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3 HEARING ON ``MAKING HEALTH CARE WORK FOR AMERICAN FAMILIES:

4 DESIGNING A HIGH PERFORMANCE HEALTH SYSTEM''

5 TUESDAY, MARCH 10, 2009

6 House of Representatives,

7 Subcommittee on Health

8 Committee on Energy and Commerce

9 Washington, D.C.

10 The subcommittee met, pursuant to call, at 10:07 a.m.,

11 in Room 2123 of the Rayburn House Office Building, Hon. Frank

12 Pallone, Jr. (chairman) presiding.

13 Members present: Representatives Pallone, Dingell,

14 Eshoo, Engel, Green, DeGette, Capps, Schakowsky, Baldwin,

15 Ross, Matheson, Harman, Gonzalez, Barrow, Christensen,

16 Castor, Sarbanes, Murphy of Connecticut, Space, Sutton,

17 Braley, Waxman (ex officio), Deal, Whitfield, Shimkus,

18 Shadegg, Blunt, Pitts, Rogers, Murphy of Pennsylvania,

Burgess, Blackburn, Gingrey, Scalise and Barton (ex officio).

Staff present: Phil Barnett, Staff Director; Karen Nelson, Deputy Staff Director for Health; Karen Lightfoot, Communications Director, David Rapallo, General Counsel; Steve Cha, Professional Staff Member; Amy Hall, Counsel; Purvee Kempf, Counsel; Tim Gronniger, Professional Staff Member; Jon Donenberg, Health Fellow; Bobby Clark, Senior Policy Advisor; Virgil Miller, Legislative Assistant; Jennifer Berenholz, Deputy Clerk; Caren Auchman, Communications Associate; Alli Corr, Special Assistant; Alvin Banks, Special Assistant; Caitlin Sanders, Staff Assistant; Brandon Clark, Minority Professional Staff; Marie Fishpaw, Minority Professional Staff; Clay Alspach, Counsel; and Chad Grant, Legislative Analyst.

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Mr. {Pallone.} The meeting is called to order.

I want to first thank every one for being here, particularly our panelists. The subcommittee today is holding the first in a series of hearings entitled ``Making Health Care Work for American Families.'' These hearings will help us better understand issues important to the health care reform debate such as quality, cost, coverage and prevention, and today we are focusing on how to design a high-performing health care system, which implies that our current system is underperforming. Indeed, as it is presently structured, the U.S. health care system is incapable of consistently providing access to quality and affordable care to every American, and a large part of this failure can be attributed to our Nation's growing uninsured population. According to a new report on the uninsured by the Institute of Medicine, who we will hear from later today, 47.5 million Americans, or an estimated 17.2 percent, of the non-elderly population went without health insurance in 2007. As we move forward with health care reform, we must understand that our failure to insure 47 million Americans has significant consequences for the health system as a whole. Our Nation's growing uninsured crisis impacts us all regardless of our own insurance status. If we are to design

a high-performing health care system, the foundation of such a system has to ensure access to quality and affordable coverage for every American.

But the problems we face with our health care system go beyond coverage issues. Our health care system is woefully disorganized, so much so it is hard to characterize it as a system at all. There is virtually no coordination of care among providers. Patients are often handed off from provider to another. In the process, information is lost, inappropriate treatments or tests are ordered and medical errors occur. This is particularly a problem when it comes to patients who suffer from chronic conditions and are under the care of multiple providers at any given time.

Researchers have suggested that part of the problem stems from the fragmented way in which we finance the delivery of health care services. We pay providers based on volume regardless of the quality of the care or service provided and regardless of the outcomes. Furthermore, there is little incentive for providers to follow up with a patient after they have provided treatment or to coordinate care among multiple providers or between different health care settings.

What has this disorganization created? Well, the United States spends more on health care per person than any other

industrialized nation and yet we do not enjoy better health outcomes by almost any measure, and within the United States there are vast disparities in how health care is delivered among the different communities. Clearly we are not getting the most value out of our health care dollars. The erratic and chaotic manner in which our health care system is organized can't continue.

We need to find a way to reorganize the health care delivery system in a way that improves quality and efficiency, thereby driving down costs, and there are a number of options on the table. For example, the President's budget contains specific proposals that would change the way Medicare pays for and delivers health care including, one, reducing readmission rates at hospitals, two, providing performance-based payments for physicians that coordinate care for Medicare beneficiaries, and three, promoting coordinated care between acute and post-acute care settings through bundled payments.

Now, I know we have MedPAC here today and I am happy that they are here because they have done work in many of these areas as well as other areas like the medical home model. As Chairman Hackbarth notes in his testimony, Medicare can be a leader in reforming the health care delivery system but changes to the way Medicare delivers and

pays for health care will only take us so far. We need fundamental change to the entire health care system in order to achieve our goals.

Now, one of the best examples of change, I think, was in the economic recovery bill. As you know, there is a pot of money for health care information technology, and that is certainly an example of the systematic change we need. As more physicians are able to adopt and use HIT, we can facilitate greater communications among providers and thereby increase the coordination of care. By passing the Economic Recovery Act, we started the process of modernizing our health care system by investing $19 billion in HIT. But not everything has to be as complicated as moving our health care system into the electronic era. There are simple changes that will produce dramatic effects. For instance, I believe that by focusing more on primary care, coordinated care models and prevention we can achieve greater savings and efficiency within our health care system, and again, there are prevention and wellness measures and pots of money in the Economic Recovery Act as well.

If we are successful in redesigning our health care system so that it performs better, there will be great rewards. Aside from the potential to improve health outcomes, a more efficient health care system that pays for

quality services will help drive down costs for American families, businesses and the federal government, all of which are struggling with the escalating cost of health care. Indeed, health care reform is fiscal reform. Those of us who have been paying attention to the President over the last month or so, he constantly talks about health care reform being fiscal reform and the need to bring down costs if we are going to effectuate an economic recovery and expand coverage for all Americans. We can't restore the financial health of the Nation and American families without tackling our broken health care system first, so let us get started.

I just wanted to say that many of us on this committee attended the President's health care summit last Thursday. I was tremendously impressed with the fact that almost everyone said that we needed health care reform now. They did not want to wait, and almost everyone said that the cost and bringing down cost was an important part of any change that we are going to effectuate. I used to be very proud of the fact that I could go around saying I was involved in health care policy and that we had the best health care system in the world. I don't believe that anymore, and I think the time to act is now and so we are going to begin today.

[The prepared statement of Mr. Pallone follows:]

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Mr. {Pallone.} I now recognize our ranking member, Mr. Deal, for an opening statement.

Mr. {Deal.} Thank you, Mr. Chairman. I want to thank you for holding the hearing today. I want to thank both panels of witnesses who are going to testify. In particular, I would like to go ahead and welcome in advance of his official introduction Dr. Todd Williamson, who is a neurologist from Georgia and is president of the Georgia Medical Association. He will be on panel II, and thank you for allowing him to testify.

You know, when you talk about health care, you are talking about how to wrestle a porcupine, and the problem I think we have encountered is that we have known different ways to deal with this issue in small pieces over a long number of years and we have failed to come to grips with dealing with those pieces and now we are trying to deal with the system as a whole and talk about how bad the system is even though we have not taken advantage of the opportunities to make it better incrementally. I am always concerned about major reforms, especially of a segment of our economy and of societal service as large as health care. But we are now apparently on the brink for whatever reason, dereliction of duty in the past or whatever, of having to deal with major

reform.

Now, let me mention a couple of things that I hope in the context of this hearing, perhaps even more specifically in future hearings, I think are important to deal with. First of all, I have had a passion for the issue of price transparency. In the health care arena, it is one of the few areas that you just cannot know in advance of a service being rendered what the charge is going to be, and the reason is, and it indicates part of the problem we are wrestling with, is the reason you don't know is because the question is always followed with a question. When you ask how much is it going to cost, the question becomes well, who is going to pay, and who pays depends on how much the cost really is, and that is something that you do not find in most other areas of service in our Nation. So price transparency is an issue and I am pleased that the chairman and the chairman of the subcommittee have both indicated a willingness to explore that issue in the future.

Let me talk about a couple of other things. I think you are going to find that throughout all of this, the issue of medical malpractice reform has got to be one of those issues that we just simply cannot ignore. Now, it manifests itself not only in private physician and hospital practices but also the one that is probably the most acute that we tried to deal

with several years ago and that is the emergency rooms with EMTALA that requires to treat everyone with no ability to divert without running the risk of being held accountable on a liability basis, you are just simply going to continue to see as in my local emergency room the primary reason for presentation is ear infections and you probably could duplicate that all across the country, non-emergencies being presented in the most costly environment, that is, an emergency room. But until we deal with the ability either to alter EMTALA, which I have no confidence that that will be done, or to provide some protections as we attempted to do several years ago for diversions to non-emergency settings in an environment close to the emergency room so as to take that pressure off and the financial as otherwise the pressure off. I think we still have a problem there.

Now, there are other issues and I am just going to deal with them in very broad, general terms. First of all, I think we have to remember that as we are dealing with an expansion of government power we never can forget about the fact that the only thing that keeps our country working in almost every facet of life is the issue of personal responsibility. When we have government assuming all of the responsibility, then it is very difficult to get people to do what they need to do for themselves, not only financially

contributing to the cost of their health care but to doing the things that they need to do that the chairman has alluded to such as prevention, such as wellness programs, et cetera. A few other things that I would like to mention. I think that as we deal with the broader context of how to reform the delivery system, hopefully we will not forget the private sector. The private sector has been the primary mechanism for providing health insurance through the employer-based system. Obviously it has some problems. I would like to see us be able to take advantage of the one that has the most personal responsibility and that is a medical savings account where a person has the right to decide how they want to spend their money and they are directly involved but they can't be the ones that are paying the highest price. If that is the case, then you can't make that kind of system work.

Thank you, Mr. Chairman. This is certainly the beginning, I hope, of a wide-ranging look at the issue of health care reform, and thank you for hosting this hearing today. I yield back.

[The prepared statement of Mr. Deal follows:]

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Mr. {Pallone.} Thank you, Mr. Deal.

I will recognize our chairman, Mr. Waxman, but let me just digress a minute here, if you will bear with me. There are a lot of people on this committee who have played major roles over the years in the health care debate, and if we do actually accomplish health care reform in a significant way this year, I think that we owe a lot to them, and Mr. Waxman, Mr. Dingell, others are amongst them, and I just wanted to say, you know, I remember 20 years ago, because this is my 20th year, I came to this room and I watched Mr. Waxman and Mr. Dingell and others talk about health care issues and I was so impressed, that is why I wanted to be on this committee, and I know that is why a lot of the new members have started. We have a number of new members on our Health Subcommittee this year and they have expressed the same thing to me, that the main reason they came to this committee was because they wanted to deal with health care reform. But if and when we accomplish this goal this year, a lot of the credit is going to go to some of these people who have labored for years on this issue and brought out a lot of the problems and solutions that are necessary for health care reform and certainly our chairman is one of the leaders among them. So I just wanted you to know that, Henry.

The {Chairman.} Thank you very much, Mr. Chairman, and when we accomplish the goal of enacting affordable health insurance for all Americans, you will be there ranking among all the members who have played a significant role. This isn't one or two, it is all of us working together, and I thank you for holding this hearing on the health reform issue.

I think we have a unique opportunity. President Obama has called on Congress to work with him to enact comprehensive health reform this year, and to underscore this commitment, the President has proposed over $630 million in new revenues and program savings to help pay for reform. This marks a sea change from the last 8 years, and as we will hear from our witnesses today, it comes none too soon. The status quo is simply no longer an option. The health of our people, the health of our economy depends on achieving affordable, high-quality, sustainable coverage for all Americans. The President has laid out the broad outlines of his preferred way to achieve this goal, and I think his approach is sensible. It builds on and protects the employer-based coverage that is now in place for most Americans. It lets those people who have coverage that works for them keep that coverage. It strengthens the safety net of our vital public programs, Medicare, Medicaid, CHIP. It

gives people a place to go to get accessible, affordable, high-quality coverage through private plans or if they prefer through a public alternative. The choice is theirs. And it recognizes the critical importance of prevention and wellness services and the management of chronic diseases. I am determined to work to find the approach that will be broadly acceptable to the American people, to the providers that are critical to making it work, and to the Members of Congress who in the end have to pass it.

This hearing begins the work of this committee in responding to the President's request. As the testimony will make clear, the health care challenges we face are daunting and finding workable and enactable solutions will be extremely difficult. Mr. Chairman, you as chairman of the subcommittee will build on the work that I and Mr. Dingell and others have done over the years and you and the newer members of the committee will bring vitality to this effort that I think will finally get us to the goal that has been so elusive, and I look forward to working with you in this regard.

[The prepared statement of Mr. Waxman follows:]

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Mr. {Pallone.} Thank you, Mr. Chairman.

Next is our ranking member of the full committee, the gentleman from Texas, Mr. Barton.

Mr. {Barton.} Thank you, Mr. Chairman, and I want to commend you and full committee Chairman Waxman for the bipartisanship in arranging these series of hearings. This it not like the hearing upstairs on climate change where there is a clear ideological difference, and we have even gotten to the point of arguing over how many witnesses and which witness and this type of thing. In this subcommittee under your leadership and Mr. Waxman's leadership, it has been a very cordial operating relationship, and I do sincerely want to commend you and Mr. Waxman for that.

Health care is very important to everybody in America and I do slightly disagree with your opening statement, Mr. Chairman, when you said that you used to think the United States had the best health care system in the world but you don't think we do anymore. I think we still do. I think our health care system is the best in the world. I think it is the best in terms of quality. I think it is the best in terms of inclusiveness. I think it is the best in terms of its research capability. I do think there are problems with it. I think that obviously Americans that don't have health

insurance are not able to take advantage of some of the wellness programs and the preventive medicine practices that are becoming more and more prevalent, but if somebody in America is sick today and needs to see a doctor or a health care practitioner, they are going to see them. Whether it is in an emergency room or a clinic or a private doctor's office, they are going to see them, and the more serious the condition, the more fortunate that person is that they are in the United States of America.

My sister-in-law has just undergone 6 weeks of chemotherapy treatment at M.D Anderson in Houston, Texas. She went home Sunday to recuperate. Her CAT scan and the tests that they ran show that the cancer that is ravaging her body is beginning to recede because of the treatment that she is receiving and hopefully will continue to receive after her body recuperates. I am darned glad that she lives in the United States of America and I am very glad that she lives close enough to M.D. Anderson in Houston, Texas, that she could take advantage of the treatment that is available there. People come from all over the world to that facility for that type of treatment.

So what we are engaged here today, Mr. Chairman, is to begin a discussion of how we can improve our health care system, and I think we can do it. I do think our health care

system is too expensive. I do think that there are lots of ways that we can improve it. I agree with you that the President's health care meeting at the White House last week was very productive. I said there and I will say here, I agree with President Obama's eight principles but the devil is in the details and that is what these hearings are going to accomplish. I think there is a difference between Republicans and Democrats. In general I think the Democrats, the majority party right now, want more government involvement in health care. I think Republicans in general would rather have the private sector and the marketplace system with openness and transparency where doctors and patients make the decisions themselves and don't have to depend on some sort of a government official or a government program but I do think the government needs to be involved and I think that somewhere in these hearings perhaps we can have a meeting of the minds.

