, for instance, highlights that 35 years after the evidence was clear on the effectiveness of thrombolytic therapy to reduce heart attack and stroke, the protocol is followed by physicians only 20 percent of the time. And the case is similar for a wide range of standard procedures.

Adoption in Clinical Practice Lags Behind Evidence by Many Years		
Clinical Procedure	Landmark Trial	Current Rate of Use
Flu vaccine	1968	55.0%
Thrombolytic therapy	1971	20.0%
Pneumococcal therapy	1977	35.6%
Diabetic eye exam	1981	38.4%
Beta blockers after MI	1982	61.9%
Mammography	1982	70.4%
Cholesterol screening	1984	65.0%
Fecal occult blood test	1986	17.0%
Diabetes foot care	1993	20.0%

Source: Balas EA, Boren SA. *Managing clinical knowledge for health care improvement. Yearbook of Medical Informatics 2000, pp65-70*

“These are habitual, behavioral, and cultural issues that will require education and lifestyle modification – difficult challenges but critically important.”

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Combined with wiring healthcare, these efforts could significantly impact the 7,000 deaths in the United States each year related to medication errors and reduce adverse drug events, which are responsible for as many as 7 percent of all hospitalizations.

Wellness and Prevention

Finally, we could reduce our healthcare spending by more than \$300 billion a year if we embraced the simple concept of wellness. Simple concept. Difficult implementation.

More than 10 percent of our overall medical spending – \$275 billion – is related to the self-inflicted conditions linked to obesity and smoking, with another \$38 billion associated with drug and alcohol abuse.

To that point, a new Medco analysis reveals that residents in states with the highest rates of obesity and smoking take twice the number of prescription medicines compared to residents in states with healthier population profiles.

These are habitual, behavioral, and cultural issues that will require education and lifestyle modification – difficult challenges but critically important. One only needs to travel abroad to understand the ways in which healthy lifestyles are culturally reinforced or supported by government initiatives.

This directly affects longevity, infant mortality, and our quality of life for those years in between.

Here's where we must have inspired and credible political leadership to fill the current void and raise the collective national consciousness.

“Such initiatives are only likely to succeed if we make wellness a national imperative, something that requires political leadership and personal responsibility.”

Most of us can remember how government-led campaigns changed behavior through vivid imagery that etched into our memories messages with impact: Smokey Bear’s sad reminder that “Only you can prevent forest fires”; the crash-test dummies Vince and Larry, serving as a testimonial for seatbelt safety by suggesting that “You can learn a lot from a dummy”; the haunting image of a stoic Native American’s tear caused by roadside littering connected to a call to action, “People start pollution, and people can stop it”; and, of course — you’ll hear the sizzle in your head when I reference the line — “This is your brain on drugs.”

These campaigns built awareness and shaped the conscience of America — to the point where kids often pestered their noncompliant parents to “buckle up.” Today, buckling up is second nature.

The private sector can never be expected to drive behavioral change, although we’ve seen employers make valiant attempts at implementing programs to lower healthcare costs — efforts that unfortunately are doomed to fall short. These range from positive reinforcement — discounted health club memberships and bonuses for employees who meet certain fitness targets — to surcharges for employees who smoke.

Meantime, HMOs and other insurers have adopted low- or no-cost preventative programs for baby wellness visits, routine check-ups, mammographies, and other procedures that are designed to detect issues early instead of simply providing treatment after the fact.

Such initiatives are only likely to succeed if we make wellness a national imperative, something that requires political leadership and personal responsibility. In the end, each of us must take on greater accountability for making positive choices in our lifestyle and in becoming more educated and empowered consumers of healthcare services.

“Innovation is helping to
redefine the standards for
quality care.”

At Medco, we're doing our part:

- Leveraging the power of information to prevent errors and drive greater compliance, we're a founding member of one of country's largest organizations to process electronic prescriptions, creating the equivalent of a superhighway that shuttles information between the prescriber, payer, and pharmacy.
- Our patient advocacy programs educate and empower our members and promote healthy lifestyles. We've also developed easy-to-use online tools, supported by information from Consumer Reports Best Buy Drugs™, that allow patients for the first time to effectively shop for the highest-value medicines covered under their specific pharmacy benefit plan.
- Innovation is helping to redefine the standards for quality care. We have trained hundreds of specialist pharmacists to handle the needs of patients with complex and chronic conditions – ranging from high cholesterol and diabetes to cancer and hemophilia – so they can provide greater expertise and advanced care on pharmacy issues, similar to the way in which a specialist physician can provide insight on the medical side.
- In addition to our Therapeutic Resource Centers, Medco is collaborating with the Mayo Clinic, the FDA, and other organizations in a leadership role related to pharmacogenomics – making personalized medicine a reality by using genetic testing to ensure individuals receive the right medicines in the right doses unique to their individual genetic makeup.

“Medco is dedicated to improving the quality of care and helping America reach a goal of trimming \$1 trillion from our current national healthcare budget.”

- And we are in Washington advocating for improvements in Medicare that will ensure America’s seniors receive the care they deserve at a cost taxpayers can afford. We’re also lobbying aggressively to establish a pathway for the approval of generic biotech medicines – something that could save \$12 billion a year, to start – a modest amount by comparison, but as they say around Congress, “A billion here, a billion there, pretty soon you’re talking real money.”

Changing behavior. Driving compliance. Harnessing the power of information. Continuous innovation. Medco is dedicated to improving the quality of care and helping America reach a goal of trimming \$1 trillion from our current national healthcare budget. With the right leadership in place – in both the private and public sectors – we could improve individual patient health, reduce waste, invest in new technologies and, by bringing per-capita spending to levels consistent with the rest of the developed world, have enough left over to extend coverage to the millions of uninsured.

Whether payer, provider, or patient, in the end, we all have a vested interest, personal role, and social responsibility to improve clinical and financial outcomes. Whether tax dollars, benefit dollars or out-of-pocket co-payments, it’s all our money. And it’s our legacy.

“I have five suggestions.
 Each is simple and
 leverages the appropriate
 roles of the public and
 private sectors...”

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Five urgent imperatives	
Wiring healthcare ¹	\$162 billion
Medicare: Fix Financial Fundamentals ^{2,3}	\$130 billion
Eliminating medical liability / defensive medicine ^{4,5}	\$200 billion
Increasing compliance and reducing errors ⁶	\$177 billion
Promoting healthy lifestyles ^{7,8,9} (overweight & obesity, smoking, drugs & alcohol)	\$314 billion

↑
~ \$1 trillion

Sources: 1. RAND Corporation study, 2005; 2. CMS, Office of the Actuary; 3. Department of Health and Human Services; 4. CMS, National Health Accounts, 2005; 5. Midwest Business Group on Health, April 2003; 6. Institute for Health and Productivity Management; 7. Centers for Disease Control and Prevention (CDC); 8. Office of the National Drug Policy; 9. Association of American Physicians.

**Medco estimate of savings from products with already expired patents and approaching off-patent products*

Five suggestions to create an opportunity to reduce current healthcare expenditures by as much as \$1 trillion. They include:

- **Wiring Healthcare:** Under conservative estimates, we could save \$162 billion a year by wiring healthcare – which improves efficiency and accuracy and enables us for the first time to begin measuring everything from the quality of hospitals to the individual performance of care-givers.
- **Medicare: Fix Financial Fundamentals:** Few realize that 30 percent of Medicare spending today, roughly \$130 billion, relates to healthcare costs incurred by patients in their last year of life – often where there is no hope for recovery or improvement in quality of life. Government needs to set policy and establish rational rules for the level of care based on medical science – it’s not the private sector’s role to pass judgment on hope.
- **Eliminating Medical Liability / Defensive Medicine:** Tort reform eliminates ridiculous litigation, averts the waste related to physicians performing unnecessary tests as they practice “defensive” medicine, and could reduce healthcare costs by another \$200 billion a year.
- **Increasing Compliance and Reducing Errors:** It has been independently documented that we could save another \$177 billion related to improving compliance and reducing errors. The fact of the matter is that doctors are well paid to offer their advice, but all too often, patients simply don’t follow the instructions.
- **Promoting Healthy Lifestyles:** Finally, we could reduce our healthcare spending by more than \$300 billion a year if we embraced the simple concept of wellness. More than 10 percent of our overall medical spending – \$275 billion – is related to the self-inflicted conditions linked to obesity and smoking, with another \$38 billion associated with drug and alcohol abuse.

DAVID B. SNOW, JR.
Chairman and Chief Executive Officer
Medco Health Solutions, Inc.

David B. Snow, Jr., Medco Chairman and Chief Executive Officer, is a health care industry veteran, innovator and entrepreneur who has created and implemented solutions to manage the rising costs of healthcare for 30 years. Mr. Snow joined Medco, one of the nation's leading pharmacy benefit managers (PBMs), in March 2003 as president and CEO, and added chairman to his title in June 2003.

Prior to Medco, Mr. Snow was president and chief operating officer at Wellchoice, Inc. (formerly Empire BlueCross BlueShield). Throughout his expansive career, he has served in executive leadership roles for several companies including Oxford Health Plans, American International Healthcare, Inc. and US HealthCare, Inc. He also co-founded and served as president and CEO of Managed Healthcare Systems, Inc., which was later renamed AmeriChoice.

Mr. Snow earned a master's degree in health care administration from Duke University in 1978 and holds a bachelor's of science degree in economics from Bates College (1976).

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About Perspectives

Perspectives is a new series of presentations by Medco executives, offering insights into the most pressing matters concerning healthcare. Perspectives will address healthcare reform and other subjects confronting patients, employers, health plans, government officials, drug makers—virtually every one of us that is affected directly by the myriad of issues related to prescription healthcare. The series will provide insight into the issues of the day and stimulate discussion around what we are all confronting across the national healthcare landscape.

About Medco

Medco Health Solutions, Inc. (NYSE:MHS) is the nation's leading pharmacy benefit manager based on its 2007 total net revenues of more than \$44 billion. Medco's prescription drug benefit programs, covering approximately one-in-five Americans, are designed to drive down the cost of pharmacy health care for private and public employers, health plans, labor unions and government agencies of all sizes, for individuals served by the Medicare Part D Prescription Drug Program, and those served by Medco's specialty pharmacy segment, Accredo Health Group. *Medco, the world's most advanced pharmacy*® is positioned to serve the unique needs of patients with chronic and complex conditions through its *Medco Therapeutic Resource Centers*®, including its enhanced diabetes pharmacy care practice through the Liberty acquisition. Medco is the highest-ranked independent pharmacy benefit manager on the 2008 Fortune 100 list. On the Net: <http://www.medco.com> <<http://www.medco.com/>>

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Business Roundtable™

Doing Well through Wellness

2006–07 Survey of Wellness Programs at
Business Roundtable Member Companies

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Introduction

2006–07 Survey of Wellness Programs at Business Roundtable Member Companies

Ask any group of chief executive officers (CEOs) to name their companies' greatest asset and they will almost always say, "Our employees." As business leaders and as people, CEOs understand the importance of having a qualified, productive and engaged workforce — so it is no surprise that Business Roundtable's 2006–07 Wellness Survey reveals "healthier employees" as the number one reason cited by member companies for having a corporate wellness program.

But U.S. employers also remain the largest source of health insurance coverage for nonelderly Americans. So, as benefit costs continue to rise faster than the rate of inflation, it also makes sense that "lower cost of benefits" runs a close second in the survey as a reason to invest in employee wellness.

Less than a decade ago, these two goals might have seemed to be at cross purposes. As benefit premiums soared by double digits year after year, health plans sought to contain costs by offering options that tightly managed how, where and from whom workers could receive care. Coupled with that approach, a number of companies recognized the potential benefits of prevention as a strategy to help workers be healthier and, therefore, reduce their use of the health care system. Companies hired wellness directors, set up on-site fitness centers and thought seriously about how they could help their workers maintain their health.

Although many companies and employees embraced the wellness ideal and services, the success of managed care as a cost containment tool proved limited. After the initial savings, health plan costs began to rise again — the result of inflation and employee demand for plans that allowed wider access to providers and services.

From those lessons learned, however, a new approach is emerging — one that encourages employees to take greater responsibility not only for their well-being but also for how their health dollars are used. At the leading edge of this trend, Consumer-Driven Health Plans (CDHPs) combine high-deductible health care coverage with Health Savings Accounts (HSAs) to provide employees with the financial incentive to make thoughtful day-to-day health care decisions while shielding them from catastrophic costs.

Coupled with their CDHPs — and in some cases in advance of them — many companies are taking a new look at wellness. Once largely a standalone enhancement, wellness is becoming fully integrated within companies: with other corporate health and safety initiatives, with health benefit plan designs, and with the corporate culture. As companies are giving employees the opportunity to direct their own health care choices, they are equipping their people with the tools they need to make the most of that opportunity: education, intervention, outreach and support — along with incentives to take full advantage of these opportunities.

About this Report

Business Roundtable's membership consists of CEOs from 160 of the United States' largest companies, with a combined workforce of more than 10 million employees. As a 10-year follow-up to the 1997 report, *Quality Health Care Is Good Business: A Survey of Health Care Quality Initiatives by Members of The Business Roundtable*, the Roundtable's Health and Retirement Task Force wanted to learn how member companies are using health and wellness initiatives to support the health of their employees while addressing rising health benefit costs.

With the support of Business Roundtable member CEOs, in late fall 2006 the Roundtable sent comprehensive questionnaires regarding corporate health promotion and wellness initiatives to the appropriate wellness, medical or benefits director at each member company. Mailings were followed up with e-mails, telephone calls and, where necessary, re-mailings to ensure that the questionnaire reached the right person and was returned in a timely way. We received an unusually high rate of 76 responses, of which all but one reported having wellness programs either fully under way or in active development.

Surveys included quantitative (multiple-choice) questions, with space for additional responses or elaboration, and open-ended questions, which invited respondents to describe in detail their signature programs, communications initiatives, return on investment and, significantly, how their programs have changed over the past five years. Based on this input, we identified companies with illustrative trends or promising practices and followed up in extended telephone interviews with program spokespeople at these companies.

Because of the limited size of the population surveyed, this report does not present full numerical results or attempt detailed statistical analysis. Instead, we use the numbers for general observation purposes to suggest trends within the member population, and we freely combine the data, open-ended responses and interviews to present what we believe is an accurate and instructive picture of how Business Roundtable's member companies are advancing the state of the art in workplace wellness today.

Overview of Survey Results

Wellness at Business Roundtable Member Companies

Many Business Roundtable member companies have longstanding wellness programs: Of the 73 wellness initiatives reported, more than half have been in operation for at least five years, and 42 percent have existed for more than 10 years. A notable number of other companies have recently launched wellness initiatives: Twenty percent of the respondents' programs were created within the past one to two years, and several other companies reported that they plan to have new programs up and running this year.

Current program offerings run the gamut from standbys, such as on-site flu shots (97 percent), health fairs and on-site screenings (91 percent), on-site workout facilities (73 percent), and organized employee walks or other challenges (66 percent), to increasingly popular tools such as health risk assessments (80 percent), nurse/health advice lines (84 percent) and online resources (72 percent).

Shifts in Focus

Interestingly, the open-ended and interview responses revealed that several companies with longstanding programs, including such wellness pioneers as **Aetna Inc.**, **CIGNA Corporation**, **Corning Incorporated**, **IBM Corporation**, **Northwestern Mutual Life Insurance Company** and **Texas Instruments Incorporated**, have recently revamped or refocused their programs into integrated, branded, companywide initiatives focused on helping employees take responsibility for their health and be more effective consumers of health care. Companies with new or developing programs reported starting directly with a comprehensive consumer-based model, and in some cases, the wellness program actually was created to support the implementation of a CDHP.

In the process of such changes, lines between health plans and wellness are increasingly blurred. Many companies are reinforcing that relationship with the use of financial incentives or consequences tied directly to their health plan premiums or health-related savings accounts. Strategies such as health risk assessments (HRAs), once introduced as part of the wellness program, have become integral tools for identifying employees who need preventive or condition management programs and getting them the health system services they need.

Similarly, the focus of many programs has moved from maintaining general health and well-being to identifying, managing or reducing specific (and potentially costly) health risks. Targeted interventions, such as disease management (82 percent), tobacco cessation (74 percent) and weight management programs (85 percent), have become common. Again, financial incentives and consequences are used to engage employees at high risk, and data are used to track outcomes.

Employees are getting the message that they can be effective partners in improving their own health and well-being. For those who participate in CDHPs or any health plan that emphasizes consumerism, this speaks loud and clear to their own bottom line. "With consumerism, when employees are responsible for their initial medical care costs, they are more interested in, 'How can I take care of myself?'" observes Sharon Kiun, manager of work/life initiatives at **Accenture Ltd.**

For their part, employers expect to see that sense of shared responsibility take hold across their companies. "We trust that the culture of wellness and personal responsibility that we've nurtured over the years will continue to serve us well," says Bridget Schulz, assistant director, benefits at **Principal Financial Group**. "As long as we're providing the tools and resources, when employees are ready, they will use them."

Trends and Strategies

Based on the numbers, open-ended responses and interviews with representatives from approximately two dozen companies, a number of emerging strategies bear additional discussion.