So Mr. Chairman, I am involved in the health care debate in this committee in a different way than I am the climate change issue. I think on health care we can improve the system and we can find a consensus and we can do something hopefully this year to make health care for Americans more affordable and more accessible and even higher quality than it is. I must say on climate change that I am hopeful we can

convince enough people that is not something that we need to do, given the state of our economy. In any event, this is a very good hearing, you have got good witnesses, and I look forward to a serious discussion.

[The prepared statement of Mr. Barton follows:]

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Mr. {Pallone.} Thank you. I want to thank our ranking member.

Next is our chairman emeritus, and I cannot have enough accolades about his involvement over the years in health care reform and Medicare, and again, I look to him as one of the giants on this issue, Mr. Dingell.

Mr. {Dingell.} Mr. Chairman, I thank you for those kind words and I thank you for holding this hearing, which is a very important one, about designing a high-performance health care system. We have a splendid health care system in this country which doesn't work. It doesn't work because we have 47 million Americans who lack care and we have a lot who have substantial deficiencies in the amount of care available to them. We have a worse situation in that the problem is fixable but it has not been able to be addressed for years because of intense lobbying by the health insurance lobby and others. I remember we lost it the last time by one vote here and we lost it in good part because of dawdling by the Administration, which made a fine speech on the subject on the Floor of the House in February and didn't present the bill to the House until sometime in November by which time we had lost in this committee and a business roundtable by one vote.

The health care system in this country is wonderful but it doesn't work, and one of the problems about it is, that we are seeing large numbers of Americans die prematurely or suffer from serious health problems back of the lack of availability of care from this extraordinarily advanced system which we are blessed with. Health care costs are far higher in the United States than in any other advanced nation. These costs have been rising significantly faster than the overall economy or personal incomes for more than 40 years, and if left unchecked will shortly create irreparable harm to the Nation's health and economic system. The two curves which are important to us in this country, the GDP and the cost of health care or the percentage of health care, will cross about 2070. That should give us a warning. We have heard the data. Health costs are consuming a growing share of federal and State government budgets. The United States spends $2.2 trillion and more on health care each year, about $8,000 per person. This represents 16 percent of the total economy and is expected to reach almost 20 percent, more than $4 trillion, by the year 2017.

Health insurance premiums have doubled over the past 8 years, rising 3.7 times faster than wages in the last 8 years, and American businesses are losing business share in world competition because of the increasing cost of health

care for their employees. For example, a General Motors car today contains about $1,600 in health care costs per car. General Motors is in fact not an automobile producer but a health care provider that makes automobiles to pay for the cost of it, and the same is true for many other U.S. corporations. American automakers spend more now on health care than steel. They only spend $750 on steel. And Starbucks spends more on health care than they do on coffee beans. No one can dispute the fact that we spend a great deal of money on health care. America enjoys the most outstanding cadre of health care professionals on the planet, the most advanced technologies, the most innovative health care institutions and the finest medical research, which is a model for the whole world. However, in spite of this great investment and the amazing talent of our health workforce, our health system continues to operate at low performance and more spending has not and does not mean better quality service and care available to the American people.

Studies have shown the United States underperforms relative to other countries on most dimensions of health care performance. It has lower life expectancy and higher infant mortality, amongst other things, but there is plenty other things wrong if you read the statistics. A number of other studies have shown that many surgeries are performed without

being clinically appropriate. Patients typically receive about half the recommended treatment and services. About 100,000 Americans die from medical errors at hospitals every year. Half of these cases are avoidable. One-quarter of medical spending goes to administrative and overhead costs, something which we must address if we are to save ourselves from a crazy system that is failing.

Across the Nation, health care costs vary substantially, however, and higher cost areas surprisingly do not generate better health outcomes. Our goal of providing health care security for those struggling to keep the coverage they currently have while expanding coverage to the 47 million Americans currently without coverage is clearly necessary. However, we must all do what we can to first make our current system of health care more efficient and effective including care provided by public programs like Medicare and Medicaid, the costs of which without reform will become unsustainable in the near future. The current payment structure of these systems does not encourage coordinated care and encourage unnecessary treatment which in turn leads to higher costs and significant inefficiencies.

I look forward to the testimony of our witnesses today and of continuing our discussion and action as we seek to reform our health care system. Mr. Chairman, this has long

been a passion of mine, as you have noted, and also of my great father, who introduced the first legislation on this in 1943. I look forward to working with you and with Chairman Waxman and the others of my colleagues on both sides of the aisle to solve this terrifying problem.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Dingell follows:]

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Mr. {Pallone.} Thank you, Chairman Dingell.

Next we have the gentleman from Kentucky, Mr. Whitfield.

Mr. {Whitfield.} Chairman Pallone, thank you very much for this hearing on making health care work for American families.

We all hear a lot about health care reform and we know that there are basically two reasons that we are moving down this avenue. One, health care costs continue to escalate, health insurance premiums go up and then access for all of the American people, and I noticed that President Obama in his budget has set aside $634 billion for health care reform, and although his plan is quite sketchy, the one thing that he has talked about specifically is a federal board to set provider rates, design coverage and ultimately control prices in the health care market.

I think from the philosophical point of view, health care reform gets down to a debate on both sides of the aisle. When we talk about these federal health boards, most of us, I think, think of Canada and Great Britain. They both have federal boards, and the key issue, as least from my understanding, is that in both of those countries while the primary health care delivery system is very good, they basically ration health care, and that is something that we

really have never done in America so that if you do not need a certain criteria then you are not going to be eligible for a particular kind of health care procedure. That is something I think we have to move very carefully with as we discuss health care reform.

A second thing, it looks like to me that--I philosophically believe that a federal board is not the way to go because when you talk about an effective health care system, I like to look at Part D of the prescription drug benefit under Medicare because today we know that the premium for that plan is less than what was originally anticipated. The cost of that plan is less than what was originally anticipated. And the reason for that in my view is that in every jurisdiction you had private companies coming together competing with each other offering plans and more important than the cost is that the senior citizens seem to be satisfied with their Part D prescription drug benefit. I know that not all of them are but generally speaking they are satisfied, and I think that is a model that as we talk about health care reform that we definitely need to explore giving patients more of an opportunity to decide for themselves rather than a federal board making all these decisions.

I yield back the balance of my time.

[The prepared statement of Mr. Whitfield follows:]

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Mr. {Pallone.} Thank you.

Next for an opening statement is the gentlewoman from Colorado, and thank you again for your work on stem cells.

Ms. {DeGette.} Thank you very much, Mr. Chairman. It was a banner day yesterday.

I want to--I was just telling Congresswoman Capps about my sister and I think I am going to talk about that because it is why we have to do something about health care in this country. My sister is married to a fellow who has worked for one of the local school districts for many, many years and she is a stay-at-home mom. She home schools her kids. And they are middle-class Americans. Their insurance premiums working for the school district are $1,100 per month with copays and exclusions and everything else you can imagine. And about a year ago my nephew, as teenage boys will, was skateboarding and broke his arm at the skateboard park and his friend's parents couldn't find my sister to ask what to do. It was a compound fracture with the bone sticking out. So they took him over to the local emergency room and then her insurance company refused to pay the bill because they said they didn't get pre-approval, and that is what kind of health care system we are living with in this country and that is why we need to have comprehensive national health

care policy and that is why, Mr. Chairman, I am so grateful to you and also Mr. Dingell and also the President for pushing this through. We have got to do something about a system where we are spending over $2 trillion a year but our health outcomes are abysmal.

I just want to reference really quickly two studies that we have seen recently. In 2007, the Commonwealth Fund did an international health care survey where they compared the American health care payment and service delivery system to six other countries and found huge disparities. For example, the United States spends $6,697 per capita on health care services, which is more than double the per capital expenditures of all the other countries. Canada was the next highest, spending only $3,326 per capita. Well, you could say we have the best health outcomes in the world, which is what many people assume. However, this is simply not true if you look at the rest of the data. For example, the most recent data from the Centers for Disease Control ranks the United States 29th worldwide in terms of infant mortality and it also ranks us 31st worldwide in terms of life expectancy and 24th in terms of women's health. The United States ranks 37th overall in the world for health outcomes, just below the Dominican Republic and Costa Rica and just above Slovenia. So if anybody thinks that we don't need health care reform in

this country, they not only need to look at these statistics but the statistics that average American families, middle-class families are dealing with every day.

Thank you very much, Mr. Chairman.

[The prepared statement of Ms. DeGette follows:]

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Mr. {Pallone.} Thank you.

Next is the gentleman from Texas, Dr. Burgess.

Mr. {Burgess.} Thank you, Mr. Chairman. I appreciate you holding this hearing as well, you know, so much of what we discuss. I have an opening statement that I will submit for the record. It is very thoughtful and well written. But let me just make a few comments because of what I have heard.

We spend so much time talking about cost and coverage, and I do implore us to remember that health care is first and foremost and always about taking care of people. I also urge us not to let the perfect become the enemy of the good. Now, we have heard the President talk on Thursday of last week at the White House at the forum that the only thing that was not acceptable is the status quo. Well, true, there are things we can make better and that we should strive to make better but I promise you, having spent 6 years now in this body, I know we can make things worse and we must be careful that we don't do that. I certainly don't want to diminish the contributions of any of the men and women who work in the American health care system because I know firsthand what they do day in and day out, a tremendous job.

Now, just a word about 1993 and 1994. I was not here then. It is often talked about in health care policy circles

as the failure to improve health care in this country but I would just simply submit, the health care world in the United States has not been static since 1993 and 1994. Indeed, some of the things that came out of the failure of the Clinton health care plan, certainly medical savings account were one of the things that came out of that. The State Children's Health Insurance Program was one of the things that came out of the failure of the Clintons' plan, and I would argue that these are good things. On the issue of medical savings accounts, fast-forward to the present time with what we have seen in the improvements with health savings accounts. Just a personal story that I will share with you. In 1994 I had an adult child who finished college and moved back home and chose not to go to work. I don't recommend that if anyone is considering that for themselves. Don't try this at home. But I could not get an insurance policy for any price. I was willing to write a large check for that insurance policy. Fast-forward to today, and last Friday I went on the Internet and looked under ehealthinsurance.com, and for what would be a comparable situation, a 25-year-old female, and I used the Washington, D.C., area code, actually you could purchase an HMO plan through Kaiser here in D.C., $98 a month with a $20 copay but not a high-deductible plan. In fact, there was no deductible. So there are options out there for people who

find themselves without insurance that were not available in 1993 and 1994. So please let us not fool ourselves that the world has been static since then.

Certainly there are examples of how we can make things worse. Look what we did with the health information technology in the stimulus bill, and I tried to offer an amendment so that we could use these funds in June of this year but instead it is June of 2011, and we have doctors' practices all over the country that have literally listed the pen off the check and are going to wait an additional 2 years before they write that out.

We must look at the things that are actually working today. Affordability does remain key in the equation but let us look at the things that work and not just focus on trying to expand the things that don't. Certainly employer-sponsored insurance, the price is increasing over 7 percent a year. Medicare and Medicaid we know increase at 7.4 percent a year. Consumer-directed health plans increase at 2.2 percent a year. Shouldn't we take a lesson from Safeway and Walmart and what they have been able to do with forward-leaning plans that they have implemented before we just simply provide a program essentially equivalent to Medicaid for all? And if we are going to do Medicaid for all, shouldn't we also do that for Members of Congress? I

introduced an amendment like that on the SCHIP bill and I got no votes in the Rules Committee for that.

Dr. Zerhouni has come to this committee and talked about a time when medical care is going to become a great deal more personalized. He said because of the human genome we are going to be a great deal more predictive. We can as a consequence be a great deal more preventive, and it is going to require us to be more participatory. That is the direction in which need to be moving, not in a direction that is going to harm that forward progress that we have already made.

Mr. Chairman, you have been generous with your time and I will yield back.

[The prepared statement of Mr. Burgess follows:]

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Mr. {Pallone.} Thank you.

Next for an opening statement is Ms. Capps. Let me mention that once again she is the vice chair of this subcommittee and deservedly so since she has done so much work on health care, particularly on health care professionals.

Ms. {Capps.} Thank you, Mr. Chairman. I am so pleased we are beginning our hearings in this Congress on health reform. It is clearly, in my opinion, the number one issue this subcommittee needs to address, and as the President has articulated in his health summit and so many other places, our efforts at overhauling our Nation's broken health system are really integral to our work in improving the economy.

I am eager to hear from today's witnesses about how we arrived at this point in the first place. Why does the United States--and we have heard a lot of documentation in the opening statements so far--with all of our innovation and our spending, why do we measure up so purely against other industrialized nations? Why do we have such high infant and maternal mortality rates? Why do we have a lower life expectancy? Why do we pay so much more but receive so much less? Our next steps, of course, are how to address these factors that plague our health care system. I am counting on

a certain absolute, that in any solution we offer or pursue, we should bring and will bring prevention and wellness back into the fold as a core ideal.

During the Bush Administration particularly, there was very little attention given to the importance of prevention in health care, and because of that our Nation's public health infrastructure has suffered. We need a system that incentivizes primary and preventive care, not only that simply responds to chronic diseases and emergencies, often in the emergency room. We need a system that invests in our health workforce so that enough nurses, physicians and a myriad of other professionals are available to treat people and to work with them, not only that divests from medical and nursing education or cuts reimbursements. I am glad to see this issue is on the agenda for future hearings.

In closing, I just want to underscore the urgency with which we must address the current crisis. It is very real today in the communities we represent and communities across this Nation in rural areas and in the inner cities. I very much look forward to hearing what our witnesses are saying today, and I yield back.

[The prepared statement of Ms. Capps follows:]

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Mr. {Pallone.} Thank you, Ms. Capps.

And next for an opening statement, another one of our health care professionals which we have quite a few on this subcommittee, the gentleman from Georgia, Mr. Gingrey.

Mr. {Gingrey.} Mr. Chairman, I thank you and I want to thank of course overall committee Chairman Waxman and former Chairman Dingell, our ranking member, Joe Barton, and the ranking member on this health subcommittee, my colleague from Georgia, Congressman Nathan Deal. I also want to thank Dr. Todd Williamson from the great State of Georgia, who is chairman of the Medical Association of Georgia, a neurologist, a practicing physician from Lawrenceville, Georgia.

Like my colleague from Texas, Mr. Chairman, I have a statement too that is fantastically written and I want to just submit that for the record, but I actually didn't write it, my staff wrote it, and I want to give them all due credit but I would like to ask unanimous consent to submit my written statement for the record, and I will just make a few off-the-cuff comments.

I agree with the President, I agree with the Democratic majority and many of my Republican colleagues that we need to do something on health care in this country which I believe

is the best in the world. At the same thing, I think that we have the best of times and the worst of times, and that is to say that while what we are doing with medical care in this country I believe is the best in the world, the reason the statistics are so bad as Ms. DeGette and others have mentioned is the fact that we have 47 million people who don't have access to affordable coverage and we have too many underinsured, and as a result of that they put off getting needed care, going to the emergency room, going to their doctor. The availability is there but they don't have the money so they wait until things are so bad that it is really costly and that is why it is the best of times and the worst of times.

I think we need to look very closely though at what we can do to make sure that we improve our system. There is so much room for improvement. My thoughts have always been that if there is a real emergency to get something done by August 1 of this year, even when we our economy is suffering tremendously and we are trying to get that back on track, then maybe the money that we are spending, the $19 billion on having a fully integrated comprehensive electronic medical records system is a direction in which we need to go as well as a liability reform, which we have needed since California did it way back in the late 1970s. So there are many things,

Mr. Chairman, that we can do.

As I close my remarks, I just want to say that we don't want to destroy the marketplace and we don't want to destroy the doctor-patient relationship, which is so important if we are going to continue to get the brightest and the best young people to go into this wonderful profession, and I will yield back at this time, Mr. Chairman.

[The prepared statement of Mr. Gingrey follows:]

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Mr. {Pallone.} Thank you.

I next recognize for an opening statement the gentleman from Texas, Mr. Gonzalez.

Mr. {Gonzalez.} Waive opening.

[The prepared statement of Mr. Gonzalez follows:]

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Mr. {Pallone.} Thank you.

And next, the gentleman from Pennsylvania, Mr. Murphy.

Mr. {Murphy of Pennsylvania.} Thank you, Mr. Chairman, and thank you for doing another hearing on what we need to do with health care reform.

I want to bring attention an aspect here which I still hope that someone in this federal government will deal with and that has to do with waste and inefficiency and its additional costs in this whole system here, and I do believe we have a great system of health care. I also believe that unfortunately sadly enough we waste a lot of money in this whole system and that leads to a lot of deaths. Let me just raise a few issues here, and here I also want to credit Dr. Gawande. Thank you for the great article in the New Yorker. I hope I am here later when you testify, but you point out a couple of things we need to pay attention to and that is that there is a lot of money and a great many lives we can save by practicing health care and along these lines making sure government supports the doctor-patient relationship and doesn't get in the way.

We look at statistics such as 90,000 to 100,000 deaths each year from infection and costs $50 billion to $52 billion. Programs like the Keystone Initiative have been

able to save a lot of lives and save a lot of money, which helps make health care more affordable. Using these numbers, so far this year there has been 378,082 cases up to this moment of this hearing, 18,713 deaths and a cost of $9,452,000,000. These are unacceptable, and as long as we continue to talk about quality, affordable, accessible health care, we have got to deal with these issues of true quality. The list goes on and on. The underuse of appropriate medication such as generic antihypertensives could safe us another $3 billion a year if that was corrected. The underuse of medications for pediatric asthma could save us another $2.5 billion. One of the things that the government did in its infinite wisdom has said that the aerosol for asthma should no longer contain air that affects the ozone, so that was removed, new substances were put in that made the asthma medications brand name and raised the prices and I don't know what that has done in terms of increasing admissions to hospitals since those studies have been reported.

The overuse of medications such as antibiotics adds $8 billion to the cost. You also have to deal with untreated complications that come from mental illness that is associated with chronic illness and yet what is happening in situations like this, we need programs that do real case and

disease management to look at what kind of complications and problems are coming from underuse of medications, overuse of medications, referrals that are not needed, treatments that are needed, but instead we are talking about cutting programs like Medicare Advantage without looking at what Medicare Advantage does.

To the extent that it works on prevention, disease management and wellness programs, I hope this committee reviews what can be done in assisting those things, but this idea of saying that what we ought to do is just look at universal health care without looking at what we are doing for health care has got to stop. Along those lines, Mr. Chairman, a report came out in the last couple weeks from the New England Health Care Institute called Waste and Inefficiency in the U.S. Health Care System, clinical care conference of analysis in support of systemwide improvements. This report says that in our $2.3 trillion health care system, we have between $600 and $800 billion of waste that is hurting people, that if we removed this it doesn't hurt health care, it actually improves health care, and that certainly helps meet our goal of affordable, accessible, quality health care.

Mr. Chairman, I would like to submit this to you and hope this is something that members of the committee would

have access to and perhaps include this in the record. It is a review of a lot of studies and the kind of things we should be looking at.

I end with this. I have known a number of people who have been hurt and harmed in hospitals, and we don't usually do this but I am just curious. We have a good-sized audience out here. How many people here know of someone who went into a hospital or clinic and ended up getting an infection that made it worse? Raise your hand. I submit for the record, Mr. Chairman, there are a lot of lives we can be saving out here if we took efforts on this.

I yield back.

[The prepared statement of Mr. Murphy of Pennsylvania follows:]

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Mr. {Pallone.} I thought that we were going to have like we did the other day with Mr. Buyer and you were going to get up with the chart and I was going to feel like I was in a classroom again. But thank you.

As I mentioned, we have quite a few health professionals. Mr. Murphy is a psychologist and now we have our colleague from the Virgin Islands who is also a physician, Ms. Christensen.

Ms. {Christensen.} Thank you, Mr. Chairman, and thank you, Chairman Pallone and Ranking Member Deal, for bringing the subcommittee into the health care reform process early and planning a series of hearings that we are going to have so that we can fulfill our responsibility on this vital issue, and although I am not practicing medicine today, I am always going to be a physician so I come to this from the same perspective of Dr. Williamson and others that I have heard speak to this today. Physicians though too often blamed are not the cause of the problem but restoring the integrity of the physician-patient relationship can be a part of the solution and I hope it will be. I put the blame, largely it rests with the reimbursement system and the failure of our country to provide universal coverage, but fixing this country's system of non-health care delivery and

making it work for families will require far more than providing coverage. It must include addressing and ending our long history of unequal access to health care for racial and ethic minorities, for women, for families in rural areas, for gay, lesbian and transgender communities and anyone perceived as different or who speaks differently or who is far enough away to be ignored such as those of us who live in the territories.

I had a chance to look at some of the testimony and I just want to make some comments. Mr. Levine, I support increasing and expanding Medicaid but I do share some of your concerns about Medicaid because increased access has not always resulted in better health outcomes but I think that this is due in part to assumptions that discriminate against women, against people of color and the poor, and that is why aggressively moving to increase providers of diverse backgrounds at all levels of our health care system has to be a part of designing a high-performance health care system.

Mr. Hackbarth, the commission has a heavy responsibility because so many important policy decisions rely on your recommendations and I hope that you will be able to assure me that the territories will receive equity in those recommendations.

Dr. Gawande, I have really been impressed with not only

your testimony but what I have heard and read from you in the past. I am concerned, though, that you don't reference the issue of disproportionate burden of disease borne by people of color and rural Americans in your testimony or address the elimination of health disparities in your recommendations.

Director Elmendorf, you are part of our Congressional family and I look forward to working with you, especially because I think we have a little work to do to convince you on the savings that really will be realized from universal coverage and prevention, so I look forward to that.

And lastly, Mr. Ebeler, I thank you for all of the work that the IOM has done on the issue of the uninsured. The institute has clearly shown that this is not just a problem of those who are unfortunate as not to have coverage but it is a problem that increases the cost and undermines care for everyone. All of the vulnerabilities you list speak directly to health disparities which must be an essential focus as we work on health care reform if it is to be successful.

So I look forward to all of the oral testimony and the dialog that will follow and I thank all of you for being here this morning.

[The prepared statement of Ms. Christensen follows:]

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Mr. {Pallone.} Thank you.

Next is the gentlewoman from Tennessee, Ms. Blackburn.

Ms. {Blackburn.} Thank you, Mr. Chairman. I thank you for the hearing, and I along with my colleagues am looking forward to a discussion of how we reform the health care system and what route we are going to travel here. There are some who would like to see it move toward a government-run entity, and coming from Tennessee, where we have had the TennCare experience and many would argue that the TennCare delivery system is probably the most broken health care delivery system in the Nation and that it is evidence or should be evidence to us that a government-run system will encourage cost overruns, mismanagement, inadequate service, rationing or elimination or diminishment of care in certain areas of the State and also it has become evident from the TennCare experience that the estimated savings or the projected savings, the expected savings were not evident because of increased usage and the other problems that I previously mentioned.

Rather than encouraging expansion of inefficient and ineffective government bureaucracy for a health care delivery system, I feel that we should be putting our time and energy focusing on how to foster competition, how we would actually

reduce cost and provide choices for patients and consumers. I do believe in consumer-driven health care, which empowers patients to make the best choices for their individual needs and to do that with a physician and also as they are choosing an insurance product that best suits them, and the medical savings accounts were mentioned earlier by Dr. Burgess and the impact that they have had. Transformation to consumer-driven health care and putting our focus there would create consumer demand for information on prices, on quality. It would also shift us toward greater transparency, which other of my colleagues have mentioned is a need that we have for the health care delivery system. Our constituents are telling us they would like to have access to information about quality, about outcomes, testing procedures so that they can be an informed consumer. Mr. Deal had mentioned the need for medical liability reform. I associate myself with his remarks there.

I welcome our witnesses today. We look forward to a robust debate and for continuing the hearings, Mr. Chairman, that you will continue to have on this issue, and I yield back.

[The prepared statement of Ms. Blackburn follows:]

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Mr. {Pallone.} Thank you, Ms. Blackburn.

Next is the gentlewoman from California, Ms. Eshoo.

Ms. {Eshoo.} Thank you, Mr. Chairman, for holding this important hearing. We know it is important just looking at the first panel, the director of CBO and the chairman of MedPAC, and of course, to be followed by the other witnesses.

I think that this is really the easy part is having the hearings, but the hearings are really the foundation for what we will come to do and that is to reform our Nation's health care system. I have been on this subcommittee for--this is my, I believe, 15th year, and what I have seen over the years are stops and starts. We have gone body part by body part to try and improve different parts of the system, have been successful in doing some of them. We have, I think, the world's finest doctors. I think we have the most innovative medical centers. We have progressed in leaps and bounds in bi technology and the life science technologies but our means of delivering care to patients is really inefficient and it is costly and it is often really counterproductive to maintaining good health, and this is now not only an issue for every American, and the American people are ahead of us on this, this is front and center an economic issue. The costs of our health care system in the country are just

absolutely killing us. We have increased it at a rate that has doubled that of inflation and that really should take everyone's breath away.

So obviously we need to reform, but I am very mindful that this isn't called the health care industry for nothing. There are tens or maybe hundreds of thousands of players and stakeholders so we have a ways to go, but as the President said, in good times we didn't do it, in recession we didn't do it, after wars we didn't do it; now is the time to do it. I don't think we can afford to keep going this way, and I think the Congress will work its will. I think that there are going to be a lot of very good ideas placed on the table. Some will be somewhat startling because they will take down some of the old systems and bring about new ones. I am open to all of those ideas, and I think that it is important for all of us to do that, and I don't think this is going to be done just by one party. We are going to really have to work together to get this done for the American people. I look forward to it, and maybe this will be--I have confidence, I am not going to say ``maybe'' that in my 15th year on the committee that we will get this done, so I welcome all the experts. We need the best ideas from the brightest and the best in our country, and I think that America is up for this. In fact, I think it is a demand of the American people that

we do so, and when we do, I think that the rest of the world will watch and learn from us because what America does is always a great lesson for the rest of the world.

So thank you, Mr. Chairman, for the kickoff on this and I look forward to the rest of it.

[The prepared statement of Ms. Eshoo follows:]

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Mr. {Pallone.} Thank you.

The gentleman from Arizona, Mr. Shadegg.

Mr. {Shadegg.} Thank you, Mr. Chairman, and I want to thank you for holding this hearing.

I want to jump off on the title, ``Making Health Care Work for American Families'' is the first part of the title and I think that is essential. I think this Congress can no longer tolerate the problems with the current system and therefore it must be reformed. The second half of the title is ``Designing a High-Performance Health Care System,'' and I believe we can do that but I believe we have to do that by beginning with an analysis of what is wrong with the current system. As the gentlelady just mentioned, one of the things that is wrong with the current system is that costs have spun out of control. It is not exactly difficult to figure out why costs have spun out of control. We do not have a system in America that rewards the efficient delivery of health care. We have a system that rewards the inefficient system of health care. What we have is a third-party control system where your employer picks out your health care plan and your health care plan picks out your doctor. I suggested to a colleague this morning, that would make about as much sense as if he said to me, okay, for the rest of my life you, John,

will pick out my homes, pick out my cars, pick out my suits and pick out my shoes and pick out everything else, pick out the food I eat and I will give those decisions to you. I suggested if he gave those decisions to me and I tried my best to make him happy, I wouldn't make him happy. We have created a system in health care in America where we have divorced the consumer of the health good from the person paying or selecting that good. Right now that system is a third-party control system where the employers pick the health care plan for their employees. Employees don't pick their own health care plan and we have biased the system to say the only economic system that works is employer care, and oh, by the way, if your employer doesn't provide you care, we are going to encourage you to buy care but we are going to punish you by saying that under the tax code you have to pay a third more for that health care than your employer does if he buys it. So we have rewarded a system that gives the decision to somebody other than you to select your health care and then we wonder why Americans aren't fit, why they don't eat right, why they don't control their blood pressure, why they don't control their cholesterol. I think if we look at the flaws in the current system that it is easy to understand where we should go. We should not go to another third-party control. It seems to me it makes no sense to

take third-party control by employers and plans and give that third-party control to the government. I got a flash. If I said to the government, you buy my cars in the future, you buy my house in the future, you buy my suits and my shirts and you pick out the food I eat, the government wouldn't do any better job at making those decisions for me than my employer is, so what is the option? The option is in fact universal health care. This country has decided that nobody should go without health care, that we can give every single American health care and at the same time preserve choice. How do you do that? Well, you let the people that have the financial means to buy their own health care buy their own health care and you give them a tax credit to do that and you say go buy your own health care, but for every other American you say to them, we are going to give you a stipend, we are going to give you a chunk of money and you go make choices about your own health care, you buy a plan that meets you. Now, what about some person who doesn't respond and doesn't take up that plan? We put them in a pool and we say to them, if you need health care and you show up at a doctor's office, we are going to give you the health care. That way we preserve choice, we preserve consumers' ability to make their own individual choices about health care. That will both bring down cost and bring up quality, and it is a system we

can implement and will cover every single American. I hope when we begin to design a system for health care in America, we look at the President's eight points. I think every single of those fits with what I have just described and I believe we can do it and we can do it for every single American, and I thank the gentleman and yield back the time I don't have.

[The prepared statement of Mr. Shadegg follows:]

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Mr. {Pallone.} Thank you.

The gentleman from Maryland, Mr. Sarbanes.

Mr. {Sarbanes.} Thank you very much, Mr. Chairman, and I want to congratulate you on now launching this discussion on health care reform, much needed, and I am looking forward to the various panels that we see. If and when, as Congresswoman Schakowsky said, we achieve health care reform, it will only be partly because of the arrival of some of the newer members in recent years. It will be mostly because of the incredible work that you and others, Chairman Waxman, Chairman Dingell and other distinguished members of this committee have performed for so many years. It is a great committee with a great challenge before it.

The broken health care system that we are all alluding to is one that really has two sets of victims. I had the privilege of working for almost 18 years as a lawyer with hospitals and physicians and clinics and nurses and other providers, and I say ``privilege'' because I have never witnessed the level of professionalism that I have when it comes to people that work so hard in our health care industry every day on the provider say, and they are one of the victims. They are one of the sets of victims here in this broken health care system because they are carrying it on

their back right now. The other set of victims of course are patients and the consumers of health care, and, you know, most Americans don't really have any idea what the perfect design or even close to good design of our health care system will be. But for millions of Americans who are uninsured and underinsured, what they do know is that they get up every morning and they can't breathe. They are burdened by a corrosive anxiety that eats away at their self-dignity and eats away at the stability of their families, and that is why we have got to get this done and I look forward to the hearings that are coming forward and I look forward to getting health care reform done in a timely fashion.

I yield back. Thank you.

[The prepared statement of Mr. Sarbanes follows:]

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Mr. {Pallone.} Thank you.

The gentleman from Pennsylvania, Mr. Pitts.