These strategies fall into three broad categories:

1. **Create a culture of wellness within the company.** Along with integrating wellness with other corporate initiatives, companies are exploring more effective ways to communicate health care consumerism, benefits and wellness; make wellness opportunities available and accessible across the employee population; increase employee participation and ownership; and build management accountability for the health goals of the organization.
2. **Focus on the health of each employee.** Companies are developing tools and approaches to target health risks, offer customized interventions, and empower employees to manage their own health and wellness.
3. **Build the business case for wellness.** Business Roundtable's member companies are tracking costs and return on investment (ROI), working with vendors to measure ROI, and developing other measures of wellness program effectiveness.

This report presents summaries of these trends along with snapshots of some of the strategies at work at member companies.

Public Policy Implications and Actions

This report highlights an important aspect of America's health care system — the commitment of U.S. businesses to offer benefits and services that help their employees lead healthier lives and make wise use of health care services. Business Roundtable members have taken the lead in developing innovative benefits and programs that promote wellness, prevent disease and manage chronic conditions to help employees maintain the best possible quality of life while becoming effective stewards of health care resources.

At the same time, Business Roundtable recognizes that the U.S. health care system needs improvement that will require the combined determination of both the private marketplace and public payers of health care. First and foremost is the goal that all Americans have access to affordable, quality health care coverage.

In addition, federal policymakers need to address certain policy issues to accelerate change and improve health outcomes. A 21st-century health care system should be powered by technology and driven by evidence-based performance and healthy lifestyles.

Most important, we need to foster greater involvement of individual Americans in their own health care. *Business Roundtable believes that every person has two responsibilities: to make the choices that support his or her own health, including participating in wellness, prevention and any necessary chronic care programs, and to have health insurance coverage that, at a minimum, offers catastrophic benefits.*

To accomplish these goals, the Roundtable supports the following policies and initiatives:

- ▶ **Release information from the public and private sectors quantifying the critical importance of healthy lifestyles, disease prevention, care management and health promotion programs.** Individuals who engage in healthy lifestyles, participate in efforts to prevent disease and follow the recommended treatment for their chronic conditions can improve their health and reduce their long-term costs. Information on the importance of these efforts to improving health care should be widely available.
- ▶ **Support incentives for wellness initiatives.** Tax incentives should be expanded and public health programs enhanced to encourage companies to offer health and wellness programs for employees and to expand options for individuals who do not have access to these programs in the workplace.
- ▶ **Preserve and protect the laws that provide the foundation for employer-sponsored health care.** The Employee Retirement Income Security Act of 1974 (ERISA) is the foundation on which most employers offer health coverage to their employees. ERISA enables employers to create health plans that are tailored to the needs and desires of their own employees. ERISA plans are federally regulated, allowing employers to create the plan, or

plans, that best serves the needs of their current and retired employees without the impediment of complying with 50 different sets of state regulatory requirements. Without ERISA there would be significantly less health care coverage and fewer healthy workers in America's workforce.

- ▶ **Expand private plan options to permit greater choices and flexibility in the design of consumer-centric health benefits.** Although progress has been made in improving the design and use of HSAs and other CDHPs, additional legislative changes should be enacted that enhance the benefits of these plans by permitting more flexibility.
- ▶ **Promote and reward quality and efficiency through the use of health information technology.** Adopting a uniform, nationwide health information system will improve the patient experience and increase positive health outcomes while realizing significant savings in health care costs for both individuals and businesses.
- ▶ **Make accessible actionable cost and quality information about health care services.** Private and public efforts at the local, state and federal levels should be expedited to provide Americans with the information they need to make wise decisions about health care services available in their communities. Such efforts must include data from both public and private plans so that consumers can make accurate evaluations based on the best information available.

We hope that the private-sector initiatives described in this report will serve as a catalyst for change in public policy — encouraging federal, state and local policymakers; business leaders; and most important, individual employees to become effective advocates for preventing disease and promoting health in the workplace, at home and in every aspect of American life.

Strategy: Create a Corporate Culture of Wellness

“Our offices are all confronted with the same question: How can we tweak the employee value proposition and use wellness to give our employees a really great work experience?”

— James Corry, Ph.D., wellness director, MetLife, Inc.

In recent years, companies have begun to think big about wellness: how to move it from a standalone program to one that supports the overall goals of the company, even above and beyond the bottom line of health care costs. And although almost 40 percent of the companies that responded to this survey reported yearly wellness budgets of \$200,000 or more and 20 percent spend at least \$1 million annually, the big thinking is not limited to the size of the program. Wellness professionals — along with the CEOs who champion their programs — understand that changing behavior starts with changing the culture that supports it.

Of course, many of Business Roundtable’s member companies have nourished a culture of wellness for years or even decades. Recently, though, even these leaders have revamped and rebranded their programs, formed partnerships with other internal health-related corporate services, and reached out to previously underserved employee populations. Perhaps most important, some Roundtable members have devised innovative ways of keeping management and health professionals explicitly accountable for the well-being of company employees and their communities.

Following is a look at some of the approaches that member companies are successfully using to build a companywide commitment to wellness.

Integration

“We are proud to be a leader in consumer-directed health care benefits. Naturally, we want our employees to understand this and integrate it into their own way of life.”

— Mary Bianchi, director, work/life programs, CIGNA

Several Business Roundtable member companies have pulled together two or more of their health-related initiatives with the shared mission of enhancing the health of their workplace and employees. The strategy has many benefits. It clarifies functional responsibilities and reporting relationships; it expands the resources a company can bring to bear on health-related activities as well as the reach of those efforts; it promotes the sharing of data and ideas to improve quality and manage costs; and it allows the company to align its health-related programs and activities to support clear, companywide goals.

Most of the respondents with integrated programs have branded those programs as well, increasing the impact of their communications while helping employees understand how various initiatives work together to support health at the company.

Although they share some elements, programs at the following member companies illustrate some of the many forms that integration can assume:

- ▶ **CIGNA's** Healthy Life model is based on using health care consumerism to drive behavior change and address health care costs by providing an integrated range of programs and services to all employees. Launched in fall/winter 2006, the program combines health care consumerism resources with health and fitness tools, including HRAs and biometric screenings. "We have created an ongoing dialogue of health at our company. We really want employees to use the information we give them, put it into practice and act on the successes we've seen in our own organization," says Mary Bianchi, director, work/life programs.
- ▶ **MetLife** created a total health and productivity model by bringing all of its health vendors together to create a comprehensive, coordinated care system across the health spectrum. MetLife worked with its health plans, condition management, employee assistance program (EAP) and other vendors to facilitate referrals among the vendors, including those who normally compete with each other. Wellness Director James Corry, Ph.D., created a system to track intervendor referrals and used quarterly conference calls with vendors to keep the effort focused. "It was a little hard for some of them at first — especially if they needed to refer to a competitor," says Corry. "But at the end of the day, they are all trying, and we are pleased with their effort."
- ▶ **The Dow Chemical Company** has launched a comprehensive corporate health strategy, which addresses primary prevention and health promotion, quality and effectiveness of health care, health system management, and health-related legislation at the national and state levels, says Catherine Baase, M.D., global director, health services. The company's integrated approach combines the health and outreach elements of the company, including occupational health, health promotion, human resources benefits and organizational effectiveness, safety, industrial hygiene, corporate communications, government affairs, and risk management, with a stated and measurable corporate commitment to improving the health of Dow's employees, their corporate environment and their communities.
- ▶ **Union Pacific Corporation** identifies links between health conditions and safety risks through a series of innovative periodic reports that integrate incident, lost work time and other safety data with wellness assessment data. "We saw that certain health conditions and behaviors, such as tobacco use, correlated with safety, which helped us target interventions at specific worksites," reports Marcy Zauha, director of health and safety.

- ▶ **Schering-Plough Corporation** is integrating its existing wellness programs under the Healthy Steps brand and adding HRAs, a multicondition disease management vendor and other programs in a comprehensive initiative to support employee health. “As a health care company, we wanted to have a program that says we are serious and committed to the health of our employees and their families,” says Teri Pazos, senior benefits manager. “This is really a very strong concern of our CEO.”
- ▶ **Humana Inc.** initiated MOCHA (More Options and Choices for Humana Associates) in 2000 to develop and evaluate consumer-choice health plans and related products. “As associates became more informed health care consumers, we expanded our wellness programs to reinforce the connection between lifestyle behaviors and health,” reports Elona DeGooyer, consultant, human resources. Toward that end, Humana developed internal programs and external partnerships to reach its goals to encompass multiple dimensions of wellness, encourage participation and goal attainment with incentives, and pilot innovative programs the company can introduce into the marketplace. “We use a multilayered approach to wellness program design to provide a variety of services and resources that address the broad definition of wellness,” DeGooyer writes. “We incorporate traditional benefit programs and components from our consumer-choice medical plans and use site-specific opportunities to create a unique and comprehensive program.”
- ▶ **Texas Instruments** (Live Healthy), **Corning** (Total Health), **IBM** (Healthy Living Rebates) and **Verizon Communications** (HealthZone) are among the other Business Roundtable member companies that have brought some or all of their health-related initiatives together under one brand.

Corning: Total Health Continuum

Corning was one of the early major companies to integrate services on an organizational level. In 1999, the company pulled together counseling and support services/EAP, workers' compensation, health and safety, corporate medical services, and employee benefits under one department with common objectives and goals.

Together, the units devised a health care continuum under the Total Health brand based on level of risk, ranging from health promotion and risk reduction on the low end, through acute conditions and chronic conditions at the mid range, to disabling conditions and catastrophic conditions on the high end.

"We populated the continuum with our existing programs, then we added any programs we needed to fill the gaps," recalls Deborah Lauper, director of compensation, integrated health and employee benefits. "Our 10,000 Steps walking program went into the health promotion box at the low-risk end, and our complex care management, cancer resources services and transplant services were at the other extreme." The result is a progression of interventions that clearly defines the connections among interventions and their impact on the employee population and on the bottom line.

Corning's team also used a data warehouse to integrate medical, dental, pharmaceutical, disability and other data from all sources, then used the information to fine-tune programs and management. "For example, we asked what we could learn from how we treat occupational health cases that would help us manage nonoccupational cases more effectively. And we saw that we had 19 different EAP programs around the country, so we decided to integrate them into a single carveout that would help us manage costs and make sure people get the most appropriate care."

In 2006, Corning took the program a giant step further with the deployment of 24/7 wellness teams at three pilot sites. At each location, existing safety teams expanded to include a nurse, representatives from human resources, plant leadership and other employees who have an interest in health. Local teams received a user-friendly data dashboard that helps them target their local health and wellness needs and measure their performance. "It's taking the integrated health approach to the grassroots level," explains Lauper.

Communications

"Once you start communicating, you can't stop."

—Tom Coogan, director of employee benefits, Case New Holland Inc.

As health plans and wellness programs become integrated, complex and proactive, companies are assigning communications a more strategic role. In many programs, including Texas Instruments' Live Healthy initiative and Corning's Total Health, communications has an identified seat at the table. "Our corporate communications department is key to what we do," declares Linda Moon, manager of wellness and health management at Texas Instruments. "We try to involve them from the front end, to help us start thinking through how things will be perceived, what we want to be careful about, what we want to emphasize. It's their specialty — why not utilize it?"

COMMUNICATING ABOUT CONSUMER-DRIVEN HEALTH PLANS

"This is the first wave of getting associates to understand health care and be more accountable for how they use the consumer-driven health plan program. To do that, we really felt we needed to educate our associates around wellness and help them understand more about their own health and well-being. Everything the team looked at directed us to a decision to redesign our communications initiative around wellness."

—Frank LaPlaca, director, benefits, Office Depot, Inc.

Several Business Roundtable member companies have developed communications strategies based on health care consumerism to support the rollout of their CDHPs.

- ▶ **Northwestern Mutual** credits the company's high CDHP participation levels at least in part to its incentive-based communications strategy. When the company introduced its consumer-driven plan three years ago, "We decided that brown bag presentations and infrequent screenings were not enough, so we revamped our program to include four- to 12-week campaigns and focused on nutrition and exercise," reports Jessie Schwade, health services consultant. Among the popular activities: a consumerism scavenger hunt, which had employees scurrying to look up information on existing company programs, such as the fitness center, a self-care guide and a health clinic.
- ▶ **American Electric Power Company, Inc.**, also credits communications for the favorable employee response when the company introduced a CDHP option in 2006. "We believe the rollout was a success as the result of an extensive communications campaign that included more than 400 face-to-face meetings," writes Karen Jenkins, senior human resources associate.
- ▶ **Office Depot** has launched a three-year communications strategy, including a Web site, 12-month health calendar, self-care manual, and other integrated programs and tools, to support the company's changing benefit platform, including a new CDHP/HSA. "As in any

organization, associates are looking at this pretty much as buying insurance, a benefit that they are 'entitled' to. We are trying to change that outlook to one of awareness and understanding of how to use this product," says Frank LaPlaca, director of benefits.

Several more Business Roundtable member companies also have integrated their communications tools and programs with their CDHPs. Others, including **ArvinMeritor, Inc.**, currently are designing consumer-based communications strategies to support planned CDHP rollouts.

Case New Holland: Communicating CDHPs

Communications are critical when rolling out a CDHP, says Tom Coogan, director of employee benefits, Case New Holland. "This is one of the most important decisions our employees have to make. We wanted to give them the tools to help them do this."

Case New Holland worked with outside consultants to build a set of four CDHP options that address the specialized needs of the company's workforce and lay the groundwork for an integrated wellness program. Focus groups at the start of the planning process in 2005 served both planning and communications goals, says Coogan. "They sent employees the message that they would have to be involved in making the right purchasing decisions and in changing their lifestyles to keep from paying more in the future."

Communications strategies also included a series of newsletters explaining various aspects of the plan, followed by test groups to make sure employees were understanding the communications.

Prior to the first open enrollment period in 2006, Coogan and his team held meetings at multiple times at each plant location — mandatory for employees, with spouses welcome — to explain features of each plan. Employees also could access an online decision tool customized for Case New Holland's CDHP designs that let them calculate which of the four options was the best cost value given their needs.

Coogan continues to use the quarterly newsletter to provide additional information about the health plans. These, along with frequent communications from the disease management and other wellness programs also initiated in 2006, are starting to bring about the culture change Coogan sees as essential.

"There's really nothing unique about what we're doing," he observes. "Employers need to plan thoroughly, do a good job with communications, be serious about disease management and choose the right vendors. The concept is really quite simple. You just have to do it."

COMMUNICATING ABOUT A HEALTH-FOCUSED CULTURE

Business Roundtable member companies also use communications strategies to increase participation and engagement in health and wellness initiatives. Following are a few of their noteworthy ideas.

- ▶ **Humana** uses its benefits enrollment period to reinforce the wellness strategy that is communicated throughout the year to associates, reports Deborah Triplett, director of associate benefit programs, human resources. “Just prior to benefits enrollment, we train approximately 200 associates (all levels) to serve as MOCHA Mentors — helping peers locate resources and resolve issues and be program champions,” she writes. “For the past two years, we have provided wellness program information to this group in addition to the human resources consultants and benefits specialists. This year we also produced a special consumerism wellness message from [healthful living advocate] Dr. Michael Roizen at our MOCHA to Market meetings and developed a podcast to explain key aspects of the wellness program.”

Humana’s associates also can participate in pilots of new wellness products developed by the company before those products are offered to consumers.

- ▶ **Texas Instruments** brands every item having to do with health with its Live Healthy logo. Bottled water available at the company also sports the Live Healthy logo plus rotating wellness program messaging.
- ▶ **Eastman Chemical Company** uses a number of creative tactics to deliver health messages to employees, including Bathroom Briefs — flyers posted on the insides of restroom stalls. New flyers are posted every two weeks.
- ▶ **CSX Corporation** is using strategic communications to lay a strong foundation for its new integrated wellness program. “Direct, person-to-person communication is vital,” reports Ken Glover, director, health and ergonomics. “Division wellness coordinators meet with management and union employees on a regular basis.”
- ▶ **General Motors Corporation’s** Life Steps Wellness Program uses lifestyle-based approaches to communicate awareness and educate its diverse employee populations, writes David Siegel, M.D., M.P.H., assistant director, health care operations and programs. Each program topic provides information, skill building and group support and tracks individual employees’ health behaviors and outcomes.

For example, a deer hunting module featured an expert hunter who shared information on deer density trends and information about the Bovine TB virus while health educators shared nutritious venison recipes, walking program how-tos, proper lifting techniques to load the deer onto a truck, and warning signs of a heart attack. Golf conditioning focused on core stretches and exercises to generate power and performance, along with healthful food choices for a golf outing and relaxation techniques to improve performance.

Texas Instruments: Reaching Out to Families

Texas Instruments has a longstanding culture of including employees' families in the company's health and wellness activities. "Families always have been welcome at our Texins Activity Centers," notes Linda Moon, manager of wellness and health management. "Spouses have full access to our aerobics, nutrition and other programs, and our spring break and summer camps for kids reinforce healthy activities and foods."

Moon and her team also have been careful to communicate with spouses about the company's health benefits. "We know that women make most of a family's health care decisions — and our employee population is 70 percent male. That means we need to reach out to the spouses as well as our employees."

In a focus group for spouses, the company probed for information on how spouses receive health benefit information and if they knew where to go to get what they needed. "We learned a lot of things we never would have known if we had not taken the opportunity to seek information from the spouse," she observes.

For example, "We learned that spouses sometimes don't get information we distribute at the worksite because the workers forget to bring it home. And mailing it to employees at home doesn't solve the problem because spouses don't open each other's mail." As a result, mailings now have an inclusive address, such as "family of." Envelopes are clearly identified as benefit information so they will not be tossed as junk mail.

Spouses also reported that they could not access benefits information on the company's Web site from their homes because the site was protected by a firewall — a problem solved by moving the information to an accessible location.

Employee benefits communications regularly feature photos and stories of families — including success stories from employees reporting how their spouses support their wellness. "They're all part of who we are and what we do," says Moon.

Targeted Strategies to Promote Employee Buy-In and Participation

"We have very high participation levels, probably due to our communications strategy and incentives. We also felt it was important to keep our programs simple and accessible to all levels of participants (not just reward the daily joggers)."

— Jessie Schwade, health services consultant, Northwestern Mutual

Employee participation in health and wellness programs is an essential component of a company's culture of wellness and contributes to the success of its health programs and interventions. Business Roundtable member companies have devised numerous strategies to reach out to their employee populations, provide them with appropriate wellness opportunities, encourage their participation and, in the process, allow them to embed their own philosophies of wellness within the corporate culture.

INCENTIVES

Incentives have been recognized for some years as an effective strategy to increase participation in health and wellness assessments and activities. Of the survey respondents, 69 percent indicated that they use some kind of program incentives, such as money rewards; logo athleticwear, pedometers or other gear; public recognition; or other positive feedback measures. Benefit designs, including CDHPs that tie financial consequences to health care choices, behaviors or outcomes, are another typical form of positive — or in some cases, negative — incentives.

Several Business Roundtable member companies have taken the lead in exploring new incentives, applying incentives in new ways, or effectively integrating their incentive programs with the company's mission or philosophy. Following are some examples.

- ▶ **Northwestern Mutual** gave employees an incentive to get to know their new self-care manuals by randomly hiding \$50 gift certificates in some books before distributing them to employees.
- ▶ **IBM** built on its successful smoking cessation rebate with its Healthy Living Rebate program. Today, the program also includes a Physical Activity Rebate to reward participation in a personalized program through the company's Virtual Fitness Center, and a Preventive Care Rebate to reward employees who take steps to identify their preventive care needs and personal health risks through completion of online personal health records and other activities.
- ▶ **Humana's** HealthMiles program from Virgin Life Care makes it simple for associates to earn gift cards for being active, tracking results and reaching goals. Steps recorded on a pedometer are automatically downloaded via USB port, and biometric data are captured at a health kiosk. Ease of use has resulted in increased participation, higher activity levels and body mass index (BMI) reduction, reports Elona DeGooyer, consultant, human resources. In addition, Humana's MOCHA Wellness Account rewards participation in a range of non-fitness programs, including clinical and lifestyle change programs, ergonomics, wellness Webcasts and healthy behavior campaigns. "Wellness awareness and participation have increased significantly since the introduction of the program a year ago," writes DeGooyer.
- ▶ **Aetna's** Healthy Lifestyles incentive program encourages employees to access preventive care, complete their HRAs, join Weight Watchers, participate in and keep track of physical fitness activities, and participate in appropriate disease management programs.

- ▶ **Caterpillar Inc.** uses a differentiated pricing strategy to encourage employees to make healthy food choices in company cafeterias. Lunch for Less offerings tempt employees with nutritious, lower-cost favorites, such as a chicken breast sandwich for \$1.99 or a four-vegetable selection for less than a dollar. "Employees can still get a double cheeseburger, but they'll pay more," says Michael L. Taylor, M.D., Caterpillar's medical director for health promotion.
- ▶ **Owens Corning Inc.** added a tobacco-free discount program in 2005. Employees qualify for a \$40-per-month discount on their health plan premiums if they pledge to be tobacco-free for the entire year or, if they use tobacco, attempt to quit and become part of a smoking cessation program.

FedEx Express: A Small Incentive Program with a Big Return

Retinopathy is a common complication of diabetes. Untreated, it can lead to blindness, but it can be successfully treated if it is detected early with a simple eye exam. So when data revealed that only about half of the people with diabetes in the company's employee population received retinopathy screenings, "we knew we had to find a way to get more people to take the exam," reports Beth Casteel, managing director of employee benefits, health and communications for FedEx Express, the largest operating company of FedEx Corporation.

In considering options for incentives, "our number one priority was to keep it simple," she adds. "If it is too complicated, people will toss it away."

Cash was the simplest possible incentive, the team decided. The team also elected to designate the cash as a partial return of the copayment for the tests, which makes it nontaxable to the employee.

To receive the payment, an employee simply needs to participate in the diabetes disease management program and take two important exams: a blood sugar test that indicates the presence of diabetes and the dilated eye exam. There are no additional forms to fill out — although the tests are performed by two different providers and covered separately by FedEx Express' medical and vision plans, the company's data warehouse integrates the claims data from both vendors.

"People automatically receive a letter signed by me, along with a check for \$50," says Casteel.

Thanks to the incentive, of the employees in the diabetes disease management program in both 2005 and 2006, participation in retinal eye exams jumped from 55 percent in 2005 to 100 percent the following year. Emergency room visits related to diabetes dropped 13 percent, inpatient admissions dropped 7 percent and the cost of a diabetic episode dropped 75 percent.

"It's a small program; that's the key," concludes Casteel. "It's something every employee understands."

Although wellness and health promotion initiatives are voluntary at most companies, some benefit designs call for mandatory participation. For example, the Preferred Provider Option at **Office Depot** requires an HRA for all enrollees.

Western & Southern Financial Group is using premium surcharges and wellness programs to encourage associates to change unhealthy lifestyles. Its self-funded health plan includes a health premium surcharge for associates who have used tobacco during the preceding 12 months and a tiered scale of surcharges for associates whose BMI exceeds 27. The company's plan offers allowances for smoking cessation programs and medical treatments for obesity, and it provides an on-site weight management program that includes counseling, healthy nutrition and exercise. Associates who lower their BMI or discontinue tobacco use are eligible for rebates of the surcharges.

Currently one-third of Western & Southern employees are paying the tobacco surcharge, and about 40 percent pay a weight surcharge.

AVAILABILITY AND ACCESSIBILITY

"Our observations and survey data tell us that many employees felt too busy to set aside time to attend to their health needs — particularly for wellness services that are often seen as elective. So we've been making conscious efforts to bring these services to our employees."

—**Jeanette Fuente, vice president, wellness, Merrill Lynch & Company, Inc.**

Business Roundtable member companies make the logical connection between how many employees participate in wellness activities and how easy it is for employees to use the services.

Of the companies that responded to the 2006–07 Wellness Survey, 73 percent have an on-site fitness center in at least one location, 57 percent have an on-site employee health clinic, 97 percent offer on-site flu shots, 81 percent offer brown bag lunches or other on-site education, and 91 percent offer a health fair or on-site screenings. Almost half of Business Roundtable members that responded to the survey offer wellness activities at every worksite.

Companies that do not have wellness facilities at every site use a variety of strategies to reach distant employees, including subsidizing the cost of membership in a local health facility (27 percent) or paying all or part of the cost of local weight management, smoking cessation or other wellness programs (36 percent).

Member companies also take care to reach their covered populations, including families of employees and retirees. Of the survey respondents, 39 percent say they extend wellness services to employees' families, 68 percent to part-time employees and 41 percent to retirees.

For many Business Roundtable member companies, on-site health and wellness services are deeply embedded in the corporate culture. For example, **Texas Instruments** opened its first

Texins fitness center in the 1960s and now runs state-of-the-art centers, open to employees and their families, in three of the company's major locations. "The centers stemmed from our employees wanting a convenient outlet to live a healthy lifestyle," reports Linda Moon, the company's manager of wellness and health management. "Many of our company's leaders are members of the fitness centers, working out there and setting that example."

Corporate leaders also regularly work out at **Principal Financial Group's** seven advanced fitness centers, two at corporate headquarters in Des Moines and five at other company sites. Principal's centers are the focus of the companywide fitness program, which includes screening, coaching, goal setting and other activities. "We started 20 years ago with one person to run the first fitness center — now we have nine people whose sole responsibility is wellness," reports Bridget Schulz, assistant director, benefits.

On-site fitness also is an integral part of the corporate culture at **The Boeing Company**, where fitness centers at 34 locations receive more than 1 million employee visits annually.

Schering-Plough provides on-site medical facilities at its major sites. In addition to performing evaluations for return to work and other occupational services, the standalone facilities provide urgent care to employees along with a comprehensive menu of physical examinations and screenings. "Services are free and convenient for employees," says Teri Pazos, senior benefits manager. An on-site pharmacy at the company's Kenilworth, NJ, facility, operated by the company's health plan vendor, fills prescriptions for employees. Schering-Plough prescription products are available through the medical plan with no copayment.

Business Roundtable member companies report using various approaches to offering wellness activities at their plants, including full professional staffs; partnerships with local vendors; volunteer wellness committees; and offering discount memberships in local gyms, smoking cessation programs or weight management groups.

Integrated health and wellness programs at many companies include unified organizational structures for setting goals, managing programs and working together throughout the corporation. Other companies with health or wellness programs at diverse sites have various strategies for maintaining communications and bringing their efforts together. Following are some examples.

- **DuPont's** Global Health Team, consisting of the company's regional medical directors and competency leaders in areas such as EAP, prevention and wellness, and occupational medicine, meets regularly to set policies, share ideas and develop tools.
- **FedEx Corporation** has a Health Task Force with directors responsible for health programs or benefits from the corporation's separate operating units, such as FedEx Express, FedEx Ground and FedEx Kinkos. "Our goal is to develop an overarching health care strategy without changing the benefit structures of the individual companies," reports Beth Casteel, managing director of employee benefits, health and communications at FedEx Express.

“Companies also learn from each other and adopt practices from others that make sense for their own populations.”

- ▶ **Navistar International Corporation** is among the Business Roundtable member companies that bring their local volunteer wellness leaders together for an annual Wellness Summit. “At this event our executives share their passion for wellness and discuss how it makes good business sense,” reports Dawn Weddle, wellness manager. “It keeps everyone energized and focused.”

Merrill Lynch: Bringing Wellness to the Employee

Merrill Lynch provides on-site clinics that offer a broad menu of services at its seven home office locations, including company headquarters at the World Financial Center in New York. Services vary by location but include preventive screenings, fitness facilities, flu shots and other medically indicated immunizations, nutrition and smoking cessation counseling, and primary and specialized medical care, including a healthy back clinic, sports medicine, travel medicine and dentistry.

To make the on-site services as easy to use as possible, employees can use the company's electronic scheduling service to arrange most appointments from their desks.

Branch offices are offered a free smoking cessation program and discount memberships at local fitness centers. In addition, the company offers on-demand assistance from its corporate wellness office to set up wellness programs at other sites. “People at our smaller locations will learn of something we offer at a home office and say, ‘We’d like to have this, too,’” says Jeanette Fuente, vice president, wellness. “They’ll get the branch manager to sign off on it, and I’ll work with them to make it happen.”

Fuente maintains templates of most of the company's existing wellness programs that she can share with the branch offices. “I don’t exactly have a turnkey kit, but I can draw on memos and planning communications and help them customize programs by location to make it their own without reinventing the wheel.” Fuente also works with national vendors and partners, such as the American Heart Association, that have local offices that can work with the Merrill Lynch sites to set up screenings, health fairs or educational services.

Other services, such as nutrition counseling, and some health seminars are available to off-site offices by phone or Webex. “I’m trying to do some things that reach everyone if they are available and interested and if it is cost neutral,” she says.

Although computer-based tools, such as e-mail counseling, have their place in her program, Fuente believes that a personal connection — even if only by phone — is essential.

“Technology is a wonderful thing, but the motivational factor is missing — the human touch is what really gets results for some people.”

TECHNOLOGY

Business Roundtable member companies with multiple sites increasingly look to technology to bring wellness to their distant employees.

“Because our population is so diverse geographically, most programs are available virtually (via either Web or phone) or at facilities in close proximity to McGraw-Hill locations,” writes Danielle Shanes, director of benefits planning and design at **The McGraw-Hill Companies**. “For example, we offer discount gym memberships to more than 1,500 fitness clubs nationwide but sponsor very few health facilities. When we conduct educational sessions, the venue is Web and telephone based so that the maximum number of employees can participate.”

Dow’s local health professionals and “health contacts” serve as a network of liaisons and primary health promoters to each work location, says Catherine Baase, M.D., global director, health services. In addition, the company uses a variety of technologies to communicate with its dispersed workforce, including video commercials on internal TVs or computers, CDs for use by salespeople while driving, an interactive feedback tool on the company’s global Web site, and informal highlights by leaders on company broadcasts.

Sun Microsystems and **IBM** are two Business Roundtable member companies that use customized virtual fitness centers to motivate and track employees’ progress toward fitness goals. In addition, several companies use Webinars to deliver wellness programming to their far-flung workforces.

Accenture: Delivering Wellness to a Virtual Workforce

Several Business Roundtable member companies have numerous small sites, but most of Accenture's employees have limited company worksites. "Many employees are consultants, often on the road, who work directly with clients, and others work out of their homes," says Sharon Klun, manager of work/life initiatives. "When they join the company, most Accenture employees receive laptops (which provide a great degree of flexibility), and they become part of a virtual workforce — even if they are in an Accenture office."

Two years ago, when an employee poll indicated wellness as the top priority, the human resources team thought hard about how to deliver the programs to a workforce that was, in large part, virtual.

To get the program moving quickly, the team created a Work-Life Web portal that brought together existing online resources that responded to the needs of Accenture's employee population. "We wanted to be sensitive to the needs of different levels of ability and activity, so we looked for programs that offered lots of choices — tennis, gardening and canoeing, as well as running and walking," says Klun. This program evolved over the next two years into the current online wellness program, which includes an HRA and other tools as the framework for the wellness and health management program.

To give employees shared goals in a virtual world, the company offered its employees the President's Challenge, an online physical activity program sponsored by the President's Council on Physical Fitness and Sports. Over time, the company identified other programs with online models that met the identified needs of employees, and it offered gift certificates, pedometers and water bottles as incentives that employees could use to manage their health while on the go.

"We also identified new and better ways to deliver programs and information that our employees wanted and needed," says Klun. Among their creative ideas:

- Conference calls on seasonal topics, such as holiday weight management in January
- Wellness education that employees can download to their MP3 players
- Water bottles with a watertight niche to hold an MP3 player while working out
- "Did you know . . ." messages recorded on the company's phone system so employees hear information about benefits and wellness instead of "hold" music

In 2007, the company also added components of consumerism to its health care benefits options and is including information to support better health care decisions in its communications efforts.

"Our high-performance workforce constantly challenges us to stay visionary, especially in the areas of wellness and other areas of work and life," says Klun. "We really want to meet and exceed their expectations."

REACHING DIVERSE POPULATIONS

Throughout the United States and around the world, Business Roundtable member companies have adopted other strategies to make wellness programs available and accessible to their varied employee populations. For example:

Shift Workers: At **General Motors**, the UAW-GM LifeSteps program has developed organizational, educational and psychological strategies and best practices to deliver a wellness program in a manufacturing environment, according to David Siegel, M.D., M.P.H., assistant director of health care operations and programs. Among the strategies: identifying ideal times for health screenings in a multishift population, strict confidentiality of records, company union and community support, programs tailored to different shift audiences, employee participation as program leaders, and a final reminder that “the program must be *fun*.”

Global Workforce: “**MetLife** is using its domestic seasonal flu campaign as a vehicle to gain competency in the global arena and as a pilot for a corporatewide intervention should there be a pandemic,” writes James Corry, Ph.D., wellness director. “Many employees of MetLife’s newly acquired Travelers Life and Annuity unit are located in parts of the world where we have concerns about avian flu,” he adds. “We’re doing a good job of flu education in the United States, so we want to apply that model to meet the needs of our employees and our clients in other parts of the world.”

Similarly, **DuPont**’s Global Health Team has developed standardized protocols for 19 different occupational health processes for its plants throughout the world, covering such issues as determining fitness for duty, modified work programming and health surveillance for hazardous agents, says Sol Sax, M.D., chief medical director. Protocols include clear process maps, methods and procedures, and they take into account cultural differences and sensitivities, says Sax. Implementation plans currently are being created by a global team of subject matter experts, he reports.

Dow translates its annual global physical activity program into 10 languages for implementation in more than 30 countries, says Catherine Baase, M.D., global director, health services.

Aging Population: “As an insurance company, **MetLife** looks ahead to anticipate demographic trends and emerging risk areas. One obvious demographic challenge we see is an aging workforce that is getting ready to retire, and this is certainly true in our company,” notes James Corry, Ph.D. The company has adopted multiple strategies to keep its older workers healthy and engaged until the age of normal retirement and even longer. It also has invested millions of dollars in research on aging issues, particularly Alzheimer’s disease, through the company’s foundation.

At **SAS Institute Inc.**, “our programs have changed in many ways over the past five years as the age of our employee population continues to rise,” observes Jack Poll, director, recreation

and employee services. SAS has modified many of its fitness programs to accommodate the needs of aging workers and their families, including adding water-based activities to sports and fitness offerings.

Case New Holland's CDHP benefits include an option specifically designed for people close to retirement, according to Tom Coogan, director of employee benefits. The plan directs unused employer-funded dollars into workers' HRAs.

Corporate Change: **Duke Energy, DuPont, MetLife** and **FedEx Corporation** are among the Business Roundtable member companies that are making efforts to integrate their health and wellness cultures with those of recently acquired companies.