Mr. {Pitts.} I will waive.

[The prepared statement of Mr. Pitts follows:]

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Mr. {Pallone.} The gentleman waives. The gentleman from Ohio, Mr. Braley.

Mr. {Braley.} I was confused by the reference to Ohio but I will be glad to--

Mr. {Pallone.} Did I say Ohio? I meant Iowa. I apologize.

Mr. {Braley.} Thank you, Mr. Chairman, and thank you for holding this important hearing. I am looking forward like many of the other members of the panel to helping the subcommittee address health care reform over the coming months, but as we look at ways to design a high-performance health care system, I want to draw everyone's attention to two issues that directly impact the overall performance of this system: one, geographic inequity in Medicare reimbursement, and two, the considerable variation in health care quality across this country.

The current system that we have in place has built-in inequities that result in a lack of access to care for residents in many rural states like Iowa. An example of this can be found in the Geographic Practice Cost Indices, or GPCIs. These antiquated figures ensure that some parts of the country receive drastically lower Medicare reimbursement rates than other parts and have led to a tremendous shortage

of health care providers in certain parts of the country, and in an attempt to achieve some leveling of geographic inequity in physician reimbursements, the Medicare Modernization Act of 2003 established a temporary floor of 1.0 for the work GPCI, which helps level the playing field for physicians in Iowa and other rural States. Congress has had to extend this floor repeatedly yet the floor on the work GPCI still does not go far enough. Despite the well-documented efficiencies of Iowa's health care system, Iowa health care providers still lose millions of dollars because they choose to care for Medicare patients. Last Congress I introduced the Medicare Equity and Accessibility Act, which addresses the GPCI problems. I will continue fighting for a permanent work GPCI floor as well as a practice expense GPCI floor, but frankly, this is only a Band-Aid for a broader problem. While Iowa's access to care ranks low, the State's quality of care consistently ranks right at the top. Iowa physicians, hospitals and health care personnel are unrivaled and are a primary reason why Iowa consistently ranks in the top 10 healthiest States. Unfortunately, the way our current health reimbursement system is set up, it is not based on the quality of care provided but instead incentivizes quantity of care, which results in considerable variation in quality around the country.

I hope this committee takes a serious look at proposals to incentivize quality and efficiency such as value-based purchasing models. This fundamental shift in our reimbursement system would lead to a tremendous improvement in the quality of American health care. Instead of a business model that encourages physicians and hospitals to get patients in and out as quickly as possible, we would have a system that encourages them to make sure the patient is healthy. That is what really matters. By including efficiency measure and value-based payment programs, we can keep costs down for our patients in our federal payment programs. By aligning incentives across hospitals, programs and physicians, we could achieve greater interoperability, and by encouraging care coordination such as through the medical home concept, we can further deliver better and more efficient health care.

So I want to thank you, Mr. Chairman, for tackling the important issue of health care reform and I want to thank all the witnesses for spending time with us today.

[The prepared statement of Mr. Braley follows:]

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Mr. {Pallone.} I thank the gentleman from Iowa.

Next is the gentleman from Michigan, Mr. Rogers.

Mr. {Rogers.} Mr. Chairman, I will submit my statement for the record in lieu of questioning time.

[The prepared statement of Mr. Rogers follows:]

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Mr. {Pallone.} Thank you.

Next is the gentlewoman from Illinois, Ms. Schakowsky.

Ms. {Schakowsky.} Thank you, Mr. Chairman. In some ways I think I have been waiting for this hearing all of my adult life. As my goal as a public official, I will die a happy woman if it says on my tombstone or urn or whatever they do with me, that she helped bring health care to all Americans, and I think this is the first of a process that I hope moves rather speedily. The President has targeted actually signing the bill after the August recess so we have a lot of work to do.

I think it is a total embarrassment that the United States of America, the wealthiest country in the world, does to provide health care to all of its people like every other country in the industrialized world. It is a moral issue, it is an economic issue, and one that may be controversial here in this body but actually outside of this room and in the country most Americans are ready for change, they are ready for big change and they see an important role for government in that change. Anyone who thinks that we have good access to health care doesn't live in the real world. In my State alone, 1.8 million people have no health care but that is just the beginning, the tip of the iceberg. The number of

people who are uninsured, over half of Americans say that they have delayed health care or foregone health care because they can't afford it. As people lose their jobs, 650 people every day in Illinois right now losing their job, 14,000 people losing their health insurance every single day, this is a crisis that cannot wait to be solved.

So I want to make one other point. There has been a lot said about having a public health insurance option, the choice which 73 percent of Americans say they would rather have a choice of a public option or a private option. If their private plan works for them, fine. But I would say it is the private health insurance industry that has some explaining to do. Medicare is one of the--people come into my office and say I can't wait until I am 65 years old, I am sick right now and I am looking forward to my 65th birthday so that I can actually get the health care that I need, and persons with disabilities and seniors have been lifted out of poverty because of the successful social insurance program along with Social Security. The Commonwealth Fund did a study and found that designing a health care system that covered everyone including a public health insurance option over 11 years would say $3 trillion to do that. In 2008, private market health insurance premiums rose by 5 percent to nearly $12,700 for a family of four, $4,700 for individual

coverage, and so private insurance is increasingly out of the reach of Americans, and so what the President has proposed is to have this option of the public health insurance program or private. I think that ought to be a centerpiece of any plan that we adopt, and I yield back. Thank you.

[The prepared statement of Ms. Schakowsky follows:]

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Mr. {Pallone.} The gentleman from Texas, Mr. Green.

Mr. {Green.} Thank you, Mr. Chairman, and I appreciate the time. Following my colleague from Illinois, I know your current Senator was concerned about what was going to be on his tombstone. I want to, like my colleague from Illinois though, having moved to the Energy and Commerce Committee in 1997, this is one of the most important hearings I think we can have because it is a start on what we are going to do in this Congress to change how health care is provided to our country.

I come from the State of Texas, where we have the highest percentage of uninsured in the country and have the highest number of uninsured in the country. There are a lot of reasons for that, and I am glad the President also in his budget released a couple weeks ago is planning to take action on health care. I also like the principles he laid out for us last Thursday instead of sending down a large piece of legislation to try to dot all the i's and cross the t's, that is Congress's job is to draft legislation. Give us the goals and we will do everything we can to get to it.

Again, this is our first hearing. We currently have 47 million people uninsured in our country, and overall health care is consuming ever-increasing amount of our resources.

Health care expenditures are now 16 percent of the GDP with the rate going to maybe 2017. Unfortunately, we are paying more for the cost of health care but seem to be receiving less and fewer people have access to quality and affordable health care. The current economic times make it even harder for individuals that are uninsured simply because their companies can't afford health premiums so their employees can't afford to pay their percentage of the premium.

We recently passed the American Reinvestment and Recovery Act, which I strongly supported and extended COBRA subsidies for these individuals that lost their jobs, which is wonderful for those who had insurance before they lost their jobs. Unfortunately, in a blue-collar district like I represent, most individuals never had access to health care in the first place because they are in low-wage jobs. Too many individuals in our country are unemployed or uninsured and all too often end up in the emergency room with very costly medical issues that could have been prevented with access to primary and preventative care. We can't continue to shore up a health care system with short-term fixes instead of long-term solutions. We also cannot continue down the path with costly health care and more uninsured.

I am glad we are taking our first step in addressing the health care crisis, and I welcome our witnesses today to be

the leadoff witnesses. I have a saying in Houston. We have one of the greatest medical centers in the world, the Texas Medical Center. On a clear day in Houston, we can see the medical center but most folks in my area can't get to it because they lack health care unless it is through our public hospital system.

And with that, Mr. Chairman, I yield back my time.

[The prepared statement of Mr. Green follows:]

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Mr. {Pallone.} Thank you.

The gentleman from Ohio, Mr. Space.

Mr. {Space.} Thank you, Mr. Chairman. I look forward to working with you as we begin this comprehensive debate on how we deliver health care in America.

I think as we move forward, many of my colleagues have raised very important and legitimate issues. The health IT program, coordinated care, preventative measures, rewarding positive lifestyles, punishing negative lifestyles, but one element that I am hoping we won't forget about is the importance of cure, curing disease. There has not been a significant breakthrough on a cure in this country since polio was cured, and cures are within our grasp and not only do we have a moral obligation to alleviate or mitigate human suffering, cures end up being a very economically effective way of handling the health care crisis. In 2007 this Nation spent $178 billion on one disease, diabetes. That is more money that we spent in Iraq. With a small percentage of those monies that were spent in that one year and that are spent every year at an increasing rate, we could cure the disease within 5 to 10 years either naturally or artificially, providing every type 1 diabetic with a closed-loop artificial pancreas, mitigating and eliminating the

expenditure of trillions of dollars over the next 30 years. That is one disease. Imagine what we could do if we invested in a cure for cancer, for heart disease, for liver failure, even for things like autism. We are, Mr. Chairman, I think, remiss in failing to address cures with an aggressive posture, and I am hopeful that that will be a part of this debate as we move forward. In the end, I think we all share a common goal and that is providing affordable access to quality health care. I don't care how we get there but we have to get there.

I yield back.

[The prepared statement of Mr. Space follows:]

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Mr. {Pallone.} Thank you.

The gentlewoman from Wisconsin, Ms. Baldwin.

Ms. {Baldwin.} Thank you, Mr. Chairman.

Addressing our health care crisis is the issue that brought me to public service in the first place so I do want to truly thank you, Mr. Chairman, for holding this hearing and getting us started on this enormous task that is before us, and I want to thank all of our witnesses in advance because your expertise is going to be invaluable to us in the process.

In a report released last week on the series of health care communities' discussions held around the country, the Department of Health and Human Services found that more than anything else, Americans want a system that is fair. No matter what your circumstance or background, the American health care system should perform well for you too. To that end, I will address briefly the three major issues that we all know so well: access, quality and cost.

As we will hear today, being shut out of the system is deadly. Uninsured adults are 25 percent more likely to die prematurely than insured adults, and if they have a serious chronic condition, the situation is worse, and every day more and more people are falling into the ranks of the uninsured.

Erosion of employer-based coverage and the challenges of the individual market demand our immediate attention.

A high-performance health care system by definition must also deliver quality care, and I strongly believe that providers can use performance measurements to drive quality improvements. A leader in this respect is a hospital in my own district, the University of Wisconsin Hospital on Clinics. They have led the way in several nationwide efforts to benchmark performance. They consistently rank among the top five academic medical centers in the country according to five key metrics: mortality, effectiveness of care, safety, equity and patient centeredness. These efforts at public reporting and the sharing of best practices demand excellence from our health care system.

Lastly, I want to quickly address the issue of cost. We are operating under an assumption today that at first glance seems implausible, hat we can pay less for our health care and get more from it, and yet the data is clear. Our current system is wildly inefficient. Some of the highest cost regions produce poor patient outcomes. Some of our lower cost regions produce some of the highest outcomes.

I would like to personally thank our witnesses on our first today for your invaluable assistance in helping us to solve this problem. MedPAC has recommended significant

restructuring of the payment system, suggesting that we pay for care that spans across provider groups and types and time in order to hold providers accountable. For me, health reform is an endeavor that is both intellectual and emotional. As a Member of Congress, I know that we must control the unsustainable spending in our health care system. As a representative of the men, women and children in the 2nd District of Wisconsin, I know we must fix our broken system so it can reach and serve everyone.

Again, thank you to our witnesses today for being here and, Mr. Chairman, for beginning our work in earnest.

[The prepared statement of Ms. Baldwin follows:]

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Mr. {Pallone.} Thank you.

The gentleman from Arkansas, Mr. Ross.

Mr. {Ross.} Thank you, Mr. Chairman, and like Dr. Burgess and some of the others, I had a prepared statement that I will submit for the record but most of what I said in that has already been said, but I would like to speak for a moment from experience and from a rural perspective, if I may.

I served for 10 years on the State health committee in Arkansas in the State Senate and that is where I learned that any real reform had to happen at a national level and it inspired me to run for Congress and to seek this committee and seek this subcommittee. It is the rural perspective I took to the health care summit at the White House last week in our breakout session. My experience as a pharmacy owner, someone married to a pharmacist and being from a small town, I can tell you I have seen too many people walk through the doors of that pharmacy that could not afford a $30, $40 or $50 medication, and living in a small town, I would learn when they were in the hospital a week later running up a much higher bill, if you will.

We have got to make health care affordable and accessible and available for everyone. My hometown is much

like my district. I represent 150 towns, and half my constituents don't live in any of them. They live down this gravel road or that gravel road, and it is important that those folks have access to health care too. My hometown is a good representation of my district. It is 3,600 people when I am home and two traffic lights. Just a few years ago we had six doctors, five pharmacies and a hospital. Today we have got three doctors, two are over the age of 60, two pharmacies and no hospital. The nearest hospital is in Hope, Arkansas, 16 miles away, and now it is struggling to keep its doors open. If it closes, we will be 40 miles from the nearest hospital.

The leadership of the hospital in Hot Springs, Arkansas, the largest town in my district, wanted to meet with me recently and they wanted to tell me how Hot Springs cannot attract doctors. It has got a high retirement-age population, a lot of sick folks, it is on a lake, and it is in a national park. By Arkansas standards, it is a prime place to live, and if we can't attract doctors there, what about these other 149 towns that are much smaller and much more rural? So I would ask that rural health care be an important part of any reform, and I can't help but think, Mr. Chairman, back to the days of Oren Harris. His portrait is right here. He comes from my district. He chaired this

committee. He began chairing this committee 5 years before I was born and he was trying to reform health care then, and that was 53 years ago, and I hope that we can get it done and get it done right this time.

With that, Mr. Chairman, I pledge to work with you. Please keep rural health care an important part of any reform debate. Thank you, and I yield back the balance of my time.

[The prepared statement of Mr. Ross follows:]

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Mr. {Pallone.} Thank you.

The gentlewoman from Florida, Ms. Castor.

Ms. {Castor.} Thank you, Chairman Pallone, for this first in a series of hearings to reform health care in America and make it more affordable for businesses and families. Together with President Obama, we have already hit the ground running to improve the health care of Americans with the enactment of the landmark children's health bill, the SCHIP. The American Recovery and Reinvestment Act also provides much-needed assistance in COBRA payments for folks who have lost their jobs and aid to States for Medicaid. We are not going to let our families fall through the safety net.

Now our larger challenge is to confront health care reform and I believe can tackle it with commitment and determination to develop quality, affordable health care options for Americans. In my home State of Florida, where we have the second highest rate of uninsured, families and businesses have been clamoring for access to affordable health care well in advance of the economic downturn and the rise in unemployment and home foreclosures. In Florida, it is estimated that more than six working-aid Floridians die each day due to a lack of health insurance. The inability to

afford basic health care poses a major threat not only to the well-being of families but to our economy as a whole. Nearly half of home foreclosures in 2006 were caused at least in part by financial issues stemming from a medical problem. As President Obama noted just last week, the cost of health care now causes a bankruptcy in America every 30 seconds.

Now, there will be many outstanding ideas and I look forward to hearing from our witnesses. I believe particular focus and attention must be paid to the primary care system and preventative medicine, also to the health care professions, especially this very arbitrary cap on physician resident slots that penalize States that have high growth and high population, nursing shortages, Medicare reform. With everyone's help and my colleagues' expertise, I am confident that we will reduce health care costs for families and businesses and hopefully our national budget. The time to act is now.

I yield back my time.