Corporate Leadership and Accountability

"Advancing the health of our employees is one of the most important things we need to do for our people as well as for the good of our organization. So it is reasonable that our bonuses should be tied to our success in making that happen."

—Catherine Baase, M.D., global director, health services, Dow

Business Roundtable member companies have long understood that their leaders play a critical role in establishing a culture of wellness, and many maintain strategies to engage top management on an ongoing basis. For example:

- ▶ **Navistar's** Executive Wellness Council regularly brings together the company's 10 top corporate leaders, including the CEO, the chief financial officer, presidents of its four business units and executive vice presidents, to set the strategy and provide visionary leadership for its program. Council members are quoted in the employee wellness newsletter, present fitness awards at company ceremonies and challenge employees to beat their performance in company-sponsored fitness challenges. "We are fortunate to have executives who truly believe in the business case for health and wellness, and we want our employees to know that," says Dawn Weddle, wellness manager.
- ▶ **Principal Financial Group's** chairman and CEO, Barry Griswell, set a companywide example of healthy choices when he made a public commitment to lose pounds. "We made a big event of it," recalls Bridget Schulz, assistant director, benefits. "Wellness isn't a hard sell at Principal — it's a top-down belief."
- ▶ Employee support for the disease management program at **Xerox Corporation** got a strong boost when Roger LaDue, the president of UNITE HERE! Local 14A, spoke publicly about how the program had improved his life. "The union sent a personal letter to every union member and Roger did a Webinar telling how the program had helped him and his wife lose weight and lead healthier lives," recalls Lawrence Becker, director of benefits and human resources policy at Xerox. "His message was extremely effective because it came from the heart — from the person our employees had chosen to be president of their union."

Top executives at many Business Roundtable member companies also are visible on national and local platforms on behalf of public policies that support employee health and wellness, including serving on the Roundtable's own Health and Retirement Task Force.

Several Business Roundtable member companies have adopted strategies for reinforcing accountability for health improvement initiatives, as well as tools to measure the results of those efforts. For example:

- ▶ **Corning** combines and distills data from its integrated programs into companywide and plant-level dashboards that show performance at a glance on measures such as HRA participation, aggregate risk levels, use of preventive services and productivity data. Plant-level 24/7 Wellness Teams will use the dashboards to evaluate local programs and see how their plants measure up to companywide performance.
- ▶ **Union Pacific's** Health Index measures the progress of local management in achieving action plans drawn up by its work units to achieve health improvement goals, reports Marcy Zauha, director, health and safety. The Health Index includes mandatory measures — such as rate of participation in the company's HRA, behavior modification programs and educational programs — as well as extra-credit measures, such as community outreach. Local units earn points cumulatively throughout the year, with interim results tabbed on scorecards that are discussed in monthly safety calls with the company's regional vice presidents.

Dow: Taking Responsibility for Performance

As part of its integrated health strategy, Dow has adopted innovative approaches and tools for holding the corporation, its leaders and its health professionals accountable for health improvement performance. For example:

- **Tying bonuses of health professionals to employee health improvement.** In 2005, Dow's team of health professionals elected to base 20 to 40 percent of the personal portion of their annual variable pay on achievement of a set of companywide and regional goals within their own employee populations, such as frequency of physical activity and reductions of risk factors, including obesity and tobacco use. Using Dow's health assessment program as the keystone, the company's 130 to 170 health professionals worldwide also work with the company's local health plan vendors to provide education, run promotions and market their available programs to their employee populations.
- **Healthy Environment Index.** In 2007, Dow's health team introduced the Healthy Environment Index, which helps company facilities measure their progress on companywide and local human and environmental health metrics, such as the tobacco use policy, access to physical activities and availability of healthy food in the cafeteria.
- **Health Message Map.** Developed as a tool to help local company leaders understand and explain the importance of health measures, the message set illustrates the company's intersect with human health and provides details — for example, ways the company supports health in nearby communities and how the company's products support public health, plus awards and recognitions the company receives for its initiatives.
- **Leadership training.** Dow incorporates several hours of health awareness training within its formal leadership curriculum, along with business case analyses on why supporting health is important to the company.

Dow also is participating in pilot research programs at 12 U.S. sites, focusing on the ways to improve the organizational environment, including supporting employee health and the effectiveness of leadership training in promoting the success of corporate health goals.

"People are our core asset. We have a stated commitment to advance the health of our employees and our communities as well as the public through our products," says Catherine Baase, M.D.

Using the Company's Unique Resources to Advance Health Goals

Many Business Roundtable member companies tap into their products, promotional capabilities and other resources to educate and motivate their employees toward more healthful lifestyles. Following are a few of their popular initiatives.

McGraw-Hill offers a robust calendar of employee Lunch and Learns — 90-minute sessions that many times feature the company's authors, who speak and answer questions on topics related to health and other work-life matters, reports Danielle Shanes, director, benefits planning and design. Recent sessions include Dr. Edward Abramson's *Body Intelligence*, Perry Christenson's *Family 360* and Robert Brooks' *Raising Resilient Children*. Employees participate via Web conference, with the audio delivered over the phone and the presentation on their computers. Sessions also are recorded and accessible to employees for six to 12 months on the company intranet. Employees who participate in the sessions given by company authors receive free books.

"As a diverse health care company, **Abbott Laboratories** has many products and resources that support healthy living activities," writes Roberta Finkler, manager, wellness. Among these are diabetic supplies and nutritional products that support disease management programs. Abbott now covers these company-made supplies at 100 percent, as well as other Abbott drugs, says Finkler.

Office Depot's employee health initiatives get great promotional mileage from the company's national sponsorship of NASCAR driver Carl Edwards and his racing team, reports Daisy Vanderlinde, executive vice president of human resources. Edwards, who is well known around the circuit for his personal commitment to physical activity and other healthy lifestyle choices, signed a statement encouraging healthy lifestyles in the recent annual enrollment newsletter sent to all Office Depot employees.

Edwards' letter read, in part, "The importance of health and wellness can't be overstated, particularly in our nation today where we are facing a crisis in terms of individual health and in the health care industry. As someone who is personally a strong advocate of health and wellness, I want to convey that message to you as well. ... We all operate in the same high-pressure, fast-paced world, whether we spend our days behind a desk, at a cash register, assisting customers in a retail store, or behind the wheel of the No. 99 Office Depot Ford Fusion. Live your life in a way that helps you be both physically and emotionally healthy. *Why? It's your health.*"

To support its healthy nutrition efforts, **Alcoa Inc.** created the *Healthy Living Cook Book*, with submissions from employees, writes Melissa Miller, manager, relocation and work life benefits. The cookbook was given free to all employees attending a company health fair.

General Mills, Inc.: Healthy Employees to Healthy Consumers

General Mills recently transformed a successful weight management program into an ongoing national consumer campaign, reports Karen Seal Grafe, manager, health and wellness communications.

"In 2004, we launched our program for our employees, 'Lose 10 Pounds in 10 Weeks,' in partnership with the Mayo Clinic," recalls Grafe. The program included speakers and activities to engage employees with a BMI of 25 or greater in losing weight in a healthy, sustainable way, using what Grafe calls "that boring but proven formula -- exercise more and eat less."

Of more than 1,300 program enrollees, 443 enrollees lost weight, with an average per-person loss of 6.7 pounds.

Several of the employees saw the potential for bigger things. "They said, 'Hey, we're a food company -- why don't we do this for our consumers, too?'" says Grafe. Champions of the idea included the company's chief marketing officer, Mark Addicks, who helped get the ball rolling.

In 2005, the company launched its consumer promotion, "Brand New You," a 10-week, Web-based program featuring popular General Mills products, such as Yoplait yogurt, Progresso soups and Cheerios cereal, that provides consumers with information, motivation and strategies they can use to maintain a nutritious and enjoyable diet while attaining a healthful weight.

Another General Mills promotion, EatBetterAmerica.com, engages consumers with food, recipes, fitness and community strategies for healthful nutrition and lifestyles. "We play down our own brands and invite people to create their own more healthful versions of favorite recipes," says Grafe. The company also has an endorsement tie-in for 12 healthful brands with the new Best Life Diet by Bob Greene, the popular author and personal trainer to Oprah Winfrey.

"We're a big brand company," observes Grafe. "We want to put a coordinated, good health face on our foods."

Strategy: Target Interventions to Employee Needs

“Today, we are more focused on identifying and lowering health risks. In the past, our programs were geared toward the entire population. While we still have programs for everyone, we are more focused on moving individuals to lower risk levels.”

—Keith Winick, wellness coordinator, Prudential Financial

As companies expand and integrate their programs and build them into their corporate culture, they also are becoming more strategic about how they use wellness to support the health of their employees. Although some companies have always made efforts to involve the workers who could benefit most from their programs, it was not uncommon for programs to appear to be “preaching to the choir” — filling their fitness centers with the already fit. Programs typically promoted broad goals such as physical activity, healthier eating and stress reduction.

Today, Business Roundtable member companies are skeptical about the one-size-fits-all approach. Serving workforces that are among the world’s largest and most diverse, they draw on aggregated claims data, HRAs and other advanced tools to identify risks or conditions that are prevalent within their employee populations, such as tobacco use or diabetes, and/or those risks and conditions that account for the highest medical benefit costs.

Companies also have become skilled at customizing their interventions for individual employees — timing offers of help to quit smoking, for example, based on an employee’s readiness to change, then providing telephone counseling and other personalized support to employees who have made the commitment. Personal self-care and health improvement services, such as nurse lines, health coaching, and telephone and online support for tobacco cessation and other behavior change programs, also are popular options within Business Roundtable members’ programs.

As a result, companies believe their programs are becoming more effective at keeping workers healthy and productive while showing more measurable results in containing costs for the population’s most expensive conditions. Following is a summary of the approaches and tools that Business Roundtable members are using to target their wellness programs.

Health Assessments and Screenings

Online or written HRAs have become a popular tool for companies — and their employees — to identify conditions that have the potential to become problems and provide targeted interventions. Of the member companies that responded to the Wellness Survey, 80 percent offer some kind of health assessment.

Many Business Roundtable members use instruments provided by their health plan or another vendor, in some instances branding them with the company logo or otherwise customizing the assessment for their own use. Other companies have developed their own assessment or other screening tools from scratch.

Employers typically make their HRAs available through the company's wellness Web site, although some companies offer them at their health fairs. Most HRAs cover the employee's medical history, current physical condition and lifestyle choices, such as frequency and duration of physical activity.

Many Business Roundtable members similarly use biometric screenings, such as blood pressure, heart rate or other data, performed either separately or in conjunction with HRAs. Roundtable companies also encourage the use of other preventive screenings, such as mammograms to detect breast cancer and PSA tests for prostate cancer, through strategies that include providing first-dollar coverage in their benefit plans or making the screenings available on-site.

Companies use the results of their assessments and screenings to classify employee risks and target interventions. A common strategy is to place employees in high-, medium- or low-risk groups and offer help in moving from a higher- to a lower-risk category.

Based on results, companies also may offer employees with identified risks the opportunity to join a disease management program or receive lifestyle change support such as tobacco cessation or weight management coaching. Companies that conduct assessments or screenings in person may offer help on the spot, using the results as a teachable moment to drive behavior change. Several companies report making dramatic, life-saving interventions when assessments or screenings revealed imminently dangerous conditions, such as extremely high blood pressure or the possible presence of a tumor.

Most HRAs are voluntary, although companies typically offer a cash reward, medical plan premium discount or other kind of incentive for completing the assessment. Several companies use the assessment as the portal for enrollment in the wellness program itself. HRAs also are mandatory in some health benefit plans. Participation rises as employees become familiar and comfortable with the tools. Several Business Roundtable companies with well-established programs say that participation rates in their HRAs and screenings consistently top 80 percent.

Companies are aware of employee concern about the privacy of their personal information and are prepared to respond when questions arise. For example, Jessica Muhlenberg, **Applera Corporation's** manager of benefits, reports that the privacy issue was at least part of the reason for low participation when the company first offered its HRA in late 2005. "Our employees are very concerned about disclosing personal information," she writes. "We focused on the confidentiality of their HRA results this year, and participation jumped."

Following are some of the ways that members of Business Roundtable are using assessments and screenings to support the health of their employees.

- ▶ **General Mills'** in-house health services staff developed the General Mills Health Number Screening tool, a personalized, "live" version of an HRA, writes Karen Seal Grafe, manager, health and wellness communications. At on-site health fairs, employees answer questions on 10 lifestyle factors, including physical activity, tobacco use, nutrition, seat belt use, alcohol use and stress. Company health professionals then measure employees' blood pressure, cholesterol, BMI and fasting blood sugar and give employees their health numbers on the spot. Those whose numbers indicate risks receive referrals to information, personal health coaching, local clinics or other resources.
- ▶ At **CIGNA's** Healthy Life Expo, employees complete biometric screenings, engage in discussions with the company's resource representatives and put together an action plan for personal health, reports Mary Bianchi, director, work/life programs. CIGNA stages the expo at more than 10 company locations.
- ▶ **W.W. Grainger, Inc.**, offers ergonomic evaluations, including carpal tunnel screenings, by company health center nurses as part of its extensive program of on-site screenings.
- ▶ **Principal Financial Group** provides on-site screenings for blood pressure, blood sugar and cholesterol at all locations with 20 or more employees. Employees at smaller sites receive screenings in their physicians' offices and are fully reimbursed. All employees fill out HRAs and set goals online.

In addition to — or in conjunction with — their other assessment and screening strategies, some companies have invested in predictive modeling software tools to target and respond to employee health risks.

Caterpillar: Assessing Risk and Readiness to Change

Caterpillar's custom-designed HRA gets much of the credit for the "best in class" results of its tobacco cessation program, says Michael L. Taylor, M.D., the company's medical director for health promotion. Caterpillar's program, which is provided by a national vendor, has achieved a four-year quit rate of 35 percent.

Along with standard information on current tobacco use, Caterpillar's HRA captures data on an employee's readiness to change risky behaviors such as smoking. This makes intervention much more efficient, says Taylor. "We're doing a better job of screening people and a better job of moving along people who are ready to quit," he says. "We don't unleash our efforts before they're ready."

For smokers identified as being in the precontemplation stage — not even thinking about quitting — efforts are deliberate, but low key. "We ask if they are ready to make a quit attempt and send them information to move them along."

"It's difficult to claim that we are more effective at moving the precontemplators, but we do work hard at it," Taylor observes. "Then, when they let us know they are ready, we invite them into the program."

Caterpillar's HRA collects longitudinal data as well, which Taylor also finds helpful in measuring the success of the tobacco cessation program. "Most programs can't measure their quit rates for more than a year, but we can track the outcomes for our employees long term," he says. "We set the standard because we have better data."

Online Strategies

"Our Web portal is an opportunity to look beyond sick care. It has trackers and modules that allow you to proactively take better care of yourself, not just in a crisis."

—Pascale Thomas, director, benefits, Verizon

Over the past decade, the computer has evolved from a passive communications tool for delivering wellness messages and benefits enrollment materials to the active center of a company's integrated health strategy.

Of the Business Roundtable member companies that responded to the survey, about three-fourths say that they use the Web to provide wellness services to their employees. Most of these companies have branded health or wellness home pages on their corporate intranets that serve as portals to all of their internal programs, with links to vendors and other resources. Some companies have built their own sites, while others have partnered with WebMD or other vendors to design customized sites.

Within that broad reach, online resources also provide virtually limitless options for targeting wellness interventions to employees — from assessing risk, to customizing and delivering programs to targeted employees, to motivating, facilitating and tracking participation. Following is a summary of some of the ways Business Roundtable companies are using virtual resources to customize and focus their programs.

BRANDING AND SUPPORTING A NEW PROGRAM

- **Verizon** partnered with WebMD to create a customized, co-branded portal, Verizon Health Zone. The portal was launched in May 2006 in tandem with a health improvement program for management employees that provides seamless and coordinated access to the company's health-related benefits and services, including integrated data from key health care vendors. "Prior to this, we had several points of entry for health information and myriad programs that were not coordinated," writes Audrietta Izlar, manager, benefits. "These programs did not allow for clear messaging or effectiveness measurement against our health claims experience."
- **Office Depot's** three-year communications strategy to launch its new CDHP benefits platform also has a Web site as its centerpiece. In its first year, the site will focus on health, bringing together all the company's wellness initiatives, health benefits enrollment information and tools, plus interactive features and links to engage employees and keep them coming back, says Frank LaPlaca, director, benefits. Next year, LaPlaca plans to add a "wealth" component, with information on company-sponsored retirement accounts, stock programs and related benefits. "Eventually the Web site will be an access point to total compensation and benefit information," says LaPlaca.

Aetna: Web-Based Communications for an Integrated Strategy

Aetna's wellness program has "transitioned from a paper-based model to a Web-based, online model," writes Dick Watson, senior benefits consultant, wellness strategy and fitness operations.

Aetna's wellness programs are complemented by an innovative engagement strategy known as the Healthy Lifestyles incentive program. Employees access the program through a home page that is part of the company's transaction-based application, so employees can reach it as part of their normal business activity, explains Watson. The page also links to other Aetna resources, such as Aetna Navigator, worksite fitness centers, DocFind and employee work/life assistance sites.

"Our communications tactics reflect a friendly style and an employee-centered focus," he continues. The Web site features reader-friendly text and formatting with links to additional information, including electronic "postcards," question-and-answer documents, and the human resources knowledge base of program and policy details.

In addition, Aetna's weekly communications strategy moves employees electronically along a continuous process from registration and health assessment to documenting goals, completing healthy living programs and preventive screenings, and tracking physical activity. The company tracks employee registrations and program use to determine the impact of monthly communications and can send just-in-time messages to areas with low rates of participation.

"Our communications strategy fits into an overall initiative to give employees the tools necessary to build excellence and accountability for their health and well-being," concludes Watson.

ESTABLISHING A LOCAL PRESENCE FOR CORPORATE PROGRAMS

Business Roundtable members use the Web to support and connect with their wellness programs at distant sites. For example:

- ▶ **Navistar's** wellness effort includes teams of local volunteers who help implement programs at the plant level, with guidance from corporate wellness leaders. More than half the teams have their own Web sites, reports Dawn Weddle, wellness manager.
- ▶ **Merrill Lynch** connects wellness champions at the company's small local worksites with the Web sites of national vendors and partners, such as the American Heart Association. "It helps our people identify people they can work with locally to set up their own on-site programs," explains Jeannette Fuente, vice president, wellness.

PROVIDING EMPLOYEES WITH PERSONAL HEALTH MANAGEMENT TOOLS

Several members of Business Roundtable, including **Verizon** and **IBM**, offer Web-based Personal Health Records (PHRs) that employees can use to enter their family medical histories, allergies, current medications and other information that affects their health.

Verizon is populating its PHR tool with claims data from selected health plans and the prescription drug administrator, retroactively from 2004. "This gives employees a greater opportunity to control their own health care because it provides a lot of information that normally doesn't exist in one secure place," explains Pascale Thomas, director, benefits.

For example, the program helps employees prepare for a doctor visit by drawing on their data to generate questions to ask during the visit. The program also can alert employees if there is an industry update about their medication. "This is a smart tool. The more you use it, the more it knows you and can help you," adds Thomas.

IBM: Virtual Fitness Based on Readiness to Change

IBM's Virtual Fitness Center (VFC) offers each of the company's 130,000 active U.S. employees a personal wellness experience based on the employee's own readiness to change. The VFC is integrated with IBM's Healthy Living Rebate incentive programs and is accessed through the company's Wellness for Life Web portal.

"We wanted to reach everyone, not just the regular exercisers, so we built the program around behavior change," explains Megan Turner, health promotion program coordinator.

On the portal, employees can assess their own readiness to make improvements in areas such as stress, physical activity, weight management, nutrition and smoking based on the stage-of-change model developed by Dr. J.O. Prochaska. "We translated our Physical Activity-Nutrition Rebate incentive into readiness as well — for example, whether your goal is to exercise four times a week or two times, you get to choose which options you are ready to adopt," says Turner. "We focused on physical activity because it affects so many other health behaviors, like weight management and stress, as well as physical conditions, like heart disease and diabetes."

Employees also can access an online workbook that uses the 12 principles of the stage-of-change model to guide employees through five stages of readiness. "We worked with Prochaska to put the workbook online," recalls Turner. "We went beyond the typical assessment — having people determine the stage they were in, but then saying, 'Here's what will help you be successful when you are in that stage.'"

On the VFC, employees are able to log their activities, check their progress toward goals, access support resources and learn about upcoming fitness programs.

IBM employees further personalize their wellness experience by creating a Personal Wellness Vision during the company's registration process, says Turner. "We wanted to put our employees in the driver's seat and make the process a little more personal. People can pick a variety of lifestyle behaviors to work on — looking better, feeling better, spending more time playing with the kids." When employees log onto the Wellness for Life portal, they reach a personal home page that refers to their vision, asking questions like, "How do you see yourself in three months? How confident are you that you will accomplish this?"

"Last year, our focus was how employees could be better consumers of health care and better informed about their decisions," adds Turner. "This year, we've moved on to the next level: How can you take better control of your habits and be successful at it?"

Disease Management Programs

“Our surveys tell us that employee satisfaction with our disease management programs is high. Once people get into the programs, they can really see a difference.”

—Lawrence Becker, director, benefits and human resources policy, Xerox

Disease management programs are an increasingly popular strategy to reduce the prevalence and complications of chronic or complex conditions such as asthma, diabetes and coronary heart disease, contributing to improved quality of life while reducing the high costs associated with these conditions.

Program designs vary, but most incorporate personal coaching and education, based on best practice treatment guidelines for the disease. Employees who are identified as having the condition or as being at risk are encouraged to receive timely and appropriate medical treatment, comply with prescribed treatments, and make lifestyle changes that may reduce the severity of the conditions or help prevent complications.

Of the Business Roundtable member companies that responded to the survey, 82 percent say they offer a disease management program or self-care tool. Disease management programs typically are offered as part of the benefits package by health plan providers or as carveout programs from other vendors. Although diabetes management is the program most frequently mentioned in the survey, some companies have begun covering many other conditions, including chronic pain, cancer and lower-back pain.

- Abbott's** Custom Care Coordination program is a coordinated treatment approach for chronic conditions such as coronary heart disease, cancer and lower-back pain. Offered through Abbott's health plan vendors, “the program can improve quality of life by preventing flare-ups and complications and minimizing symptoms through oversight of all treatments,” writes Roberta Finkler, manager, wellness.

Custom Care Coordination services can include supportive care, education, helping patients find community resources or helping members better understand their treatment plans, adds Finkler. “As the team of nurses interacts with Abbott members, they assess the whole situation and connect members to the appropriate Abbott resources and programs like employee assistance programs [EAPs]. This type of integration is not usually seen with disease management programs offered.”

- Caterpillar** worked with a local provider to create its own programs to manage diabetes and coronary heart disease. “We wanted a program that focused on conditions that were problems in our own populations and that evidence showed could be prevented by making lifestyle modifications and other strategies,” says Michael L. Taylor, M.D., medical director for health promotion.

Taylor and the local hospital crafted their own program, which draws on a multidisciplinary team that includes a nurse, dieticians, a social worker and a health educator with an exercise physiology background. The program is telephone based to serve the company's workforce in plants across the United States. Taylor tracks the program's performance on process measures such as use of screenings and clinical outcomes.

- **FedEx Express** integrates data from disease management and other vendors to track results and design improvements to its programs. Based on data showing that few participants in the diabetes management program were receiving dilated eye exams to detect a common but preventable complication of the condition, the company created an incentive that substantially increased use of the screening (see sidebar, page 16).

Many companies include disease management strategies in their integrated health and wellness programs. For example, **Corning** identifies chronic disease management on the company's Health Care Continuum. **ExxonMobil Corporation**, **Schering-Plough**, **Owens Corning** and **Pactiv Corporation** are among the companies that report that they have recently added or plan to add disease management components to their wellness programs.

Although participation in disease management programs usually is voluntary, some companies offer incentives for participating. For example, along with a \$200 medical premium reduction for taking an HRA, **McKesson Corporation** offers additional incentive dollars to employees who complete a health improvement or disease management program.

Texas Instruments: Managing Risks beyond Disease

Like many companies, Texas Instruments contracts with an outside vendor to identify employees to participate in disease management programs and deliver the appropriate services.

"What makes us uncommon is that our identification is not based on costs alone — but on a combination of costs and potential risks based on a variety of factors, including employees' use of medical and pharmacy services and disability data along with their diagnosis," says Linda Moon, manager, wellness and health management. "As a result, we can identify employees whose utilization might not be in the highest cost range, but their combination of medical conditions might put them at higher risk."

On the other hand, she notes, some employees diagnosed with diabetes may be managing their diseases well, so they would not be identified to participate in the program. "These people would not be high risks, so why would we spend that money?"

"We also don't focus solely on disease," adds Moon. "Our program is more behavioral or holistic. For example, people with some conditions tend to have certain comorbidities — like diabetes is often seen with cardiovascular disease. Our program is about identifying employees on the basis of total health risks for all diseases and reaching out to talk about their quality of health in all those areas."

Moon notes that many people with multiple risks or conditions already are aware of what they can do to improve or manage them. "So the issue isn't determining what they should be doing, but determining why they're not doing it. That takes a skill set that digs deeper than 'did you keep your doctor's appointment?'"

Changing behavior at that level also is an opportunity to engage with the family, especially the spouse. "There may need to be changes in the family's lifestyle involving diet or exercise. Or both the employee and the spouse should know what questions to ask the doctor," says Moon.

Texas Instruments considered designing its own disease management program along these lines but was pleased to find a contractor who shared its philosophy, says Moon. "We don't identify the condition, we identify the people who need help."

Support for Healthier Lifestyles

"We look upon food service as a health promotion opportunity, not a dining experience."

—Michael L. Taylor, M.D., medical director for health promotion, Caterpillar

For many companies, programs aimed at lifestyle improvements, such as increasing physical activity, managing weight, quitting smoking or reducing stress, have been traditional points of entry into wellness, and they remain among the most popular offerings. Of the Business Roundtable companies that responded to the Wellness Survey, 85 percent offer a weight management program, 74 percent offer a smoking cessation program, 73 percent offer an on-site workout facility, 66 percent offer organized wellness activities that promote physical exercise, and 47 percent provide on-site massages or another stress-reduction program.

As companies become more sophisticated about tracking the costs associated with these lifestyle-related conditions as well as the effectiveness of interventions, they also are increasingly creative in how they design their programs — using HRAs, predictive modeling and other tools to identify high-risk populations; using incentives, readiness to change and personal goal-setting strategies to encourage participation; providing personal coaching, tracking and other approaches to customize interventions and feedback; and closely integrating their programs with the corporate culture. Following is a sampling of ways that Business Roundtable members have added their signatures to healthier lifestyle programs.

- ▶ In **Navistar's** companywide challenge, *Trucking Across North America*, employee teams from 26 company sites use a Web-based tracking tool to track their physical activity for 13 weeks. Employees use a pedometer to add up miles walked or run to a virtual destination. They get credit for all forms of physical activity from gardening to running, and receive bonus miles for other beneficial activities like community service or getting a flu shot, according to Dawn Weddle, wellness manager. Plenty of incentives and rewards keep the competition interesting; the winning team also keeps a traveling trophy for the year along with a letter of congratulations from the CEO.
- ▶ **Sprint Nextel** turned its weight management initiative into a highly successful team-building event, reports Collier Case, director, health and productivity. Approximately 3,200 employees signed up for a 10-week program that combined friendly competition, weight-loss goals and physical activity. Employees assembled four-person teams, registered online and tracked their workouts. Most teams also had weekly weigh-ins, reports Case. Every employee who participated received a sports bottle, and teams that met their goals were eligible for eight cash drawings of up to \$100 for each team member. "People appreciated the opportunity to do something different," says Case. "They had just been through a merger, and this changed their focus a little bit, giving us a good reason to get out and take a walk, feel healthier and lose some weight."

- ▶ **Caterpillar** formed a partnership with its food service vendor to provide healthier choices in its employee cafeterias and vending machines. “Up to this point, their job was managing the dollars and cents and the quality. Now, they are part of our change model, and their job is to provide healthier alternatives,” says Michael L. Taylor, M.D., medical director for health promotion. Caterpillar also made corporate food service a division of its integrated Healthy Balance program.

Company cafeterias now offer nutritious Lunch for Less entrees at lower prices and supported by signage. The vendor also provides nutrition labeling and uses more healthful ingredients. “We did this before it became popular,” reports Taylor. “We told our vendor this would become a competitive advantage for them and it has — now they are replicating it with other companies.”

- ▶ **Boeing's** telephonic tobacco cessation program uses Web integration and special programming to help employees control their weight while they attempt to quit smoking, reports Michael Brennan, wellness programs manager. “Our program serves all employees at all sites globally, and we continue to attract at least 2,000 new registrants annually,” he writes.

Boeing also pays one-third of the cost of employees' participation in a pilot Weight Watchers enhanced-for-business program. “So far, the results have been impressive,” writes Brennan.

- ▶ **SAS** provides an extensive on-site services program that saves employees and their families time and money on necessary daily errands and amenities, reports Jack Poll, director, recreation and employee services. Popular offerings include a hair salon, skin care services, massage therapy, dry cleaning, alterations, car detailing, a podiatrist and a bakery.

Accenture: Bringing Work-Life Benefits Home

Accenture offers a menu of creative programs to help its consultants maintain a healthful balance in their work and personal lives. "Our company always has been interested in having our employees succeed personally as well as professionally," says Sharon Klun, manager of work/life initiatives. "And when you look at the long-term effects that mismanaging wellness can have on your health, it makes a compelling argument for providing that kind of benefit."

Most of Accenture's employees are consultants who work irregular hours and spend considerable time on the road, so the company extends backup dependent care services to children as well as elders, spouses and domestic partners. Services are available 24/7, says Klun. "A consultant might need child care at midnight while working on a report, so we think the service is a good investment in our people and the business. We encourage people to use the resource in ways that are valuable to them."

Accenture's holistic approach extends to career management and planning — especially career on- and off-ramps. For example, the company's Future Leave program allows employees to bank a percentage of their salary to self-fund planned sabbaticals of up to three months. Accenture continues to fund the employee's medical insurance during the sabbatical. Employees come back after dealing with what was important to them.

"Research tells us that top performers often value work-life balance more than compensation," says Klun. "Organizations need to think differently about where they're looking for answers. Work/life and wellness strategies provide healthy ways to help employees manage stress, take care of themselves, manage their lives and stay engaged in growing a successful organization."

Strategy: Make the Business Case for Wellness

“We don’t consider it a cost because the net effect is to improve health, reduce overall health care costs and improve productivity impacting the bottom line.”

—Deborah Lauper, director, compensation,
integrated health and employee benefits, Corning

Wellness programs can involve a substantial investment. Of the Business Roundtable member companies that responded to the Wellness Survey, almost 40 percent spend more than \$200,000 annually on their programs, and 20 percent spend at least \$1 million.

Most companies that offer wellness programs believe that their investment pays generous returns, both financially and in terms of valuable intangibles, such as employee health and satisfaction. “We track the effectiveness of our program by evaluating the use of our programs by our employees and the feedback we get for our programs,” says Jack Poll, director, recreation and employee services, SAS.

When it comes to estimating an ROI in terms of dollars and cents, however, many companies find the calculation harder to make. Although costs, such as salaries, vendor fees, facilities, equipment, assessment tools and volunteer time equivalents, are readily known, the value of improved health status is harder to reduce to numbers.

Jeanette Fuente, Merrill Lynch vice president of wellness, sums up the situation faced by many wellness professionals: “Although the program recognizes that promoting health and preventing disease save money through reduction in health claims costs, increased productivity and reduced absenteeism, it is difficult to systematically estimate those savings because of the complexity of accurately quantifying the savings from health behavior change, averting illness, early detection of disease or saving a life.”

Still, Business Roundtable member companies are making significant efforts to track the ROI of their wellness programs, advancing the state of the science as they make a strong case for their programs. They include a growing number of companies that accompany launches of new or refocused integrated health plans with initiatives to track and analyze data that help them target at-risk employee populations, deliver appropriate services, and evaluate and refine their programs.

Calculating Dollar Return on Investment

Business Roundtable member companies use qualitative as well as quantitative program measures to place real dollar values on their program results. Following are some of their strategies.

- **MetLife** estimates the 10-year cost savings effect of regular exercise on reducing cardiovascular risk. An initial profile of 200 randomly selected fitness center members showed that 65 percent had low or no risk of cardiovascular disease, while 35 percent were in the high-risk category, writes James Corry, Ph.D., wellness director. Over time, the proportion of participants in the low- to no-risk categories increased to 90.4 percent, while the percentage of employees in the high-risk category dropped to less than 10 percent.

With annual medical costs estimated at \$1,166 for employees in low- or no-risk groups and \$3,803 for higher-risk employees (those with three or more risk factors), MetLife estimated a savings of \$1.38 million per year by improving the risk profiles of nearly 2,100 members in its fitness centers at the time of the study. Against annual fitness program costs of \$550,000, this resulted in an estimated ROI of 2.52 for the fitness program, reports Corry.

- **Coming** measures ROI for programs in which the company has baseline costs and some years of data, reports Deborah Lauper, director of compensation, integrated health and employee benefits. "For example, our disease management program ROI is 3.7:1 over a two-year period, measuring health care costs for the participating group and tracking year after year.

"Each program is measured separately and not always related directly to cost," adds Lauper. "We determine if the risk factors are improving from year to year and can quantify the estimated health care costs of various risk groups."

- **Prudential** tracks ROI based on the use of its on-site clinics, wellness programs, flu shots and ergonomic workstation assessments, writes Keith Winick, wellness coordinator. "Our return on investment for 2005 was approximately \$4 million." The company will track short- and long-term benefits costs for employees who participate in the HRA, its wellness programs or both.
- With a self-funded, self-administered health plan, **Western & Southern** has its entire medical and prescription cost details, reports Laura Hauter, associate director, benefits department. The company is tracking medical and prescription drug costs related to its weight, diabetes and tobacco cessation programs and is in the process of measuring the return based on a net decrease in health care expenses.
- **Navistar** estimates the potential cost avoidance savings for seven key wellness programs, including disease management, its health club subsidy and its Trucking Across North America fitness incentive campaign at \$6.2 million. "If we were to reach 100 percent participation, these savings could reach \$19 million," reports Dawn Weddle, wellness manager.
- **W.W. Grainger** annually reviews its companywide claims history. The company targets programs such as disease management to address conditions associated with the greatest claims costs. The company plans to track those claims going forward to evaluate the impact of the program. W.W. Grainger also uses cost avoidance to evaluate the impact of some programs, such as carpal tunnel screenings performed by its health center nurses.