[The prepared statement of Ms. Castor follows:]

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Mr. {Pallone.} Thank you.

The gentlewoman from Ohio, Ms. Sutton.

Ms. {Sutton.} Thank you, Mr. Chairman, for holding the first of many important hearings on health care reform.

Health care reform is a critical component to our economic recovery and our Nation's competitiveness. As health care costs rise, neither employers nor employees can afford them, and if one loses their job, the situation is even more daunting.

I would like to begin today talking about a family in my district, the Lee family. Mr. Lee has always had health insurance through his job but when his company laid him off last year, he and his family lost coverage. Mrs. Lee tried to get coverage through her job but she didn't qualify because she was a part-time employee. Now, having a family with medical problems ranging from diabetes to degenerative joint disease and being without health insurance has created a very, very difficult problem for the Lees, and unfortunately, Mr. Chairman, this is a situation that is familiar to far too many Americans. The Lee family is certainly not alone. In Ohio, there are over 1.2 million people without health insurance, and Mr. Chairman, this causes an amazing outcome. According to Families USA, two

Ohioans die each day because they lack health care coverage. I want to say that again. In Ohio, two Ohioans die each day because they lack health care coverage.

Many Americans have to forego health care in order to put food on the table or keep a roof over their head. That is unacceptable. Our health care system must be reformed, and as a member of this subcommittee, I look forward to working with my colleagues and the American people to make it happen finally, and I look forward to hearing from our panelists today about this important issue and their insight into how we might go about making this become a reality.

I thank you, and I yield back the balance of my time.

[The prepared statement of Ms. Sutton follows:]

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Mr. {Pallone.} Thank you.

The gentlewoman from New York, Mr. Engel.

Mr. {Engel.} Well, thank you for holding, Mr. Chairman, this hearing today on making health care work for American families.

It is clear to so many of us that our health care system is broken. For years we have been talking about the 47 million and growing uninsured Americans and 25 million underinsured Americans, and it is apparent that some people have come to accept this tragedy as a fact of life, that some people are fortunate to have health coverage and some people, millions and millions of people aren't, so too bad for them. In truth, it has often been said, everybody does better when everybody does better. We can do better. The status quo is no longer acceptable.

In the first 2 months of the Obama Administration, we made significant strides toward improving our current health care system. Our reauthorization of the State Children's Health Insurance Program provided health care coverage for 11 million children, preserving coverage for the roughly 7 million children already covered by SCHIP and extending coverage to 4.1 million uninsured children who are eligible for but not enrolled in SCHIP and Medicaid. We made a solid

investment in modernizing our health care system in the stimulus by making key investments in health information technology. Wide-scale adoption and implementation of health information technology will be a fundamental part of any true health reform bill. The $19 billion designed for HIT will eventually enable our health care system to save billions of dollars, reduce medical errors and improve quality of care. Many of the measures included in the stimulus ranging from extra Medicaid funding for States to subsidizing COBRA insurance for unemployed workers will help to stop the bleeding during this terrible recession.

Long term, though our health care delivery system requires a comprehensive implementation of sustainable reforms in order to succeed. The President is off to the right start with this commitment to health reform. His $630 billion down payment towards health reform coupled with the Administration's eight principles will guide Congress in our joint efforts to revamp our health care system. With the United States paying more than $2 trillion a year for health care, we should ensure that we are getting what we are paying for, a world-class health care system for our Nation's hardworking citizens, and yet it is clear that our payment systems are flawed. As MedPAC has noted in its testimony today, Medicare's fee-for-service payment system rewards more

complex care without regard to the value of this care. Bizarrely, for those with multiple ailments, coordination among providers is not encouraged financially by Medicare where clearly coordinated care would result in improved health conditions.

Mr. Chairman, thank you again for holding this hearing. You have a really been a champion in pushing these reforms and I commend you for it. I look forward to the work ahead of us this spring and summer on reforming and designing a quality health care system, and I yield back the balance of my time.

[The prepared statement of Mr. Engel follows:]

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Mr. {Pallone.} Thank you.

The gentlewoman from California, Ms. Harman.

Ms. {Harman.} Thank you, Mr. Chairman. I am very pleased to be a new member on this subcommittee though not new to these issues.

I am the sister and daughter of physicians and I recall very well a half century ago how my father handled his general practice of medicine. He was the neighborhood physician. He made house calls most evenings. He served three generations of patients in a small group practice in Culver City, California, during the time he practiced medicine. I was very proud of what he did and now I look back on it and it seems an Ozzie and Harriet alternate reality.

We can't go back there, Mr. Chairman, and we surely have to grapple with the problems described by so many of our colleagues this morning, but I must commend you for the panels in this opening hearing today and I especially want to mention Doug Elmendorf and congratulate him in his new role as director of CBO. He has been a valuable asset to many of us as we have tried to grapple with budget issues, and what I think he brings to this is obviously an understanding of the cost piece of health care but also great compassion for the

need to extend coverage to as many as possible in our country.

So I commend you for this hearing and I commend our witnesses and count me in on all plots to make a huge down payment on solving this problem this year. I yield back.

[The prepared statement of Ms. Harman follows:]

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Mr. {Pallone.} Thank you.

I believe that concludes our opening statements and so we will now turn to our witnesses. First of all, let me welcome the first panel and the two gentlemen and let me introduce you. On my left is Glenn Hackbarth, who is the chairman of the Medicare Payment Advisory Commission, or MedPAC, and to his right is Douglas Elmendorf, who is director of the Congressional Budget Office. We are really looking forward to your testimony. I have kind of looked at some of the written testimony and you deal very effectively with new ways of doing things and the whole cost efficiencies, which are so important to us.

We will start with Mr. Hackbarth.

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^STATEMENTS OF GLENN HACKBARTH, CHAIRMAN, MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC); AND DOUGLAS ELMENDORF, DIRECTOR, CONGRESSIONAL BUDGET OFFICE

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^STATEMENT OF GLENN HACKBARTH

} Mr. {Hackbarth.} Thank you, Mr. Chairman and Ranking Member Deal. I appreciate the opportunity. Many of my comments in my opening statement will echo themes that have already been heard.

Let me begin with a brief definition of health reform, at least in my mind. Health reform equals expanded coverage plus lower cost growth while maintaining or even improving quality of care. MedPAC's focus, as you well know, is on the latter set of issues, in particular using payment policy to improve the efficiency and the effectiveness of the care provided to Medicare beneficiaries. In some quarters, this has been labeled moving the system toward high performance. Let me start by emphasizing that the U.S. health care system has tremendous resources in the professionals who serve in that system. I have been fortunate in my career to work with talented physicians and advanced practice nurses and psychologists and other professionals and I know what talent

1707 and commitment they bring to their work. The problem we have
1708 is that Medicare's payment systems and those of most private
1709 insurers reward more care, more-complex care without regard
1710 to the value of that care to the patients. But equally
1711 important is that Medicare's payment systems enable what we
1712 have referred to as siloed practice whereby individual
1713 clinicians and organizations act independently of one
1714 another, even while caring for the same patient. Too often
1715 efforts at coordination and integration of care are sporadic,
1716 and where they occur their testimony to the commitment of
1717 individual professionals. They are not inherent in the
1718 system itself. The result is the care is all too frequently
1719 fragmented, duplicative and gap filled, and on occasion even
1720 conflicting as is the case sometimes with adverse drug
1721 interactions. Care of this sort isn't just expensive, it is
1722 dangerous, and it is dangerous in particular for patients
1723 with multiple complex illnesses, which is a common problem,
1724 as you well know, in the Medicare population.
1725 In the last several years MedPAC has recommended a
1726 series of changes in Medicare payment policy that we believe
1727 would help move health care to a higher level of performance,
1728 and let me just quickly mention some of those
1729 recommendations. First is increased payment for primary care
1730 services and perhaps a different method of paying for primary

1731 care services as is embodied in the idea of a medical home.
1732 Research demonstrates conclusively, in my view, that a strong
1733 primary care system is the foundation of a high-performance
1734 health system. In the United States at this point, our
1735 primary care system is weak and rapidly deteriorating. The
1736 second recommendation has been that we begin providing
1737 confidential episode-based feedback to physicians about their
1738 practice so that they can better understand how their
1739 practice compares to their peers, both in their local area
1740 and in their specialty. Third, we have recommended
1741 authorization of what we refer to as gain sharing between
1742 physicians and hospitals. The goal here it to encourage
1743 collaboration between physicians and hospitals both in
1744 reducing cost and in improving quality of care. Next we have
1745 recommended reduced payments for hospitals experiencing
1746 unusually high levels of potentially avoidable readmissions.
1747 About 18 percent of all Medicare admissions are followed by a
1748 readmission within 30 days at a cost of about $15 billion per
1749 year. A sixth recommendation is a pilot of what we have
1750 referred to as bundling whereby payment for a hospital and
1751 physician service provided during an admission would be
1752 combined into a single payment and perhaps combined with
1753 payment for post-acute services as well. Next, we have
1754 proposed reforms in the Medicare Advantage program so that

1755 participating private plans are engaged in promoting high
1756 performance in health care instead of offering plans that
1757 mimic traditional Medicare except at a higher cost. And
1758 last, we have urged public investment in comparative
1759 effectiveness research, which the Congress has already acted
1760 on in the Economic Recovery Act.
1761 This week at our MedPAC meeting we will also be
1762 considering the potential for what we have referred to as
1763 accountable care organizations, organizations that assume
1764 clinical and financial responsibility for a defined
1765 population of patients. We will be trying to figure out
1766 methods to pay such organizations that could reward
1767 efficiency and reduce cost for the Medicare program.
1768 Let me close with two quick cautions about the challenge
1769 ahead of us. First of all, changing payment systems and
1770 especially trying to do so quickly requires a lot of
1771 resources and I am very concerned, the Commission is very
1772 concerned about the level of resources that CMS has to pursue
1773 this agenda. A second caution is that while striving for
1774 payment reform, as important as it is, as vital as it is, we
1775 must also apply steady, indeed perhaps increasing pressure on
1776 unit prices under Medicare's existing payment systems.
1777 Thank you very much, Mr. Chairman, and I look forward to
1778 the discussion.

[The prepared statement of Mr. Hackbarth follows:]

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Mr. {Pallone.} Thank you, Chairman Hackbarth. Director Elmendorf.

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^STATEMENT OF DOUGLAS ELMENDORF

} Mr. {Elmendorf.} Thank you, Chairman Pallone, Ranking Member Deal, members of the subcommittee. I appreciate the invitation to talk with you today about the challenges and opportunities that Congress faces in trying to make the health care system more efficient so that it can continue to improve Americans' health but at lower cost.

Policymakers could seek to improve efficiency by changing the way that public programs pay for health care services or by encouraging such changes in private health care plans. In both sectors, these changes could in turn exert a strong influence on the delivery of care. To assist the Congress in its deliberations on this topic, CBO released last December a report titled Budget Options for Health Care. Drawing on this report, my testimony makes three key points.

First, a substantial share of spending on health care contributes little, if anything, to the overall health of the Nation. Second, reducing unnecessary spending without also affecting services that do improve health is challenging but many analysts will concur with the importance of providing stronger incentives to control costs and generating and disseminating more information about the effectiveness of

care. Third, despite broad support among analysts for moving in these directions, there is substantial uncertainty about the effects of many specific policies and many policies might not yield substantial budget savings or reductions in national health spending within a 10-year window.

Let me discuss these points briefly in turn. First, as you know, spending on health care has grown much faster than the overall economy for decades. This imposes an increasing burden on the federal government for which the principal driver of the unsustainable budget outlook is growth in per capita health costs, not aging. It also imposes an increasing burden on the private sector where the growth of health spending has contributed to slower growth in wages because workers must give up other forms of compensation to offset the rising costs of health insurance. When confronted with these costs, ever more firms and families drop their health insurance coverage. Concerns about the level and growth of health care spending might be less prominent if that spending was producing commensurately good and improving health. Unfortunately, substantial evidence, detailed in my written testimony, suggests that more spending does not always mean better care.

The second main point is that many analysts would concur with the importance of providing stronger incentives to

control costs and of generating and disseminating more information about the effectiveness of care. Many analysts would agree that payment systems should move away from a fee-for-service design and should instead provide stronger incentives to reward value. These incentives could be created in a variety of ways including fixed payments per patient, bonuses based on performance or penalties for substandard care. However, the precise effects of these policies are highly uncertain. Many analysts would also agree that the current tax exclusion for employment-based health insurance which exempts most payments for such insurance from both income and payroll taxes dampens incentives for cost control because it is open ended. Those incentives could be changed by restructuring the tax exclusion in ways that would encourage workers to join plans with higher cost-sharing requirements and tighter management of benefits. Moreover, many analysts would agree that more information is needed about which treatments work best for which patients and about what quality of care different doctors, hospitals and other providers deliver. But absent stronger incentives to improve value and efficiency, effective information alone will generally be limited.

Third, many steps that analysts would recommend might not yield substantial budget savings or reductions in

national health spending within a 10-year window. There are a number of reasons for this, again, further details in my written testimony, but briefly, in some cases, savings materialize slowly because initiative is phased in. In other cases initiatives that generate savings such as prevention efforts or disease management have costs to implement. In some cases the federal budget does not capture the reductions in national health spending. In other cases, new structures for health care delivery improve health but do not provide incentives to reduce costs. And in yet other cases, limited evidence about the effects on efficiency is available.

Let me conclude with two general observations. One is that given the central role of medical technology and the growth of health spending, slowing spending over the long term will probably require decreasing the pace of adopting new treatments and procedures or limiting the breadth of their application. Such changes need not involve explicit rationing but could occur as a result of market mechanisms or policy changes that affect the incentives to develop and adopt more costly treatments.

The other observation concerns the urgency of health care reform. In contrast with the situation in the economy and financial markets, our system for delivering and paying for health care is not fundamentally different this year from

last year. However, very few analysts think that the relatively gradual pace of change in health care is an argument for deferring reform. On the contrary, our current health system evolved over years and decades, and the changes needed to substantially improve efficiency will take years and decades to come fully to fruition. Nearly all analysts think those changes should begin soon.

Thank you.

[The prepared statement of Mr. Elmendorf follows:]

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Mr. {Pallone.} Thank you.

So we are going to have questions now from the members, 5 minutes, in some cases more, I think, if the members passed on their opening.

I wanted to start with Mr. Elmendorf because of the issue of primary care. Many experts such as Dartmouth researchers maintain that a lack of access to high-quality primary care contributes to inefficient care and geographic variations around the Nation and they say that if we invest more in primary care to improve quality and lower cost, you know, that that would be one of the main efficiencies that we could achieve. And I have to say that when you listened to President Obama at the summit last Thursday, he stressed, you know, this whole idea of health inflation and that somehow we have to curb the growth in cost. I think Karen Ignani from the health insurance trade group or whatever actually at my breakout session talked about, you know, curbing the growth of the inflation, if you will, and I have to give you a person experience. A couple of my staff people in my office in New Jersey have Cadillac health insurance, Blue Cross, whatever, and have had a problem getting a primary care doctor and on two occasions because they couldn't get a primary care doctor ended up going to an emergency room for

something that really wasn't necessary to go to the emergency room. We keep talking about people who have no insurance that go to the emergency room. Well, what about a Congressional staff person who has insurance and can't get a primary care doctor and goes to an emergency room?

So my question is, with regard to primary care and particularly within the Medicare program, I mean, you mentioned this patient-centered medical home as an option but talk a little bit more about what you see in terms of enhancing primary care and how important that is to the overall system in terms of cost efficiencies and trying to make a better quality system.