- **Principal Financial Group** has begun tracking ROI for its health screening and disease management programs, according to Bridget Schulz, assistant director, benefits. "We have had only one year since we've implemented health screenings, so the ROI is not positive yet at 0.51." Looking only at claims and not measuring lost productivity, ROI for disease management is 2.71, she reports.

Principal does not look at every component of other programs and services, but it does look at some individual metrics. The company also looks at aggregate cost compared to savings, says Schulz.

- **Verizon's** integrated program, launched in May 2006, includes methodology for measuring ROI by tracking reduction in health risks over three to five years.

Aetna: Returning the Investment in Fitness

Aetna measures ROI for its wellness programs using medical claims data and productivity studies using data from the Work Limitations Questionnaire, according to Dick Watson, senior benefits consultant, wellness strategy and fitness operations. In 2004, the company conducted a formal investigation of the relationship between health care costs and employee participation in Aetna's on-site fitness center during the previous year.

In the study, an Active Participating Group (fitness center participants who exercised two or more times a week) and a Total Participating Group (fitness center participants regardless of frequency of exercise) were each matched with a control group of fitness center nonparticipants by age, gender, state, job family code and medical product class. General Two-Sample T tests were used to compare the means for the Active Participating Group and the Total Participating Group to their respective matched control groups.

The study concluded that regular, active participation in Aetna's on-site fitness centers was associated with lower combined medical and pharmacy costs during 2003. On average, the Active Participating Group experienced total combined costs that were \$28.30 lower per member per month than the matched control population, for an annualized savings of \$340 per member. The Total Participating Group also showed a trend toward lower costs compared with the control group of nonparticipants. "Based on the results of this study, the ROI for the physical fitness component of the Healthy Lifestyles program is 3.4:1," Watson reports.

Working with Vendors

“Consistent with one of MetLife’s core values — People Count — we engage our vendors to address health issues across the entire health spectrum, from high-level wellness to acute disease to chronic conditions.”

— James Corry, Ph.D., wellness director, MetLife

Business Roundtable member companies are turning to disease management and other vendors to provide ROI and other cost-benefit metrics. Although this approach relieves the company of the burden of tracking and analyzing data, it may not always give the company a comprehensive, consistent or precise picture of the impact of the program.

“We work continuously with our vendors to evolve useful, accurate cost-benefit metrics,” writes James Corry, Ph.D., wellness director, MetLife. “Given our health and productivity goals, however, these measures are not always perfect in capturing the full business impact of our health enhancement programs.

“For example, our vendors typically report on cost savings attributed to reduced use of medical services, more cost-effective drug selections or the use of equally effective but lower-cost alternative medical procedures. The cost-benefit ratios reported for medical savings alone have ranged from 1:2 up to 1:7.85,” observes Corry. Adding reliable measures of productivity would make these estimates even more impressive.

Following is a sampling of ways that Business Roundtable companies work with vendors to track ROI.

- ▶ **Sprint** uses an integrated hierarchy of vendor-reported ROI for its complex case management, disease management and behavior change programs and for its HRA, according to Collier Case, director, health and productivity. The programs have produced results of up to 7.86 ROI, he reports.
- ▶ **Abbott’s** Custom Care Coordination program resulted in a \$2.5 million cost avoidance, most significantly with coronary artery disease and cancer care, and affected the overall health care cost trend by 1.5 percent, reports Roberta Finkler, manager, wellness. Abbott measures ROI by evaluating medical trends by disease state as well as comparing baseline illness costs to post-program costs.
- ▶ “**Verizon** is beginning to review methodologies for disease management programs with our key health vendor partners,” reports Audrietta Izlar, manager, benefits.
- ▶ **Xerox** has negotiated 2:1 return guarantees with its disease management vendors, reports Lawrence Becker, director, benefits and human resources policy. Guarantees include a sliding scale of penalties. “They are sharper below 1:1 and go away above 2:1,” reports Becker.

- ▶ **Union Pacific** has just completed a data warehouse to track relationships among health management program participation and claims costs, disability costs and productivity costs. The company also has done lifestyle claims analyses as well as a series of studies to determine relationships between safety and health risks, according to Marcy Zauha, director, health and safety.

Business Roundtable companies also partner with outside resources, including leading researchers, to provide data, program design or other support to determine ROI. For example:

- ▶ **Navistar** recently partnered with researchers at the University of Michigan and plans to track ROI data for the coming year, reports Dawn Weddle, wellness manager.

Dow: Targeting ROI

Dow tracks three primary financial outcomes: cost per employee for medical benefits, presenteeism and absenteeism, writes Catherine Baase, M.D., global director, health services. To track presenteeism and absenteeism, the company uses annual survey data from a statistically random sample of employees from each country. Presenteeism is assessed using the Work Limitations Questionnaire. For both presenteeism and absenteeism, the company uses average salary as a proxy for financial impact.

In addition to the economic measures, Dow also tracks employee health status. Considering just the top three target risks of obesity, tobacco and physical activity, Dow trends from a 2004 baseline showed that in 2006, the company experienced a 14 percent reduction in its high-risk population and a 4 percent increase in the low-risk group.

Improving employee health status has significant value, Dow has found. In a study, "Estimating the Return-on-Investment from Changes in Employee Health Risks on The Dow Chemical Company's Health Care Costs," published in the *Journal of Occupational and Environmental Medicine*, the company estimated that reducing each of 10 risk factors by just 1 percent per year would result in an ROI of 3:1 — an estimated savings of more than \$50 million in just the health benefits plan costs over the 10-year period.

"It is important to note that this ROI estimate assumes the only benefit is changes in direct dollar expenditures for health care," adds Baase. "We also expect that health risk reduction would result in indirect dollar savings of about the same magnitude, therefore increasing the ROI. The estimate also did not account for any intangible benefits, such as morale or recruiting."

Among its analyses of individual programs, Dow assessed the ROI of its internal "health advocacy" case management efforts by using disability guidelines to calculate lost days saved by supporting employees' return to health and return to work. "Across our U.S. sites in 2006, we estimate a savings of more than \$6 million," writes Baase.

Other Measures to Track Program Effectiveness

Business Roundtable companies also use outcomes and other metrics to measure how well their programs are serving their employee populations.

- ▶ In addition to its ROI studies, **Aetna** measures the effectiveness of its programs through productivity studies using self-reported data; risk reduction studies using biometric data from health assessments and screenings; self-efficacy questionnaires using before-and-after results of selected wellness interventions; and literature-based savings based on participation in wellness interventions, according to Dick Watson, senior benefits consultant, wellness strategy and fitness operations.
- ▶ **Eastman Chemical Company** measures the impact on risk levels after participation in a face-to-face coaching program. Before-and-after risk levels are assessed, and a statistical significance test is run against the outcomes, according to Amanda Dean, human resources representative.
- ▶ **Case New Holland** tracks the number of employees who stop tobacco use at six-month and one-year intervals. The program has been in effect since October 2006.
- ▶ **CIGNA** uses individual program metrics including participation, costs, goals achieved, weight loss, HRA scores, multiple employee surveys on benefits and behavior change, biometric screening data, and results of incentives for enrollment and participation in disease management programs, reports Mary Bianchi, director, work/life programs. The company will analyze data from claims and outcomes post-intervention.
- ▶ The wellness program at **DuPont's** Pioneer facility supports four key company market channels: maximum employee engagement/capability; attraction and retention of a world-class workforce; quality, efficiency and sustainable affordability of health care; and the safety goal of zero occupational injuries or illnesses.

To measure wellness program impact on the quality health care channel, Pioneer applied a three-tiered metric approach: Tier 1 — program payroll as a percentage of revenue; Tier 2 — health care cost trend; and Tier 3 — health care benchmarks, such as use of generic versus brand name prescription drugs, inappropriate visits to the emergency room, use of preventive screenings and change in employee health status.
- ▶ **IBM's** goal is to measure success at four levels, reports Megan Turner, health promotion program coordinator. The levels are penetration as a measure of participation; behavior change, such as increased physical activity or improved nutrition; health risk reduction or maintenance of low-risk status; and cost savings for the company, including lower health care costs and improved productivity.
- ▶ **Sprint's** cost-benefit measures include calculating and evaluating total medical costs, tracking changes in risk factor distribution and use of HEDIS® (Health Plan Employer Data and Information Set) metrics, reports Collier Case, director, health and productivity.

- **Principal Financial Group** is collecting baseline data for a dashboard to track costs, participation and results, says Bridget Schulz, assistant director, benefits.
- **Corning** uses dashboards to measure and compare year-to-year progress at each company location. Measures include risk factors, productivity, participation levels, use and program spending, reports Deborah Lauper, director, compensation, integrated health and employee benefits.

Merrill Lynch: Putting a Value on Savings

"Our wellness programs are supported by existing medical clinics and staff," says Jeanette Fuente, vice president, wellness.

"We monitor clinical outcomes and, to the extent possible, follow up with employees found at screening programs to have treatable conditions, such as skin cancer, breast cancer, high blood pressure or high blood cholesterol. [We follow] how health promotion programs impact employees' health risks. We also estimate time saved as a result of offering programs and services on-site."

In one demonstrated ROI, a survey of more than 1,500 Merrill Lynch employees who participated in health promotion, wellness and clinical care programs in 2004 found an average per-employee savings of more than four hours of productivity. Estimating 20,000 visits and an average salary of \$40 per hour, the company arrives at an estimated savings of \$3.2 million for the year.

"Keeping employees healthy is good business, and it contributes to the company's bottom line — not only in health dollars saved but in positive corporate image, increased employee morale, and enhanced recruitment and retention," says Fuente.

Acknowledgments

We thank these Business Roundtable member companies for participating in the survey.

Abbott Laboratories	CSX Corporation	Office Depot, Inc.
Accenture Ltd.	Deere & Company	Owens Corning Inc.
ADP	The Dow Chemical Company	Pactiv Corporation
Aetna Inc.	Duke Energy	Peabody Energy Corporation
Air Products and Chemicals, Inc.	DuPont	PPG Industries, Inc.
AK Steel Corporation	Eastman Chemical Company	Principal Financial Group
Alcoa Inc.	Eaton Corporation	Prudential Financial
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Arch Coal, Inc.	FMC Corporation	Springs Global US, Inc.
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December 17, 2008

The Honorable Max S. Baucus
Chairman
Senate Finance Committee
219 Senate Dirksen Office Building
Washington, D.C. 20510

Dear Chairman Baucus:

This letter responds to your December 1, 2008 letter requesting our response to Senator Stabenow's question submitted for the record, following the Finance Committee's hearing, "Health Care Reform: An Economic Perspective," held on November 19, 2008. Specifically, Senator Stabenow asked:

How will the economy impact our nation's children? How will the Bush administration's failure to reauthorize CHIP and to address the Medicaid regulations impact our nation's ability to ensure children have access to health care?

Business Roundtable is very concerned about our nation's economy and our ability to compete in the global marketplace. Business Roundtable believes that the Children's Health Insurance Program (CHIP), is a critical component of our nation's safety net, and as such, we supports its reauthorization to ensure that low-income children can have access to health insurance coverage. Our goal should be to ensure that all Americans have access to coverage, either through their employer, by purchasing coverage on their own or through public programs for low-income Americans who need subsidies.

In September we released, "Health Care Reform in America," that outlines how reforms could create a more competitive private health insurance marketplace while maintaining a strong, stable public safety net. Business Roundtable will continue to work with you and others in Congress to advance health care reforms so that every American has access to health insurance coverage. We appreciate your work and leadership on health reform, as well as the opportunity to present our views during the recent hearing. We look forward to a continued dialogue with you as you advance this critical issue.

Sincerely,

Ivan G. Seidenberg
Chairman & CEO, Verizon Communications
Chairman, Business Roundtable Consumer Health & Retirement Initiative

Enclosure

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Before the Senate Finance Committee Hearing

Health Care Reform: An Economic Perspective

November 19, 2008

Mr. Chairman, Senator Grassley, and Members of the Committee, on behalf of SEIU's 2 million members—including more than 1 million workers who went to work today in hospitals, nursing homes, and people's homes—thank you for inviting me to testify this morning. We recognize the significant challenges in addressing the economic problems of our country. But we also believe we have a once in a lifetime chance to address the economic insecurity of too many Americans by responding to the urgent need to address our nation's health care crisis.

We appreciate and applaud Senator Baucus in particular for your most recent proposals on how to take the next large steps to make our health care system have quality, control costs, and expand access—the holy grail of health care reform.

You'll hear a lot of facts and statistics today—if you haven't heard enough already over the years; yet the facts are truly alarming:

- 46 million uninsured.
- Annual premium growth that is *double to quadruple* the size of wage growth.
- US business spending on health care nearly twice as much per person as our OECD competitors, but our investment is not rewarded appropriately, as medical outcomes are no better and in many categories we're actually doing much worse than many other nations.

But the facts are for the head. To get to the heart of the matter, you simply need to hear the story of Paula Hall, a childcare provider and SEIU member in Spokane, Washington:

In 2001, after Paula's husband was hurt working in a machine shop and lost his job, they both lost their health insurance. They couldn't afford COBRA payments, and they didn't qualify for state aid because they made too much money, so Paula and her family lived without health insurance.

Four years later, after open heart surgery and three angioplasties, Paula was left with \$250,000 in health care bills.

Now, Paula and her husband rent a much smaller house so Paula is only licensed to take care of seven children. Ironically,

because her income has fallen, Paula now qualifies for state aid and health coverage again.

In the richest country on earth, bankruptcy, foreclosure, and lower incomes should not be the path to health coverage for Americans who work hard, and take responsibility for their families. America is better than that.

And if we are going to solve the economic insecurity crisis of working people living in fear in this country—of losing their jobs, of not being able to afford their health care or being just one illness away from financial ruin—the only cure is to fix health care.

Too many families are faced with impossible choices today. Do they pay their premium share or pay for groceries? Do they pay their mortgage or take their prescription every other day? Does fear of the future and increased co-pays mean postponing doctor visits and treatments? Do they take on credit card debt with outrageous interest rates or loans?

We see the alarming results: according to the Commonwealth Fund, there are now 72 million Americans struggling with medical debt, many of whom thought they had insurance that protected them. Another study indicated that crushing medical debt accounts for half of bankruptcies.

And without a sense of health care security, families will not begin to spend at the levels we need to revive consumer spending in retail which dropped an astounding 2.8% in sales just last month!

With these kinds of choices facing working people today, it's hard to argue that health care *isn't* tied to the economic crisis. If we do nothing, health care will only continue to fuel the economic crisis for years to come.

Working families and our economy can no longer survive the status quo. Failure to act is a policy decision with dire consequences:

- According to the New America Foundation, if we fail to act to address the current trends, the full cost of a typical, employer-based family health insurance plan will rise 84% to more than \$24,000 by 2016, which will collapse the employer-based system. The full cost of paying for health care—that is, the worker's share and the employer's

share—could skyrocket to half of total income for one in two households by 2016.

- If we do nothing, our national health expenditures will double from more than \$2 trillion to more than \$4 trillion in less than ten years. And as we spend all that additional money, American businesses who we need to create jobs will become less competitive as they not only take responsibility for their own employees' costs but an even greater cost-shifting tax from other employers' workers who are not offered affordable insurance.
- Federal spending on Medicare and Medicaid accounts for 4% of our economy today. If we do nothing, spending on these programs will grow to 12% of our economy by 2050.

The single most important way to dramatically improve our economic and fiscal outlook is to take steps to put health care spending on a growth rate more closely in line with overall economic growth.

Chairman Baucus and members of the Committee, we have a moment here. Post-election polling by Lake Research Partners showed voters continue to name health care among their top issues—and those who cited the economy as their top issue said health care was their number one economic concern.

As opposed to 1993, remarkably, voters, business, consumers, unions, the insurance and pharmaceutical industries are all ready to work for real change.

We understand this is not a Democratic or Republican problem, it is an American problem that threatens our country economically every day we fail to live up to our responsibilities as leaders—to find common ground and act as voters have demanded.

SEIU's millions of working families have been participating in coalitions with diverse and sometimes unlikely partners—including the Business Roundtable, NFIB, Wal-Mart, Intel, and Manpower—employers we may disagree with on a lot of other issues, but who all agree we need to fix health care now. In fact, Mr. Seidenberg and I come to you today as two of the partners of Divided We Fail. We stand ready to work with you, Mr. Chairman, and members of the Finance Committee, to get the job done.

That is why the Chairman's "Call to Action" last week was so timely, so bold, and such an important step to move this process forward. We were especially pleased to see strong support for access and coverage (including a public plan option that ensures coverage for every American), strategies for cost containment, payment and delivery system reform, transparency, and more options for long-term care. We agree that the only way to fix the problem is to address access, quality, and cost together.

Senator Grassley has a long record of supporting policies that ensure coverage for all Americans, and SEIU is proud to be working with him on transparency and long-term care. Senators Rockefeller and Hatch have shown great commitment to all of these issues. Senator Wyden has also shown true leadership and has been calling for action well before this economic crisis, and President-Elect Obama has promised voters that he will reach across the aisle to ensure we pass comprehensive health care reform. We urge all of you to work together and take action to ensure health care for every man, woman, and child in this country is enacted in the first 100 days of the new Administration.

When it comes to the health care crisis, we have to take a lesson from the economic crisis: the longer we wait, and the less we do, the worse it gets.

There are those who will say we can't afford to reform our health care system. But we say we can't afford not to. As you, Mr. Chairman, have said, if we try to fix the economy and don't fix health care, "America will just have more economic problems down the road."

Chairman Baucus and members of the Committee, it's time to fix the health care system so it works for Paula, for American businesses, and for our country. We look forward to working with you to build a stronger, healthier America.

Thank you.

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**STATEMENT FOR THE RECORD
SUBMITTED TO THE
SENATE FINANCE COMMITTEE
FOR HEARING ON
HEALTH CARE REFORM: AN ECONOMIC PERSPECTIVE**

November 19, 2008

**AARP
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HEALTH / FINANCES / CONNECTING / GIVING / ENJOYING

Jennie Chin Hansen, President
William D. Novelli, Chief Executive Officer

On behalf of AARP's more than 40 million members, thank you for convening this hearing regarding the economy and health care.

As Congress considers a second stimulus package, we believe it is essential to include additional temporary funding to states for Medicaid, our nation's health care safety net. The current economic crisis is forcing many states to consider cuts to Medicaid that would deny care to people who cannot afford health insurance. They also would worsen the economic crisis and drive up health care costs in the long term. That's because Medicaid does much more than help people with low incomes pay for care. Medicaid is essential for millions of middle-class families who rapidly deplete lifetime savings when they need costly long term care. And, by covering one out of every six Americans, Medicaid is a cornerstone of our nation's entire health care system and economy.

Medicaid cuts harm the economy, and increased federal funding boosts local economies and can help prevent our economic crisis from getting worse. That's because for every dollar a state cuts in Medicaid, the state loses between \$1 and \$3 in federal matching funds. For every Medicaid dollar a state can avoid cutting, between \$2 and \$4 is put into the state's economy. That money then flows through the economy, providing jobs and generating tax revenue for both state and local governments.

With Congress considering its second fiscal stimulus package, and federal deficits rising, we understand that some may advocate delaying action on health care reform as a priority. However, we believe that there is a cost to individuals, employers, and society in general to doing nothing on health care reform, and we urge you to continue making enactment of health care reform a top priority.

Cost of not enacting health care reform

Without health care reform, personal health care costs will continue to increase. For the past eight years, health insurance premiums for a family of four have outpaced overall inflation and workers' earnings.¹ The average total annual premium for family coverage increased from \$6,438 in 2000 to almost double in 2008.² And studies show that the more employees have to pay for premiums, the less likely they are to enroll in their employer's health plan.³ People with private non-group insurance are even worse off; they likely spend more than 10 percent of their income on health care.⁴

¹ HRET/Kaiser Family Foundation. 2008 Employer Health Benefits Survey

² Ibid.

³ Kaiser Family Foundation. February 2007. Snapshots: Health Care Costs. Insurance Premium Cost-Sharing and Coverage Take-up.

⁴ Jessica Banthin, "Out-of-Pocket Burdens for Health Care: Insured, Uninsured, and Underinsured" presentation. September 23, 2008.

Employers are also facing the high costs of health care. For example, U.S. automakers estimate that \$1,500 is added to the price of each car to provide health insurance to their employees.⁵ The percentage of small employers offering coverage has declined by six percent from 2000 to 2008 as the cost of offering coverage has increased.⁶ For those without employer coverage, purchasing health insurance in the individual market may not be possible or affordable. For instance, a recent report found that 21 percent of individuals were turned down or charged a higher price because of a pre-existing condition.⁷ Of those who sought to buy individual coverage in the past three years, 89 percent never bought a plan.⁸

Going without health insurance generates costs for society. People who lack health insurance will receive about \$56 billion in uncompensated care in 2008.⁹ Furthermore, they have a 25 percent higher risk of dying prematurely than their insured counterparts.¹⁰

Without health care reform, medical costs will continue to soar. The Centers for Medicare and Medicaid Services (CMS) estimates that national health expenditures will nearly double over ten years, rising to \$4.3 trillion by 2017.¹¹ Medical price inflation accounts for 51 percent of this health care spending growth while population increase accounts for only 15 percent.¹²

Overall cost increases in our health care system will continue to drive increases in Medicare costs as well. Total Medicare expenditures are estimated to increase from \$432 billion in 2007 to over twice that amount (\$882 billion) in 2017.¹³ Without reform, Medicare Part B premium increases will continue to outstrip Social Security cost of living adjustments.¹⁴ In addition, large employers

⁵ Lisa Girion. "Healthcare costs pinch employers." *Los Angeles Times*. May 6, 2008.

⁶ HRET/Kaiser Family Foundation. 2008 Employer Health Benefits Survey.

⁷ S. Collins et al., *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families* (New York: The Commonwealth Fund, September 2006).

⁸ *Ibid.*

⁹ J. Hadley et al., "Covering the Uninsured in 2008: Key Facts about Current Costs, Sources of Payment, and Incremental Costs." Kaiser Commission on Medicaid and the Uninsured, 2008.

¹⁰ Institute of Medicine, "Care Without Coverage: Too Little, Too Late" (Washington, DC: National Academy Press, 2002)

¹¹ Centers for Medicare and Medicaid Services. National Health Expenditure Projections 2007–2017. Table 1.

¹² California HealthCare Foundation. Snapshot, Health Care Costs 101, 2008.

¹³ Centers for Medicare and Medicaid Services. 2008 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Table III.A1.

¹⁴ Centers for Medicare and Medicaid Services. 2008 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Fund, Table V.C1 and V.C2.

are continuing to cut back on their health coverage, and the share of large employers offering retiree health coverage has declined for both pre-Medicare eligible retirees and Medicare eligible retirees.¹⁵

Framework to achieve health security

The current health care system costs too much, wastes too much, makes too many mistakes, and too often returns little value for money. AARP believes there are options to improve health care and its delivery. First, we must build the infrastructure for expanded coverage. This would include implementing health information technology, using comparative effectiveness to determine the most appropriate treatments, and ensuring that the health care workforce has enough primary care providers, including nurses. Health care delivery can become more efficient with this infrastructure in place. Payment reforms are also necessary to transform Medicare and other payers into value-based purchasers. Health status can be improved with increased attention to healthy behaviors, health promotion, and public health. We also need to review how we pay for long-term care.

AARP has identified at least seven ways to achieve cost containment:

1. Evidence-based guidelines and comparative effectiveness research to underpin benefit design and clinical practice, including evidence-based incentives to avoid inappropriate use of technology
2. Standardized and simplified administrative process and adoption of health information technology (including electronic medical records) throughout the system to lower administrative overhead, reduce medical errors, and improve quality
3. More effective disease prevention and health promotion efforts
4. Better coordination and management of chronic conditions, combined with personal assistance and support services
5. Wider use of palliative care, especially at the end of life
6. Incentives for health providers based on performance ("pay for performance") and episodes of care across a continuum of services and settings ("episode- based reimbursement") rather than fee-for-service reimbursement
7. Effective health navigation and decision supports to enable patients to make evidence-informed decisions and better manage their own health

¹⁵ Mercer Health & Benefits. National Survey of Employer-Sponsored Health Plans. 2006 Survey Report.

Conclusion

We commend the Committee for holding this important hearing to focus more attention on the economy and health reform. We hope that this hearing is just the beginning. AARP looks forward to working with you and your colleagues on both sides of the aisle to promptly provide states with a temporary increase in Medicaid funding in order to prevent harmful cuts and boost our sagging economy. We also look forward to working with you to make meaningful, comprehensive health reform a reality.

Statement of Cheryl Heaton, Dr. P.H.
President & CEO, The American Legacy Foundation
1724 Massachusetts Avenue, NW
Washington, DC 20036

Submitted to the United States Senate Committee on Finance
In regard to the November 19, 2008 hearing,
“Health Care Reform: An Economic Perspective”

Chairman Baucus and Ranking Member Grassley, on behalf of the Board of Directors and staff of the American Legacy Foundation, I appreciate you holding this important and timely hearing and I am glad to have the opportunity to submit this statement for the record. One important aspect of our economy is our health care system. One issue that has significant impact on health care costs is tobacco use and the diseases and conditions related to it. As you and your staff continue to work on reforming our health care system, we wanted to provide you our key considerations regarding tobacco prevention and cessation.

The American Legacy Foundation (“Legacy”) is a national, independent public health foundation created in 1998 out of the landmark Master Settlement Agreement (“MSA”) between the tobacco industry, 46 state governments and five U.S. territories. Legacy is dedicated to helping young people reject tobacco, and providing access to tobacco prevention and cessation services. Our core programs include:

truth® - A national youth smoking prevention campaign cited as contributing to significant declines in youth smoking.

EX® - A new innovative smoking cessation public education campaign designed to identify with smokers and change their approaches to quitting by helping them “re-learn” their lives without cigarettes.

Research Initiatives - Examining the causes, consequences and approaches to reducing tobacco use.

Outreach to Priority Populations –Priority Populations Initiatives and grants provide critical interventions using methods that are culturally competent and tailored for the specific needs of communities disproportionately affected by the toll of tobacco, including African Americans, Hispanics and American Indians/Alaska Natives the Lesbian/Gay/Bisexual/Transgender population and those of lower socioeconomic status. Socio-economic differences, historical factors, and cultural practices—as well as aggressive marketing by the tobacco industry targeted at particular groups—have all contributed to a higher rate of tobacco use and related disease in these populations.

It is impossible to ignore the impact smoking has on our current health care system and the economy. When assessing that impact, here are a few points to consider:

- An Institute of Medicine report cited the combined public and private health care expenditure for smoking-related health conditions total approximately \$89 *billion* with joint federal and state Medicaid costs alone amounting to \$28.4 *billion* per year.¹
- Lost work productivity attributable to death from tobacco use amounts to more than \$96.8 billion annually.²
- An estimated 8.6 million people in the U.S. have serious illnesses attributed to smoking, including cancers, heart disease, emphysema and stroke.³
- Recently, the CDC estimated that 443,000 people a year died prematurely from smoking or exposure to secondhand smoke in the years between 2000 and 2004.² Of those, 49,400 deaths were attributed to secondhand smoke exposure.²

The cost savings for successfully getting smokers to stop smoking, let alone preventing people from taking up smoking in the first place, could have a major impact on the economics of health care, as well as the economy generally. Fortunately, there are currently programs and services available to help people quit and prevent people from starting, but that those who need them can access those services. Legacy believes that with a relatively modest investment in effective smoking prevention and cessation programs, we can both save lives and achieve significant savings.

Tobacco Prevention: Preventing people from starting to smoke is critical, and it is imperative to focus prevention efforts for young people on “inoculating” them from developing an addiction before becoming lifelong smokers. Eighty percent of smokers begin before the age of 18⁴, and 90% before the age of 20.⁵ Tragically, one out of three youth smokers will die prematurely from tobacco-related disease. Recently the National Cancer Institute released a report that concluded that most tobacco advertising targets the psychological needs of adolescents, and at the same time, that mass media campaigns can reduce smoking.⁶ The American Legacy Foundation’s award-winning **truth**® campaign is one example.

The **truth**® campaign is the only national youth, peer-to-peer smoking prevention campaign in the country. In its first two years, **truth**® was responsible for 22% of the overall decline in youth smoking.⁷ That translates to approximately 300,000 fewer youth smokers in 2002 as a result of the **truth**® campaign. However, the annual budget for **truth**® is less than the daily marketing budget (\$36 million per 24 hours⁸) of the tobacco industry. Ensuring that prevention programs like **truth**® are funded and reaching their target populations is a critical investment with big returns in preventing health problems associated with smoking.

Tobacco Cessation: There are 43 million adult smokers in the US.⁹ In 2005, 70% of smokers said they wanted to quit¹⁰ and nearly 90% of smokers say they regret having started smoking.¹¹ Forty-one percent of them actually tried to quit, but **only 4.7 percent succeeded.**¹¹

These statistics take on even more significance when you take into account the smoking rates of the uninsured and Medicaid populations compared to the general public. Among adults under 65 years of age, 18% with private health insurance coverage were current smokers compared with 34% who were uninsured and 35% who had Medicaid health care coverage.¹² This disproportionate number of smokers in these populations makes it that much more difficult to help them to quit, since many smoking cessation interventions are either difficult to access or not available to them at all. Even for those who have private health insurance, access to those services is spotty and often insurance only covers the minimum recommended level of programs. Only eight states have required that insurance plans provide a certain level of coverage for cessation programs.¹³ Furthermore, those with insurance coverage for cessation programs, whether it is private or public, often encounter other barriers to access, such as high co-pays, limits on the length of treatment, or prior authorization requirements. This discourages smokers from taking those crucial steps toward quitting.

Quitting is an uphill battle, but there are interventions that are proven to work. However, the key to quitting often involves employing multiple interventions. Nicotine replacement therapies are helpful, but studies have shown that practical counseling and social support delivered as part of treatment are also especially effective, and the U.S. Department of Health and Human Services recommends that they be used with patients attempting tobacco cessation.¹⁴ It takes more than a pill to quit smoking – it requires a change in behavior, which is not easily done without counseling.

In response to this need Legacy has created the **National Alliance for Tobacco Cessation**. This public private partnership includes seventeen states (AR, AZ, CT, DC, IN, MO, NC, ND, OK, NH, NY, OR, LA, RI, VT, WA and WY) and eight national organizations combining resources aimed to provide smokers with the “how-to” of quitting primarily through public education. Public private partnerships like these should be adequately funded so that smokers ready to quit have access to available resources.

In closing, because of the significant impact tobacco-related disease and medical costs have on our health care system, any health care reform program should include smoking prevention programs and ensure access to smoking cessation programs. Legacy would be happy to provide further information on tobacco prevention and cessation. We thank you for your work on this critical national priority.

¹ Ending the Tobacco Problem, A Blueprint for the Nation, Institute of Medicine of the National Academies (2007), p. 30 (available at www.americanlegacy.org).

² CDC. Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses—United States 2000-2004. MMWR 2008; 57(45)

³ CDC. Cigarette Smoking-Attributable Morbidity—United States, 2000. MMWR 2003; 52:842-844

⁴ Mowery PD, Brick PD, Farrelly MC. Legacy First Look Report 3. Pathways to Established Smoking: Results from the 1999 National Youth Tobacco Survey. Washington DC: American Legacy Foundation. October 2000.

- ⁵ CDC. Projected Smoking-Related Deaths Among Youth—United States. MMWR 1996; 45(44)
- ⁶ National Cancer Institute. *The Role of Media in Promoting and Reducing Tobacco Use*. Smoking and Tobacco Control Monograph No. 19 Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute, NIH Pub. No. 07-6242, June 2008.
- ⁷ Farrelly MC, Davis KC, Haviland ML, Messeri P, Heaton CG. Evidence of a Dose-Response Relationship Between “truth” Antismoking Ads and Youth Smoking Prevalence. *American Journal of Public Health*, March 2005, Vol 95, No. 3; 425-431.
- ⁸ Federal Trade Commission Cigarette Report for 2004 and 2005, 2007.
- ⁹ CDC. Cigarette Smoking Among Adults—United States, 2007. MMWR 2008; 57(45)
- ¹⁰ CDC. Cigarette Smoking Among Adults—United States 2000. MMWR 2002; 51(29)
- ¹¹ Fong, Geoffrey T., Hammond, David, Laux, Fritz L., Zanna, Mark P., Cummings, K. Michael, Borland, Ron and Ross, Hana(2004)'The near-universal experience of regret among smokers in four countries: Findings from the International Tobacco Control Policy Evaluation Survey',*Nicotine & Tobacco Research*,6:6,S341 — S351
- ¹² Pleis JR, Lethbridge-Çejku M. Summary health statistics for U.S. adults: National Health Interview Survey, 2006. National Center for Health Statistics. *Vital Health Stat* 10(235). 2007.
- ¹³ American Lung Association. Tobacco Policy Trend Report, Helping Smokers Quit: State Cessation Coverage 2008, 2008.
- ¹⁴ Treating tobacco use and dependence: 2008 update. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service; 2008 May.



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**Written Statement of the
American Nurses Association
To the
United States Senate Committee on Finance
Health Care Reform: An Economic Perspective
November 19, 2008
215 Dirksen Senate Office Building**

The American Nurses Association (ANA) congratulates Chairman Baucus on putting forward a vision for health care reform that emphasizes the urgency for action in 2009. ANA is the only full-service professional organization representing the interests of the nation's 2.9 million registered nurses, and advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, and sharing a constructive and realistic view of nursing's contribution to the health of our nation. We agree that reform of the current broken health care system is desperately needed in order to meet the needs of all people living in the United States.

ANA believes that any national health strategy, such as that articulated by Chairman Baucus, must begin with the premise that health care is a basic human right. Our country's current fragmented, inequitable health system bears witness to the lack of a clear national vision and strategy for optimizing the health and productivity of its people. The U.S. health care system must be restructured to guarantee high-quality, affordable health care for all.

Chairman Baucus' proposal emphasizes many of the key elements that ANA believes are essential to a reformed health system. Among these are prevention and screening, health education, cultural competency, chronic disease management, coordination of care and the provision of community-based primary care. These are precisely the professional services and skills that registered nurses bring to patient care. As the largest single group of clinical health care professionals within the health system, registered nurses are educated and practice within a holistic framework that views the individual, family and community as an interconnected system that can keep us well and help us heal. Registered nurses are fundamental to the critical shift needed in health services delivery, with the goal of transforming the current "sick care" system into a *true* "health care" system.