Mr. {Elmendorf.} Mr. Chairman, many analysts have worried for some time that our system does not reward primary care physicians the same way that it rewards physicians in specialties, and if you look across the country and compare medical centers that seem to be delivering very efficient medical care in the sense of low cost but medical care of high quality, those medical centers tend to have higher relative numbers of primary care physicians to specialists, and I think that sort to evidences the basis of some of MedPAC's recommendations in this area.

The options that CBO looks at, we looked at a number of them, regarding ways to empower or reward primary care

physicians, one is a proposal for establishing medical homes in which all Medicare recipients are assigned to primary care physicians and those physicians then oversee the way in which those patients receive care from other providers. The crucial issue for--and I think many analysts would agree that sort of focus on primary care physicians would lead to greater coordination of care, fewer duplicative tests and better health. Whether it leads to cost reductions depends in our judgment crucially on the incentives that those primary care physicians receive. So one approach to this is to provide those incentives to primary care physicians by rewarding them for reductions in spending while maintaining high quality and the effectiveness of those sorts of provisions, so we look at some other provisions. There are other ways in addition to medical homes in which primary care physicians can be empowered to make decisions and to coordinate care but again it is crucial if one wants to reduce federal outlays that they have incentives focused on not just recommending a whole range of additional services that aren't necessary.

Mr. {Pallone.} Okay. I want to get a second question in but I appreciate that. You know, I want to ask Mr. Hackbarth this. Mr. Elmendorf talked about how you might limit the pace of new procedures not through rationing but

through some other means. You know, the President, I commend him. He has been so honest about everything in terms of budgeting. You know, he came up with this $600 billion reserve fund. He said look, that is only going to pay for half the cost of covering everyone. Within that he said, you know, half of it can be done through cost efficiencies, the other half you are going to need a new source of funding. All these things are very controversial but he doesn't hesitate to bring them up, to his credit. But, you know, when you talk about these cost efficiencies which MedPAC is really the key, you know, as you know, you came out with your report I guess a week or so ago and, I mean, every time it comes out the phone rings endlessly in my office because they see you as like their ultimate bad guys that want to cut back on all the providers and on the imaging and everything else.

So the question is, how realistic is this? Can we really pay for all these things through cost efficiencies? I mean, are we really going to be able to pay for a quarter of the cost of expanded coverage through these cost efficiencies? Can we pay for even more than that? Because the President's reserve is only half. Can you move towards what Mr. Elmendorf said and actually limit new procedures without having an uproar and without--I mean, I am not asking you to--I know you are not a politician but I just wanted you

to comment on that, if you could. It is endlessly obviously but--

Mr. {Hackbarth.} Yes. Well, let me break it into two parts, first addressing the issue of new technology, how it is introduced to the system, how it diffuses. In terms of slowing the rate of increase and long-term health care costs, that is going to be a principal focus of our efforts, and that is why we strongly supported the idea of a large-scale public investment in comparative effectiveness information. We don't think that that necessarily means that you have to have a single entity making rationing decisions. Indeed, what we have advocated is creating more information so that individual physicians and their patients, private health plans, public health plans and others can more thoroughly evaluate the choices that need to be made, and we have advocated that the choices continue be made on a decentralized basis, not in one federal bureaucracy, but we can't make sufficient progress on this technology issue without far better information than we have had in the past. The private market has not and will not produce that information so public investment is very welcome in that.

Having set aside the technology issue for a second, there are very large inefficiencies in the delivery of care, many of them, most of them rooted in how we pay for care.

Realistically though, as you say, Mr. Chairman, when you change those payment systems, you are doing two things. One, you are redistributing income across different types of providers, sometimes geographically. In addition to that, you are bumping up against really entrenched ways of behaving, you know, cultures that exist within these organizations, and we need to be realistic about how quickly those things will change. They will not change overnight. But to me, what that does is emphasize how important it is we start today and not delay these things further and further into the future. The decisions will be controversial. You are going to need to make those decisions. We will provide you the best information and analysis we can to support you in that effort.

Mr. {Pallone.} Thank you.

Mr. Deal.

Mr. {Deal.} Thank you.

As I listen to opening statements and your testimony, two words come to mind, and I want to focus on those two words. Much of what you just responded to in the chairman's questions you will respond I am sure the same to mine but maybe you want to elaborate further. The two words are cost and results. Now, they are not always equated with each other. In fact, we know the statistics. First of all, cost,

and I think we all recognize that much of the escalation in the cost has been related to new procedures, new treatments, new pharmaceuticals, and Mr. Elmendorf, a partial quote from your testimony about two weeks to the Senate Finance Committee, you said, ``Reducing or slowing spending over the long term would probably require decreasing the pace of adopting new treatments and procedures or limiting the breadth of their application.''

Now, I have two questions. My first question is, are there ways to encourage doctors and patients to take into account the cost when making a treatment decision without requiring third parties such as the insurance company or other people including Congress to make those decisions for them? So that is the question on cost. The second question relates to results. Now, comparative effectiveness is a term that has sent shock waves through the medical delivery community, as you are aware. Now, when I think of cost comparative effectiveness, I think it can be defined as either the mode of treatment which is generally most effective, which is, I think, the equivalent of a protocol or best practices, but it can also be interpreted as a limitation of treatment, which is where the scary part of rationing comes in. And in that regard, my second question is, what steps can we take to ensure comparative competitive

effectiveness research helps improve patient and provider decision making while avoiding the blunt centralized access restrictions? My two questions.

Mr. {Elmendorf.} On your first question, Congressman, there are several steps that can be taken to increase incentives for providers and patients to focus on value, on getting results, not just on spending money. One, as I mentioned in my testimony, is changing the tax exclusion for health insurance so as not to be open ended so that we don't provide essentially a federal subsidy at fairly high rates for people to get ever more expensive policies. Changing that would induce people and firms to be more cautious in the policies that they bought, to hunt harder for bargains, and that in turn would induce the providers to be more careful in the money that they spent. We could provide incentives for Medicare beneficiaries to choose more carefully additional treatments by increasing the cost-sharing rates. Of course, those policies have consequences as well. More generally, the Medicare program reimburses providers in certain ways and CBO reviewed a number of potions in its volume of ways to encourage providers to economize on spending while maintaining quality, and that includes the way we pay for post-acute care after hospitalization. It includes the way we reimburse doctors, very importantly, because they tend to

be paid now on a fee-for-service basis, not on a more bundled basis.

On comparative effectiveness, more information is absolutely crucial. There is a very large share of medical care delivered in this country where many analysts think there is very little evidence about what works and what doesn't and the largest variation in spending across geographic regions is in the aspects of care where there is the last consensus among medical professionals about what is the appropriate treatment so that providing that information can then provide understanding about what is useful and not, can try to reduce these disparities, but I think it is absolutely crucial to really get the effectiveness of this sort of research to provide incentives for using it, and that comes up against your concern which is well, who is saying that you can't get a certain treatment. And I think the answer here is not to--don't rule out certain treatments. What it does it to change the incentives so that doing another treatment is not a financial winner, it is more of a neutral proposition for providers who would then recommend services only if they really are necessary and not otherwise but the incentives have to go with the information to get the maximum effect.

Mr. {Hackbarth.} If I could, I would like to focus on

the cost-sharing piece of your question. I addressed the technology piece in my earlier comment. Having patients understand the cost of alternatives can be a part of the solution but it has to be structured very carefully. One of the areas where we think it can be particularly helpful is in Medicare Advantage where we give incentives, rewards to patients who enroll in more-efficient, high-performance private health plans. That could be a step in the right direction. Our chief concern about Medicare Advantage as currently structured is that we are rewarding Medicare beneficiaries for enrolling in private plans that simply mimic Medicare except at a much higher cost. So we think with restructuring, Medicare Advantage could be a significant contributor.

As far as cost sharing at the point of service is concerned, when care is actually being delivered, of course that could be very problematic for very low-income Medicare beneficiaries who don't have much income and could impede access to care, and there is a body of research showing that in fact if you have cost sharing for some types of services, you can end up with worse results and higher costs. An example of that is drugs for diabetics. You don't want to impede access by having them share in the cost.

A third point there is that well-structured cost sharing

with protections for low-income people that doesn't discourage really needed thins like drugs can be okay but for the really sick patients, they are going to exceed cost-sharing limits and the real money in our health care system is in the care of people that are really complicated and have very high bills so cost sharing isn't going to solve that problem, we need other tools to address the issue.

Mr. {Pallone.} Ms. DeGette.

Ms. {DeGette.} Thank you, Mr. Chairman.

I want to explore two sort of issues as we start to think about how we are going to fund health care reform. The first is an issue that I have been thinking about for quite a long time, which is that under the current system the way the CBO funds health care is just simply by estimating how much it will cost to treat diseases and then paying for that, and a concept I have been working on, I am calling it the prevention dividend. That is just what I am calling it. The concept would be that we would try to figure out--and I have actually spent quite a bit of time talking to Peter Orszag about this. We would try to figure out if there are certain treatments or efforts that can prevent disease that we don't necessarily fund now because we can't afford it and shift the way that we fund health care in this country. I will give you one example. When we did the Medicare Part D benefit in

this committee a few years ago, I went to then-Chairman Barton and I said Joe, I think we should fund smoking cessation programs for senior citizens in this bill, and he said I think it is a great idea, Diana, but we can't do it because I have got a $50 billion price tag and I can't go beyond that. So I thought well, that is swell. We are not going to give them the patch but we are going to give them treatment for their heart disease, lung cancer and emphysema.

Mr. Elmendorf, I am wondering what you think of a concept like that and how trying to structure a payment program for some kind of health care reform could take advantage of prevention.

Mr. {Elmendorf.} Congresswoman, if you propose policy to enhance prevention for single or a range of possible diseases, then we would certainly try to take account of the effects of that policy on the subsequent prevalence of those diseases and the costs of treating them and the estimates. I think there are a few general points to make. One is that some researchers have looked at a range of possible preventive measures. Some seem to be very cost-effective and are not done enough. Others do not look particularly cost-effective much like the range of results people see for different sorts of health treatments in which some things are not done enough and others are done probably too much. So I

think it depends. The effects on the future disease and the cost of that disease depends importantly on the particular preventive service or strategy you have in mind.

The related second point is that when one engages in preventive services, there are certainly some number of people who won't suffer very health-damaging and costly problem later but one is providing a lot of additional services to a very large number of people, many of whom would not have had that cost later. So part of the reason that that preventive actions end up being less cost-saving than one might think is because one is providing them to a lot of people at a small cost per person to be sure but--

Ms. {DeGette.} But some of them do--I mean, in line with what the President said yesterday, I think all of this should be based on science rather than just our gut feeling and so that would be part of what I would say is, you would have to have some kind of longitudinal studies or some evidence that would show in fact that by giving a dividend to these prevention efforts you would either, A, improve people's health, or B, prevent longer term disease. It is not just about preventing long-term diseases, it is also about improving quality of life.

Mr. {Elmendorf.} Yes.

Ms. {DeGette.} Mr. Hackbarth, I see you nodding your

head. I am wondering if you can comment on this as well.

Mr. {Hackbarth.} Yes, I very much like the idea of it being science based because I agree with Mr. Elmendorf that you will have cases where prevention can improve quality but it may not reduce cost and then you have cases where it would reduce cost a little bit but not as much as the investment. So you need to have a very focused effort driven by science.

Ms. {DeGette.} And you have to decide your criteria because is your sole criterion saving money or do you have the additional criterion of improving quality of life. I completely agree, but would you think that would be an appropriate consideration, prevention as we develop--

Mr. {Hackbarth.} Oh, absolutely, guided by science as you have described.

Ms. {DeGette.} Thank you very much.

Mr. {Pallone.} Thank you.

Mr. Burgess.

Mr. {Burgess.} Thank you, Mr. Chairman.

Glenn, always good to see you and glad you are back here in front of our committee. It seems like old times. Let me just concentrate on a few things that you listed in your list of where we can see savings. I was really encouraged by the physician group practice demonstration project at CMS and I hope that has not died a natural death with the change in

helm, but really that seemed to be--you look at the 20 percent of the people that account for 80 percent of the costs and that really seemed to follow the old Willie Sutton's law: you rob the bank because that is where the money is. That is where the money is in the Medicare system. I am concerned and I think I heard both of you talk about increasing dollars to primary care physicians, a good thing, but any time--since we are in a purely transactional environment, any time we increase dollars to one, we are probably taking it from somewhere else. Is that a fair assumption, that this would be a redistribution across providers?

Mr. {Hackbarth.} That has been MedPAC's recommendation, yes, that it be a budget-neutral change, and the reason that we have taken that approach is that as you know, total expenditures on physician services have been growing quite rapidly. As that has been happening, there has also been a shift in the distribution of dollars away from primary care services towards more subspecialty services and imaging and the like, so there has been a shift that we think needs to be addressed in the name of enhancing our primary care system. We don't think the problem is too few dollars in the pool, just how they are distributed.

Mr. {Burgess.} And along that line, and of course, we

always hear that removing the cost to administer drugs and imaging would be some way to provide perhaps more equanimity in that situation. Is that possible to do that in the current structure?

Mr. {Hackbarth.} Are you talking about under the SGR, how the SGR is calculated?

Mr. {Burgess.} Yes.

Mr. {Hackbarth.} We have not really looked at the issues, not taken a position on the issue of whether drugs ought to be included. We think that those are more issues of budget baselines than they are of health policy.

Mr. {Burgess.} Let me ask you a question on--because you had talked about readmission, and that is one of the things that makes me enthusiastic about the process but also frightens me at the same time because of some of the things I have seen us do in the past that tend to be heavy-handed. Now, under the physician group practice demonstration project, a patient is hospitalized for decompensation of congestive heart failure. If they are given as they leave the hospital the appointment to see their primary care physician within 5 days, the risk of readmission really plummets, and if they are simply given the instructions to see their primary care doctor within 2 weeks as opposed to actually having an appointment made, the readmission rate is

significant and those readmissions are terribly costly readmissions. So that seems to me to be a good thing. But if we simply say that we want you to take care of everything that might happen, or this is the way it might be interpreted by the hospitals and the physicians, we want you to take care of everything that might happen within the next 30 days because we are not going to pay you anymore, this hospitalization is going to be it. Are we perhaps going to tend to drive utilization in a way that we hadn't intended?

Mr. {Hackbarth.} Well, we too, like the physician group practice model, that is what we refer to as accountable care organizations, and the ideal approach is to have aggregations of clinicians and providers with a broad target and then give them freedom to allocate resources in the name of both improving quality and reducing cost, just as you described it. The challenge that we face in Medicare is that not everybody is prepared for that format. Not all physicians are part of large group practices or even involved in, you know, a hospital IPA-type format as is used in Connecticut in the demo. And so we need tools to apply in situations where the group practice model doesn't fit.

Mr. {Burgess.} Correct, and that is why of course it was important to do it as a demonstration project and I understand from the 10 institutions that participated, there

was probably one that was not actually institutionalized as an IPA. It was more of a group without walls and organized through the hospital structure. But at the same time, these were groups that were then allowed to, gain sharing is perhaps not the right word but if they met a certain threshold, they certainly were rewarded for meeting that threshold and that incentive to drive behavior. You don't want to pay doctors not to see patients because that it what we will do, we will not see patients, and then you get into the problem of his staff not being able to find a primary care doctor. That was the whole problem with the staff model HMO and a fully capitated environment. We don't work. We made all our money at the beginning of the money. Why struggle? You close the doors and take the phone off the hook. That is the way to make money in that environment. Doctors are not stupid. We will do that if that is what you pay us to do. We have to be paid based on productivity as a general rule.

Mr. {Hackbarth.} So our goal, which I think aligns with yours, is to find ways to align physicians and hospitals and other providers to do the right thing, which is what they want to do, better quality at a lower cost. Our payment systems get in the way. So what we are trying to do is put some pressure on some places like readmissions, open some

doors for people to go through with new opportunities like gain sharing and bundling of hospital with post-acute services and say collaboratively physicians, hospitals work together, reduce the cost, improve the quality and share in the benefits with the Medicare program.

Mr. {Burgess.} I think the group practice model is on the right track and I think sharing in the savings that occurs is on the right track. We will save bundling for another day because I am not sure I am ready to go there yet. Doctors and hospitals and insurance companies do not trust each other at the present time.

Thank you, Mr. Chairman.

Mr. {Pallone.} The gentlewoman from the Virgin Islands, Ms. Christensen.

Ms. {Christensen.} Thank you, Mr. Chairman.

I will begin with Director Elmendorf as well, and I am going to follow up, try to follow up on Congresswoman DeGette's question. I was reading in Congress Daily today that there is a coalition of high-profile organizations on the Hill arguing that requiring offsets within a 10-year budget window does not look at the full picture and it becomes a barrier to doing things that we are going to have to do if we are going to reform health care as well as eliminate health care disparities. Because you don't see the

benefits, you don't see the savings inside of that 10-year window necessarily. It takes a longer period of time. So what can we expect from CBO? Will this continue to be a barrier? Can we go outside of that 10-year window and budget for the savings that would be realized both to fix the broken system that we have, to eliminate the health care disparities so that we won't be behind every industrialized nation and some developing ones for health status?

Mr. {Elmendorf.} So Congresswoman, CBO will continue to provide detailed estimates of the effects of health reform proposals over the 10-year window. We will try where the evidence allows to offer our qualitative judgment about the effects of certain reforms on spending beyond that. I understand your concern that there can be larger savings down the road that aren't captured. Unfortunately, we don't have the evidence or the modeling capacity to play out a whole set of specific reforms and how they are going to matter 10, 20, 30 years down the road. As I said in my remarks, many analysts agree on the general directions of policy but there is much less consensus about whether the particular approach should be bundling, should be accountable care organizations, should be penalties for readmission rates and things like that, and that is the limits of the evidence as it currently exists.

Ms. {Christensen.} We look forward to continuing this conversation and seeing if we can find a way to address the costs that will have to be--the money that will have to be invested to get to where we need to be.

Mr. Hackbarth, we all know that Medicare plays a key role in our health care system and there are several very strong aspects of the system but there are still some areas that need work. We found that reimbursement rates within a city vary by zip code, for example, and we know that some of the proposed changes to Medicare like those to Medicare Advantage and some of the ESRD reimbursement provisions sometimes have a negative impact on some populations, largely African-Americans and other communities of color. So we make changes to programs, is MedPAC taking this into consideration and looking for ways to reassure us or to assure us that we are not inadvertently cutting access to needed services to some populations?

Mr. {Hackbarth.} That is an area of increasing focus for us. For a number of years now, 3 or 4 years at least, we have been looking in particular at ESRD, the dialysis program, because that is so important to African-Americans as well as others, and looking for any indication that changes in that system have eroded repeated access for African-Americans. In addition, we will be looking at the issue of

access to kidney transplants where there are some disparities in terms of access. So this is going to be a focus of ours. We have also tried to look more broadly at differences in access to physicians and satisfaction with access to physicians. We found some issues.

Ms. {Christensen.} So you are looking at it. The bundling does bother me, and I believe as a physician and having been a medical director that information will change behavior. You are going to make the information public. Hospitals are not going to want to have a negative report given to the public. And I believe also that once hospitals are better reimbursed, which they would be when everyone is covered, they will be able to provide the better services, so why a bundling pilot? It is going to put doctors and hospitals in competition, you know, in ways that--I just don't see why you think that would work.

Mr. {Hackbarth.} Well, our goal is the opposite, not to put them in competition--

Ms. {Christensen.} Or why it is needed.

Mr. {Hackbarth.} --but to put them in collaboration with one another. In the current system where they are paid separately, there is often competition, and as Dr. Burgess indicated, unfortunately some places, some open conflict and hostility. We think that they need to be engaged working

together collaboratively to improve care, and we think bundling could be a step in that direction.

Ms. {Christensen.} I agree, but I think--that they need to work collaboratively. I just think there are other ways to do it. Thank you.

Mr. {Pallone.} Mr. Gingrey.

Mr. {Gingrey.} Mr. Chairman, thank you.

Chairman Hackbarth, you had mentioned in your testimony, your written testimony on page 7, regarding payment system bias and the fact that many physicians who are subspecialists who do a lot of procedures are causing a problem in our manpower, physician supply, particularly in regard to our primary care physicians. I know we have one sitting here in the audience from my State of Georgia, Dr. John Antalis, a former president of the Medical Association of Georgia, who is a primary care physician, and, you know, I think about him. I think about my colleague, Donna Christensen, who is also a family doctor. Do you feel like this patient bias system may be a factor contributing to the various physician and nursing shortages we are seeing across the country, and what would you recommend that we do about that possibly in regard to payment incentives?

Mr. {Hackbarth.} Well, first of all, I want to emphasize that physicians are responding to the system that

we created and the incentives that we create speak volumes about what kind of activities we value, and over a period of years that means more subspecialization, more high-end imaging and the like. So I am not blaming them for what they are doing. They are responding to a system that we created.

In the interest of a high-performance system, though, we need to redirect those signals that we are sending, and as I said earlier, we do think that payment deficiencies is one reason for the growing problems that we have in primary care. It is not the only reason by any stretch but we think it is a very important reason, and so we need to go about changing that and we have made a series of recommendations about how to change primary care payment.

Mr. {Gingrey.} Well, certainly, Chairman, that makes sense to me, and as a practicing physician for 26 years, as an OB/GYN specialist, I concur that we need to do something about that, to increase the number of primary care physicians and opportunities for medical homes as we have talked about for all of our Medicare recipients.

Director Elmendorf, let me shift to you for just a second. You talked about in your testimony in response to some of my colleagues' questions in regard to 10-year window and that, you know, a lot of times you can't really measure or see the savings that are going to occur from various and

sundry things that we have done, and it made me think about Medicare Advantage or Medicare Plus Choice, and the fact that we are on the verge if we follow the President, well, indeed in the economic stimulus package and what he plans for health care to create that reserve account so we can do all of this reform of health care to take, I think it is $178 billion out of the hide of Medicare Advantage. Now, I don't know whether Medicare Advantage is working the way Congress originally intended for it to work but certainly it was my understanding that the 10 million people that have signed up for Medicare Advantage are getting more than just episodic care. You know, they are not just going when their head hurts or their tummy hurts or whatever. They are getting a good annual physical, they are getting a call back from a nurse practitioner to make sure they are taking their medication, and clearly that is going to cost a little bit more. Now, I am not sure it is worth 15 percent more and I know that is a concern of Congress, but it is worth more in that you are investing in something and you are investing, I would think, that in the long run, in the final analysis that at the end of life, let us say, we don't spend beaucoodles of money on those who have been under Medicare Advantage because they are healthier, they have taken care of themselves and the doctors have taken care of them in a better way. We can't capture

that. We can't score that dynamically, unfortunately. But I think at the end of their lives when you look at it and compare the cost of fee for service versus something like Medicare Advantage, there may be a tremendous savings, and we are on the verge of gutting that. Would you like to respond to that in the few seconds that I have got left?

Mr. {Elmendorf.} I think you were right that the patients in Medicare Advantage who are under the care of managed care organization are receiving more-integrated, more-coordinated care than they might otherwise. Not all patients in Medicare Advantage are being seen by HMOs, though, for example. There have been patients under Medicare Advantage who are going through private fee-for-service plans and Congress has taken action to reduce the number of people in that category, and that is the point that Mr. Hackbarth has made before about the importance of not just paying more for patients to receive essentially the same kind of care in Medicare Advantage, because some have been in that category. The others who are receiving this more-integrated care, I think there are some advantages to that. I think most analysts though would be concerned about the point that you alluded to which is that the reimbursement rates have risen relative to costs over time and those patients are now receiving a variety of additional benefits that are of some

value to them but are costing taxpayers more per patient than would be the case in the traditional Medicare program.

Mr. {Gingrey.} Thank you.

Mr. Chairman, thank you for your patience in letting us go a little bit over. Thank you.

Mr. {Pallone.} Thank you.

Mr. Sarbanes.

Mr. {Sarbanes.} Thank you, Mr. Chairman. Thank you all for being here.

I wanted to pick up on this discussion of the primary care providers again because to me, in many respects, that is sort of the elephant in the room. In other words, I have seen some statistics that say that if we were able to provide coverage for all those who don't currently have it, that in order to meet the demand that represents, we need another 60,000 primary care physicians. That is not even talking about nurses and other primary care professionals. So that is potentially a new train wreck that is coming. We talk a lot, and much of the debate and much of the focus is over the coverage side of this discussion. Is it going to be hybrid public-private, is it going to be Medicare for all, is it going to be single payer, is it going to be employer based, et cetera. But if we make the assumption for the moment that we will achieve universal coverage, then the question of who

is going to provide that care becomes critical, and there is a kind of chicken-and-egg dimension to this so if you could speak to that just a little bit more and maybe comment on the notion of having the design of the insurance be driven by the kind of providers that we are trying to bring, you know, if we build it, then will come kind of concept. Because I can make the argument that we should choose the insurance model based on which providers--I am going to talk through this. We should pick the insurance model based on wanting to get more primary care providers so what will incentive them to do that. You can wait until that stops.

Mr. {Pallone.} I am sorry. I don't know exactly what is going on. Hold on. Does somebody have their phone on? I think it is over. All right. We will continue.

Mr. {Elmendorf.} On your first point, Mr. Sarbanes, that if we move towards universal coverage we may increase the demands on an already weak primary care system, I think that may well be true. Dr. Gawande can maybe talk about Massachusetts where anecdotally, at least, I have heard that that become something of an issue. We think there are several responses appropriate within Medicare, and if you want, I can talk in detail about those but in general there are ways of increasing the payment for primary care and changing the method of payment so that primary care practices

can afford the infrastructure that allows them to provide appropriate coordination of care. Realistically, no matter what we do in the payment side, even if we did all of these things tomorrow, the increase in the primary care physicians is going to occur slowly over a period of years, and that is going to be a real challenge for us. I think practically speaking, what we are going to have to do is expand our use of some non-physician clinicians, advanced-practice nurses, for example, so that we can provide basic primary care to a broader population. I used to be the CEO of Harvard Vanguard Medical Associates in Boston, a very large group practice, that made extensive use of advanced-practice nurses to improve access to primary care, and I think as a national health care system we are going to need to do more of that to deal with this issue as well.

Mr. {Sarbanes.} I think one way to approach this health care reform is to figure out what elements of everybody's proposal are in common and that is where the final design will be in terms of critical components, and I haven't heard any proposal with regard to coverage or provider or anything else that doesn't include the notion that we need more focus on primary care. So because it is going to take so long to get the pipeline going, we probably need to bet now that that need is going to be there regardless of what we design and

get going on it.

Mr. {Hackbarth.} Absolutely. There is a real urgency to move quickly on that front.

Mr. {Sarbanes.} Thank you.

Mr. {Pallone.} Thank you.

The gentleman from Illinois, Mr. Shimkus.

Mr. {Shimkus.} Thank you, Mr. Chairman.

I want to congratulate my colleague, Mr. Sarbanes, too. I think that was a great line of questioning, something I hadn't considered, so I thought it was good. I think if we adequately compensate and then I would say protect physicians. I come from a big litigious State and medical liability issues really drive people out and my family practitioner, who delivered my three boys, no longer delivers babies because of--and we have talked about that but in comprehensive reform, especially if the government takes a larger role in our community health clinics, there is liability protection there, I mean, the programs that are funded and so that--some people aren't going to want to debate this but it is a way to incentivize people to be in these professions, to give them some security. We still want people to get a redress for their grievances, especially if they are harmed, but that has got to be, I would think, a very--and I didn't think about that until the line of

questioning, so I do appreciate that.

I would also--in an opening statement, my colleague from California listed the things, well, why don't we do this, why don't we do that. I would ask the question, why do people from industrialized nations that have national health care, why do they come here for catastrophic care? Or I would ask another question. Why are all the major medical advances around the world, whether it is in devices or pharmaceuticals, why is that done here for the most part? There is something that is still going right in this country that is helpful to health and lifestyle and longevity that we just want to be careful that we don't disregard.

To that point, I think the thing that I fear most is a one-payer system, and the OMB Director Orszag talked about no one is talking about using cost information to deny needed care to beneficiaries and that patients need to be protected from being denied what they need. This comparative effectiveness debate that we have now entered into raises, maybe not intentionally but raises that concern that we are going to use cost, and I will let you answer. I will just tell you the story that I used. I was at a local university talking to nurse anesthetists, and it was a pretty big group and we were talking about a competitive model versus a one-payer system and they were asking about it. Readily upfront,

I am highly biased in opposition to a one-payer government-run system and I am a market-driven individual, so I wasn't trying to deceive them so I said here is an example and I talked about some of the industrialized nations having formularies and if you don't fit that formula, you get denied care. And then I get a hand raised in the back of the room. I used New Zealand as an example. And the lady stood up and she said I am from New Zealand, and I thought I am either right or I am busted. And she told me that her father had to wait for kidney stone surgery for 8 months. Now, for those of you who have had kidney stones knows that that was a terribly long wait. I guess my question would be, do you share these concerns as we move in this direction on a debate on a national policy?

Mr. {Elmendorf.} So Congressman, I think many analysts worry that our current system provides no reason for many providers and patients to think about whether extra treatments are cost-effective or not. It is also quite fair to worry as you do that we could device a national health system in which costs would become the predominant criterion for what is provided or not. And that is why I think many analysts suggest moving in the direction of learning what works and providing incentives to take that knowledge seriously, but I think few analysts suggest that we should

move to a system where one person in Washington decides who gets what, and one thing we will discover in future comparative effectiveness research, as has been discovered in past research of this sort, is that some procedures are very good for some patients and not very helpful for others.

Mr. {Shimkus.} Can I follow up? And I don't want to cut you off but I want to--I am going to ask this of the second panel, defensive medicine and liability protection, will that be part of the cost-effectiveness analysis?

Mr. {Elmendorf.} I think the consensus of researchers is that defensive medicine is a factor but not a particularly large factor in the decisions of providers.

Mr. {Shimkus.} But do you think we will see that in this cost-effectiveness analysis? Will that be considered? I mean, we won't know until we get the stats, and if this is an issue of trying to figure out the cost, you would think that that would be part of the variables.

Mr. {Elmendorf.} So I think the most direct connection is that currently if one is facing a patient with a particular problem and there is very little evidence about what to do, then there can be reason for the provider to do the most that can be done and that can be expensive, whereas if there were clear evidence on what worked and what didn't, that would help providers avoid having to prescribe

everything to protect themselves. So in that sense I think having the knowledge can reduce the amount of defensive medicine that is practiced, apart from the liability issues that you have raised as well.

Mr. {Pallone.} Thank you.