RNs are the backbone of hospitals, community clinics, school health programs, home health and long-term care programs, among many other roles and settings. The support, development and deployment of this keystone profession is essential for any quality health reform plan to succeed.

It is with some concern, then, that ANA notes the negligible acknowledgement of registered nursing's essential role in providing those exact services to which Chairman Baucus would give heightened attention in the delivery of care. We believe this is based

American Nurses Association Written Statement
November 19, 2008 Senate Finance Committee

THE US MEMBER OF THE INTERNATIONAL CONFEDERATION OF NURSES • AN EQUAL OPPORTUNITY EMPLOYER



on a fundamental, and common, misunderstanding of the problem at hand. Simply put, access to *coverage* is not access to *care*. These two concepts are not synonymous. Concentrating one's focus on a guarantee of coverage only promises to place more people into a broken system. Failure to address issues related to the delivery of care will strain the health infrastructure even more than it already is today.

While Chairman Baucus' proposal describes in some detail renewed consideration for physician education and training toward primary care, certainly a component of workforce reform, it completely fails to appreciate the significance of the growing nursing shortage and the neglected systems that exist within our communities – such as public health and preventive services, community clinics, hospitals, mental health services, long term care, primary health care, schools, work places, and other venues where health services are delivered – that will have to serve the greater number of individuals that would be covered under his proposal. Simply tweaking Medicare GME – while certainly in need of reform – will not result in creating a health workforce that will be able to meet the care needs of the United States. A high-level, on-going system for national health workforce planning is needed to develop solutions, not only to the current flaws in education, distribution, and utilization that have resulted in our existing inequitable, fragmented system, but to explore innovative delivery solutions to meet future needs. Substantial investment is needed in the people and places where health care is provided – this will be the foundation to successful reform. This investment must move toward the creation of patient-centric delivery models that expand choice and access to innovative primary care models, featuring interdisciplinary care teams and enhanced coordination of care services, such as those delivered by advanced practice registered nurses. This reflects a similar approach describe in the Chairman's proposal to invest in community health teams.

Chairman Baucus' vision builds on the existing employer-based health insurance system, while also creating a public Health Insurance Exchange. As a matter of policy, ANA believes that a single-payer system is the most desirable structure for financing a reformed system. However, we also acknowledge merit in reform plans that would create a public-private coverage partnership, based on a principle of shared responsibility. In any public-private approach, significant health insurance market reforms will be necessary so that all plans would be held to the same high quality standards and meaningful benefit designs regardless of whether they are offered through the improved public system or through the private employer-based system. For an individual mandate to be equitable, it must be paired with such market reforms as are described in Chairman Baucus' proposal.

ANA applauds Senator Baucus' initial thinking around significant issues that would move the current health care system in a new direction, such as:

- Creation of a Comparative Effectiveness Research Institute
- Establishment of a national system for performance measurement and reporting.
- Continuing the movement toward standardized quality measures.
- Addressing social determinants that affect health status
- Attacking health disparities and seeking respect for cultural and language differences

Each of these elements supports a framework to create a system that not only *covers* the health needs of people but also *cares* for people. Senator Baucus describes his vision for reform as a trigger for this crucial conversation with consumers and patients, providers and other key stakeholders within the health care industry. ANA hopes to work with Chairman Baucus, the Senate Finance Committee, and other progressive voices seeking comprehensive health reform, in order to assure that the promise of coverage is backed up by high-quality, accessible, affordable health care for all.



Statement of:

The National Association of
Chain Drug Stores

On:

Health Care Reform: An Economic Perspective

Submitted To:

United States Senate
Committee on Finance

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The National Association of Chain Drug Stores (NACDS) appreciates the opportunity to submit a statement for the record on health care reform. We commend the Finance Committee for holding this important hearing, *Health Care Reform: An Economic Perspective*, and are committed to working with members of this committee and others to advance health care reform legislation in the 111th Congress.

NACDS represents traditional drug stores, supermarkets, and mass merchants with pharmacies. Its more than 170 chain member companies include regional chains with a minimum of four stores to national companies. Chains operate more than 39,000 pharmacies, and employ a total of more than 2.5 million employees, including 118,000 pharmacists. They fill more than 2.5 billion prescriptions yearly, and have annual sales of over \$750 billion.

When one considers all stores with pharmacies, chains and independents alike, annual sales reach \$827; however, their total economic impact reaches well beyond this figure. Retail stores with pharmacies have a total annual economic impact of \$2.42 trillion – equivalent to approximately 17% of the gross domestic product. Every one dollar spent in these stores creates a ripple effect of \$2.93 throughout other segments of the economy, including manufacturing, information technology, construction, real estate, transportation, and others.

Pharmacies are the face of neighborhood healthcare. Americans rely on their neighborhood pharmacies and pharmacists as easily accessible and trusted points of care. As Congress develops healthcare proposals that focus on accessibility, prevention, and affordability, a logical course of action is to expand the role of pharmacists in providing healthcare.

Pharmacists play a key role in helping patients take their medications as prescribed. When patients adhere to their medication therapy, it is possible to reduce higher-cost medical attention, such as emergency department visits and catastrophic care, and the preventable human costs that impact patients and those who care for them. Specifically, pharmacists are uniquely qualified as medication experts to work with patients to manage their medications and chronic conditions. Pharmacists also provide prevention and wellness services, such as immunizations, and promote lower cost alternatives, such as generic drugs, when in the best interest of the patient.

Evidence of the value of the pharmacist in the delivery of healthcare includes:

The Patient Self-Management Program (PSMP) for Diabetes, implemented in 2003, offers employees of five nationally known companies scheduled consultation with pharmacists to receive counseling on management of their diabetes. The PSMP program resulted in a mean total healthcare cost reduction of \$918 (10.8%) per patient per year from the employers' projected expenditures.¹

Pharmacist-Delivered Immunizations Impact Public Health

Pharmacists provide patients with convenient access to immunizations and forty-nine states now allow pharmacists to administer vaccinations. Each year, more than 50,000 adults and 300 children in the United States die from vaccine-preventable diseases or

their complications.² Meanwhile, immunizations, including those administered by pharmacists, help prevent 14 million cases of disease and 33,000 deaths every year.³

America's Medication Use Experts Are Guardians of Patient Safety

Failure to take medications as prescribed costs over \$177 billion dollars annually.⁴ As medication use experts, pharmacists help patients every day by counseling on proper use of medications, checking for possible side effects, drug interactions or allergies, and helping to coordinate insurance benefits. Pharmacists providing pharmaceutical care to patients with high cholesterol in their community improved patient compliance with medication from a national average of 40% to 90%.⁵

With these substantiated demonstrations of the value of pharmacy in mind, NACDS believes the following principles should guide the development of any healthcare reform proposal:

- Providing high-quality, affordable and accessible healthcare coverage to as many Americans as possible should be the goal of any healthcare reform proposal.
- The reformed healthcare infrastructure should consist of a combination of private insurance plans augmented by existing public insurance programs, rather than a single-payer model.
- The value of prescription drugs and retail pharmacy professional services should be recognized in healthcare reform, and patients should be able to choose where to obtain their prescription medications and pharmacy services.
- Financing mechanisms for reform initiatives should be broad-based, fair, and proportionate. They should be crafted to avoid negative consequences, such as creating excessive burdens on employers that might lead to the elimination of jobs, raise the prices of consumer goods, and negatively affect the overall economy. The flexible and nationally uniform framework for employer provision of healthcare benefits through the Employee Retirement Income Security Act (ERISA) should be maintained.
- Patients should have access to the most appropriate cost-effective medication to treat their particular medical condition. Lower-cost, equally effective generic medications should be encouraged when appropriate.
- Preventive services, such as medication therapy management, should be encouraged. The medication and healthcare expertise of the pharmacist should be reflected in any efforts to facilitate collaboration in patient care.
- Methods of evaluating the costs of legislation and regulations should take into consideration the role of pharmacy professional services in preventing poor health and acute healthcare events that result in more costly forms of care.
- Cost-sharing, such as patient co-payments, should be set at affordable levels that encourage the use of the most cost-effective medications. However, cost-sharing

should not prevent patients from seeking appropriate medical care, or create barriers to accessing providers.

- Reimbursement to healthcare providers should be equitable to prevent access limitations that result when providers are forced to reduce or eliminate services. In the case of pharmacies, reimbursement should include those costs related to dispensing medication and pharmacist-provided care, as well as medication costs, both of which should be determined fairly.
- Non-pharmacy healthcare and educational services such as in-store clinics and healthy living presentations should be explored, in collaboration with other healthcare providers including the physician community.
- A robust and standardized health information technology system, including e-prescribing and electronic medical records, should be the backbone of healthcare reform. Speeding the adoption of this technology will increase the likelihood that patients will take their medications as prescribed, helping to prevent medication errors, and enhancing medical decision-making and collaboration.

Pharmacies are the face of neighborhood healthcare. As Congress looks to reform our nation's healthcare system, improve access to vital healthcare services, control costs, and improve outcomes, NACDS urges policymakers to expand the role of the pharmacist. Trusted by patients, trained as medication experts, and accessible in virtually every community, pharmacists are a critical resource to our healthcare system.

Thank you for this opportunity to submit a statement to the hearing record. We applaud the leadership of the Finance Committee in healthcare reform, and look forward to working with you on this important issue.

¹Garrett DG, Bluml BM. Patient self-management program for diabetes: first-year clinical, humanistic, and economic outcomes. *J Am Pharm Assoc*. 2005 Mar-Apr;45(2):130-137.

²Institute of Medicine Report. Shaping the Future for Health – Calling the Shots – Immunization Finance Policies and Practice. Accessed at: http://books.nap.edu/html/calling_the_shots/reportbrief.pdf, October 26, 2008.

³Department of Health and Human Services, Fiscal Year 2008. Centers for Disease Control and Prevention. Justification of Estimates for Appropriation Committees. Accessed at: http://www.317coalition.org/documents/cdc_fy2008budget_immunization.pdf, October 26, 2008.

⁴Ernst FR, Grizzle AJ. Drug-Related Morbidity and Mortality: Updating the Cost-of-Illness Model. *J Am Pharm Assoc*. 2001 Mar-Apr;41(2):192-199.

⁵Bluml BM, McKenney JM, Cziraky MJ. Pharmaceutical care services and results in Project ImPACT: Hyperlipidemia. *J Am Pharm Assoc*. 2000 Mar-Apr;40(2):157-165.



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Statement for the Record
 Senate Finance Hearing "Health Care Reform: An Economic Perspective"

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From: Quentin Young, MD, MACP, Volunteer National Coordinator
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Physicians for a National Health Program respectfully requests an opportunity for one or more of our members to testify about the merits of single-payer national health insurance (as embodied in the U.S. National Health Insurance Act, H.R. 676, which currently has the support of over 90 members of Congress) at the Senate Finance Committee's hearings titled "Healthcare Reform: An Economic Perspective." Wednesday November 19, 10:00am.

Single-payer health reform, sometimes characterized as an improved "Medicare for All," is the only reform model that offers \$400 billion in annual savings in administrative costs. It is the only approach that contains effective cost-containment provisions, such as bulk purchasing and global budgeting. Such economies would allow for expanding health coverage to everyone – with no co-pays or deductibles – with no overall increase in health care spending.

The single-payer model is the only fiscally prudent proposal available, an especially important consideration at a time of economic distress. By basing itself (and improving upon) Medicare, it presents itself as a uniquely American way of guaranteeing care to all who need it. Such an approach has proven its effectiveness.

With a single-payer national health insurance program we can assure lifelong, high quality, comprehensive and affordable coverage for everyone. Such a program will lift the heavy burden of crushing medical expenses off the shoulders of our population, expenses that often lead to personal bankruptcy. And we can save lives: the Institute of Medicine estimates that more than 18,000 Americans die each year from lack of health insurance.

Single payer is the only evidenced-based health policy model that best reflects American's needs and values.

Support for single payer is extensive. In a peer-reviewed scientific study in the *Annals of Internal Medicine*, 59 percent of U.S. physicians said they support government action to establish national health insurance (1). In a recent Associated Press poll 65 percent of the respondents said, "The United State should adopt a universal health insurance program in which everyone is covered under a program like Medicare that is run by the government and financed by taxes" (2).

In addition, over 480 labor organizations, including 39 state federations of the AFL-CIO, have endorsed single payer legislation, as have numerous professional associations, city and state governments, and religious denominations.

We therefore expect that single-payer proponents will be invited to testify before the Committee and we look forward to your affirmative response.

In conclusion we offer the following commentary on behalf of Physicians for a National Health Program Senior Health Policy Fellow, Don McCanne, MD.

On November 19, America's Health Insurance Plans (AHIP) announced their Proposal to Guarantee Coverage for Pre-existing Conditions and Promote Affordability in the Individual Insurance Market (<http://www.ahip.org/content/pressrelease.aspx?docid=25068>). Their proposal summary included the following, "1) Guarantee-issue coverage with no pre-existing condition exclusions. 2) Establish an individual coverage requirement with an insurance coverage verification system, an automatic enrollment process and effective enforcement of the requirement that all individuals purchase and maintain coverage; 3) Promote affordability by: providing refundable, advanceable tax credits for moderate-income individuals and working families; and promoting tax equity whether coverage is obtained through an employer or the individual market; and 4) Ensure premium stability for those with existing coverage through a broadly funded reimbursement mechanism that spreads costs for the highest-risk individuals."

Also on November 19, BlueCross BlueShield Association (BCBSA) also announced its support for an individual mandate coupled with a requirement for insurers to offer coverage to all. The press release reads, "To assure truly meaningful reform, the Blue Cross and Blue Shield Association (BCBSA) and the 39 member Blue Cross and Blue Shield companies today announced support for every individual being required to have coverage and all insurers being required to accept everyone regardless of their health status" (<http://www.bcbs.com/news/bcbsa/bcbsa-announcs-support-for.html>).

Dr McCanne writes, "If anyone has any remaining doubt that comprehensive reform is close at hand, just look at the response of the private insurance industry. AHIP, representing 1,300 insurance companies, and BlueCross BlueShield Association, insuring over 100 million individuals, in simultaneous press releases have confirmed that they understand that, if they want to continue to insure the majority of Americans, they must abandon their current business model and come to the table with policies that work. Policies that work means that everyone must be included, and that risk must be distributed in an equitable manner, based on ability to pay.

So what is their current business model that no longer works? They have been successful in limiting their exposure to the very large numbers of us who are relatively healthful: the healthy workforce, their young healthy families, and the healthy sector of the individual insurance market. But health care costs are now so high that the premiums that must be charged for these healthy risk pools are no longer affordable for the majority of us.

The industry's response was to reduce benefits thereby reducing the upward pressure on premiums, but that has resulted in the rapidly growing epidemic of underinsurance. As a result, health care is now often unaffordable even for those who do have insurance. Also, in response to high premiums and mediocre coverage the numbers of uninsured continue to rise.

The private insurance industry has been trying to ride this out, but no more. Their hand is being forced by the political tidal wave that is sweeping over our health care system with the demand for reform that works for all of us.

They understand that in a truly universal system they must guarantee coverage for everyone regardless of preexisting conditions. Since that would push premiums up, they know that they must add larger numbers of healthy individuals to dilute the risk in their pools. An obvious source is the large numbers of young, healthy individuals who are uninsured. But the only way those individuals would pay the high premiums would be by forcing them to participate. Thus an individual mandate must be coupled with guaranteed issue.

The industry pretends that an individual mandate with guaranteed issue is all that they need to be major players, but they are reticent on revealing the most crucial barrier that they face. Although premiums for private plans are already too high for average-income individuals to afford, they must reverse the innovations that have led to underinsurance. Obviously that will significantly increase premiums. Also, since they currently sell to mostly healthy individuals, adding those with preexisting disorders will result in even higher premiums.

What to do, what to do? The AHIP release gives us a couple of hints.

Those supporting universal coverage through private health plans have long conceded that tax credits (or vouchers) must be used to assist low-income individuals with the purchase of their plans. In their press release, AHIP now states that we must use "refundable, advanceable tax credits for moderate-income individuals and working

families." Finally, the industry explicitly concedes that most of us can no longer afford to purchase their health plans. So who is going to help? The taxpayers. Gee, isn't that us?

The other problem is how are they going to pay for the high-risk individuals who now must be covered? Their solution is somewhat more cryptic. They are going to "ensure premium stability for those with existing coverage through a broadly funded reimbursement mechanism that spreads costs for the highest risk individuals." "Premium stability" means that other sources will be paying the higher costs of the higher-risk individuals. What other sources? They propose "Guarantee Access Plans" which are "loosely modeled on state high-risk pools." Oops. The taxpayers - us - again.

Think about it. The private insurance industry has just the solution for us, but only if we agree to foot the bill for those who actually need health care, while they continue to collect large premiums to pay for their egregiously wasteful administrative excesses.

Their proposal is to shift the real costs of health care to the taxpayer. They are right. We need to establish a universal risk pool and fund it equitably based on ability to pay. The only sensible way to do that is through a single payer national health program. Why would we want to implant on our health care financing system the cancer of private health plans?"

1. AE Carroll & RT Ackerman. Support for National Health Insurance among U.S. Physicians: 5 years Later, *Annals of Internal Medicine*. Vol1148 (7)
2. Associated Press/Yahoo News Poll, Dec. 14-20, 2007