Mr. {Shimkus.} The chairman is going to let me--

Mr. {Pallone.} You wanted Mr. Hackbarth to answer the same question?

Mr. {Shimkus.} Yes.

Mr. {Hackbarth.} I was going to pick up where Mr. Elmendorf left off. Ideally what we do is develop scientifically based, evidence-based standards of practice based on the best available evidence. It seems to me that if you have that information, then it can provide some comfort and protection to physicians that practice in accordance with that guideline, that standard of practice. When we are information starved, as we are so often now, the response is well, do more. More is synonymous with better because we don't have sufficient evidence to show otherwise. That is the refuge. We need to create another refuge, if you will, so more isn't always the response to uncertainty.

Mr. {Pallone.} Thank you.

Ms. Schakowsky.

Ms. {Schakowsky.} Thank you, Mr. Chairman.

You know, we just heard an anecdotal story about somebody who had to wait for kidney stone surgery, which my husband having had them, that certainly is a problem. But you know what? There is also millions of people insured as well as uninsured who wait a lifetime for the care that they need in this country because we do ration health care, and by and large that ration card is a dollar bill. You can shake your head but--

Mr. {Shimkus.} If the gentlelady would yield, everyone who needs care gets it because when they go into the emergency room, the hospital has to serve them.

Mr. {Pallone.} The gentlewoman I assume has yielded to the gentleman?

Ms. {Schakowsky.} No, I am going to take back my time because the myth that everyone in this country receives the care they need has got to be dismissed because that is not true. Over half of Americans, I said in my opening statement, the data shows actually have gone without or postponed health care because they can't afford it. That is just a scientific fact. We have looked at the American people and that is just true.

But here is my question. First of all, I wanted to ask Mr. Hackbarth, you talked about the percent of readmissions in hospitals. What was that percentage?

Mr. {Hackbarth.} About 18 percent of Medicare admissions are followed by a readmission within 30 days.

Ms. {Schakowsky.} Okay. I just wanted to have that. I wanted to get back to this model. You know, we do have a single-payer health care system in Medicare right now for elderly people and again, I had said before, that this is a widely accepted and much liked and it still has holes on it, and I wanted to ask about what are those holes. We have heard Medicare Part D lauded as something that has worked so well but certainly in my office, we get people all the time confused over those many, many options. Senator Durbin and I and others in the House have introduced legislation that would create a public pharmaceutical option under Medicare. I wanted to get comments from both of you on whether or not--and that that option would be able to negotiate with Medicare for--with the pharmaceutical companies for lower prices, hopefully to fill the donut hole. I wanted to get your opinion on that.

Mr. {Elmendorf.} So referring to drugs specifically, CBO's judgment is that the private providers of the drug benefit do negotiate for low prices. They negotiate with the threat of moving drugs off of their formularies or charging higher prices for their use and that there is no reason to expect that a public program would do better unless it were

prepared to be tougher in not covering certain drugs. If it were tougher in writing its formulary, then it could avoid--then it might negotiate for lower benefits, but that would be the crucial--lower drug costs, that would be the crucial factor.

More generally in health care reform, when people talk about public plans competing with private plans, I think designing a system in which a public plan could compete on a level playing field is extremely difficult. It raises issues of what the providers are paid. It also raises issues of selection, of patients across plans and how sick they are. It is issues about how the financial risk is dealt with.

Ms. {Schakowsky.} Are you saying whether a public plan could compete with a private plan? Who would be disadvantaged? Which would be disadvantaged?

Mr. {Elmendorf.} I am saying that if the objective is to have them complete on a level playing field--

Ms. {Schakowsky.} Well, I know. Who would be disadvantaged? For whom would it not be level?

Mr. {Elmendorf.} Well, under current payment rates, then a public plan would be less expensive because--than the private plan, the reasoning from the Medicare example, where the government does push down reimbursement rates. That would be a benefit for the public plan. The issue is, it

depends on how you design the system. So there are risks associated with running health plans. If the public plan didn't have to insure itself against that risk, it was just the taxpayers holding the bag, then that would be an advantage for a public plan relative to private plans that have to charge enough to cover that risk. It depends on how it is designed. If public plans ended up with sicker patients than private plans because perhaps they managed benefits less tightly, that would be a disadvantage to public plans relative to private plans. So it is a set of parameters that you and your colleagues will pick that would affect whether a public plan is advantaged or disadvantaged.

Ms. {Schakowsky.} Does it matter that the CEO of Cigna in 2007, for example, made $22.7 million, a cool $23 million more than the President of the United States in a year, and the kinds of overhead costs that private plans have as opposed to Medicare, for example?

Mr. {Elmendorf.} Yes. So administrative costs are including the costs of paying executives are another fact that I forgot to mention. Medicare does have lower administrative costs--

Ms. {Schakowsky.} For profits for shareholders.

Mr. {Elmendorf.} --and large employer returns. That is right. But remember, the profits for shareholders, part of

that covers the risks that I have just discussed. It covers the cost of the capital that goes into managing these plans. So some of that--that is why I said, it depends importantly on--

Ms. {Schakowsky.} How is it--my time is running out. How is it that the United States of America pays 40 percent more than the closest country for health care, causing the President of the United States to say I think in response to something that Mr. Pallone said, are you saying that there is not enough money in the system currently to cover everyone. Are you saying there is not enough money in the system right now to cover everyone?

Mr. {Elmendorf.} Oh, no. I didn't say anything like that. What I said in my testimony, and is the position of CBO, is that covering everyone would be expensive, that there is also a lot of dollars spent in the health care system for which we are getting a little or no improvement in health, but that rooting out those dollars without also reducing some services that do improve health is challenging, and we talked and I think most people agree about the importance of information, the importance of incentives to use that information, but exactly how to do that and how to do that in the short run is not so clear. Again, the direction is clear but how effective that can be, whether that can save enough

money to cover the increase in health care that would be delivered to the currently uninsured is much more difficult.

Mr. {Pallone.} I am going to take 30 seconds here as the chairman. What the President actually said in response to my question at the summit, and I think, you know, it hasn't been laid out here, is that, you know, you can have a lot of cost efficiencies and that can contribute to expanding coverage but he said that you do need a lot of up front. In other words, those savings may occur as the reforms kick into place but initially you are going to need a new source of revenue up front because a lot of things that we are talking about have large costs up front and then the savings come later. So, I mean, that is one aspect of this that we have to think about. But I want to thank the gentlewoman.

Mr. Rogers.

Mr. {Rogers.} Thank you, Mr. Chairman.

Thank you both for being here today. You said some things made me scratch my head a little bit and I think we are kind of dancing around some pretty important issues here because we don't want to use the words that we know inflame the fears of most Americans, and that is rationing. And I have to tell you that as a Michigander, you know, we can see directly the impact of a government-controlled system for health care in Canada, and as one Canadian told me, that if

you break your leg in Canada you have the best health care ever. If you get sick, it is the worst in the world. And I think what they are talking about is sustaining that system of health care is very difficult, and I find it interesting that there is a great number of our surgeons who do cash business with Canadians on weekends for hips and knees because the system in Canada just rations care for elderly, and elderly starting in their 60s.

And you said, Mr. Elmendorf, a couple of things that I found interesting. You talked about in this government-run plan that they would hunt for bargains and do those kinds of things and you said and in order to work they would limit what coverage they had and then later in answering questions you said in order for this to work there had to be some limitation for maximum effect on costs. And then I want to go back to something you said in your testimony. You were talking about the comparative effectiveness language would ultimately have to change the behavior of doctors and patients, and if they are basing that on information available in a doctor's decision between a doctor and a patient, I am for it. That is a great idea. But later you say bringing about those changes would probably require action by public and private insurers to incorporate the results in their coverage and payment policies. You are

quite clearly advocating for rationing care through what is covered, and here is my concern. Eighty-five percent of Americans have coverage. We often talk about the 15 percent. And it seems odd to me that we are going to say because we have this 15 percent that we should figure out a way to get access to health care, we are going to start rationing care for the other 85 percent who enjoy some pretty good health care in the United States. And maybe you can help me untwine that in both your oral comments and your written testimony.

Mr. {Elmendorf.} So first let me be clear. I am not advocating for anything. CBO does not make policy recommendations. So nothing in the testimony or in my answers to questions says that Congress should proceed certain ways on policies. What my testimony does say and which I stand by is that more information by itself is not going to have as large an effect on--just providing information will not have as large an effect on practice patterns and on costs as creating incentives for providers and patients to make use of that information. And I think that is consistent in what is written here and the answers I have given to questions.

Mr. {Rogers.} Okay, but it says you require action to incorporate the results of coverage. So when you say incentives, are you saying they should build that into the

coverage, meaning they should restrict certain--

Mr. {Elmendorf.} I am not saying they should. I am saying that the rising costs of health care, which are linked to the increasing utilization of expensive services, that that rate of increase would be changed more if private insurers or public insurance plans created incentives for providers to take account of information about what was and was not most effective, and some of that information will be able to get counted anyway but not as much if there are financial incentives.

Mr. {Rogers.} I think we are still talking around it but you say that you are not advocating, even though I would say ``probably require'' sends a pretty clear message where you are going there. But in the other countries, and we have seen it in the U.K., breast cancer, kidney cancer, Alzheimer's and hip and knee replacements happen to be a big one. I think in the U.K. they just had one as young as 62 was denied care and coverage for a knee replacement. How do we avoid that? I mean, I think if we were going to be honest with Americans, we have to tell them, hey, this is what is coming because the only way we can fix the 15 percent problem is, we are going to take it away from the 85 percent who have coverage. I just think we are smarter, better, more innovative than that. I think there is a way to do that.

But how do you stop that from happening, given your testimony today?

Mr. {Elmendorf.} So let me just be clear one more time. The testimony says to reduce health spending, results of comparative effectiveness would have to be used in certain ways. Bringing about these changes would probably require--again, it is not a statement of CBO's preferences. It is the chain of logic of what would be required to affect the path of health spending.

I think the crucial point that many of us have made here today is that a large share of U.S. health spending does not seem to be improving health. You can look at--and one particular piece of evidence for this is the geographic variation in spending under Medicare that does not appear to be correlated with quality of care, as judged by the measures that are available. That holds open the possibility, I think the very important possibility, that more evidence of what works and incentives to use it could squeeze out that money. It is a lot of money, by some estimates $700 billion a year. As I noted before, doing that without affecting care that does improve health is not an easy task to accomplish, even if analysts generally agree on some other plausible directions. So I think that holds open the possibility that we can reduce care that is not very useful and save a lot of

money through doing that.

Mr. {Rogers.} That I understand. I just--I think your words sometimes--you were kind of parsing around what you are trying to say and you are trying to say in order for it to work, you have to limit coverage in the future under government-run plans. I get it. As a matter of fact, you also said that under a government plan, they would push down reimbursement. Well, if you have ever had a meeting with a medical provider in the last month and a half, and I am sure you have, they can't get the reimbursement they need today, and it is having this inverse impact on private insurance companies trying to be asked to hold the burden of the government-run plan that pushes it down. So you are going to destroy competition in the market. I don't know how you think that works. And I don't know about my colleagues, we are getting calls in my office, people are in a panic because in cancer care reimbursement, where I think that you all have completely missed the boat, they are calling and saying they are not taking any new patients under Medicare because the reimbursement rates are wrong and they lose money. So to start out the premise that the government is going to push down reimbursement rates as a way to control costs and somehow a private plan is going to survive, it defies the logic of what is going to work in the marketplace. How do

you reconcile that?

Mr. {Elmendorf.} Again, I am not advocating pushing down reimbursement rates. What I am saying is that under the current Medicare system, Medicare pays less to providers than private payers pay. A number of options that we have considered, a number of MedPAC has recommended in fact, but we don't make recommendations, a number of those options that have been discussed would reduce payment rates. In fact, under current law, as you know, physician payment rates under Medicare will drop very, very sharply this year. The evidence suggests that the shifting of costs to the private sector is not as acute as one might worry, that in fact the private insurance companies negotiate with the providers and achieve the rates of reimbursement that they can. To the extent that Medicare and even more so Medicaid pays less to doctors and to hospitals, that is taken out mostly in some combination of reduced quality or reduced amenities for those hospitals and doctors. I am not clear how much of that, though, as I said, spills over to the private sector.

Mr. {Rogers.} I appreciate it.

And just as a follow-up to Mr. Hackbarth, if we had had a government-run prescription plan under Part D, what would it have done to the competitive plans in Part D, in your estimation?

Mr. {Hackbarth.} Well, MedPAC has never looked at that issue specifically. Of course, we have spent a lot of time looking at Medicare Advantage, which is a system where we have a public plan and private plans competing with one another, and there, far from the playing field being tilted in favor of the public plan, it has been tilted significantly in favor of the private plans. So in one real-world experience we have with this idea, the fears that well, the public plan gets favorable treatment has in fact not been the case.

Having said that, you know, I am a strong believer that we need both strong public plans and private plans in our health care system. I have worked in both. I worked in what was then HCFA, obviously deeply involved in Medicare issues now. In my prior lives I have worked at premier HMOs. So I understand a bit about both. I think they bring distinctive strengths, different strengths, complementary strengths. On the one hand, Medicare is a public plan, as noted earlier, has low administrative costs, in part because of scale, in part it doesn't incur marketing expense and profit as discussed earlier. In addition to that, because of its size, it is able to command low prices. On the other hand, private plans have some advantages as well. They are more flexible than a government plan can ever be. It is easy for a private

plan to change how it pays providers to better regard the sort of behavior that we have been talking about today. It is a cumbersome process for Medicare to make those changes. It involves legislation and regulation writing in CMS and the like. So private plans have more flexibility there. In addition, private plans have the opportunity to try to identify a select group of particularly efficient high-quality providers and direct patients to them, which is not feasible in a public program like Medicare.

So you have two types of health plans potentially competing with one another, offering different things to Medicare beneficiaries. Some will like the public plan for what it offers, the free choice of provider and the like. Others might like Kaiser Permanente as an alternative. Rather than saying we want one or the other, I think we ought to be striving to build a system that has both strong public plans and private plans competing on a level playing field.

Mr. {Pallone.} Thank you.

Ms. Baldwin.

Ms. {Baldwin.} Thank you, Mr. Chairman. One quick comment before I get to my questions. I know we have had a little of discussion about public plans versus private plans and the playing field, and even in the Medicare Part D context. I would draw attention to the fact that I think

Wisconsin is the only State that does have a public plan in the Medicare Part D program called Senior Care. It was based on a pharmacy waiver that was granted prior to enactment of the Medicare Part D program. It is wildly popular to the degree that on a bipartisan basis, every member of the Wisconsin delegation weighed in to try to keep that program in existence as the Medicare Part D program was phased in. And I think it would provide an interesting analysis for some of the--you know, to see whether some of the comments we have been hearing really have a basis or not.

Chairman Hackbarth, I wanted to explore with you and have you talk a little bit about the value of demonstration projections as a way to go from current payment systems to perhaps testing some of the recommendations that MedPAC has made for reform. Congress, it seems, has funded through Medicare legislation for years demonstration projects such as the physician group practice demonstration or the premier hospital demonstration yet it seems like we fund those projects and don't insist that they are replicated elsewhere or expanded on a much more broad scale. I am curious about their value to inspire confidence that new models of payment will achieve desired results and whether we ought to be looking at more. Please comment.

Mr. {Hackbarth.} I worry about this a lot, and more and

more over time, and I think it is an issue that MedPAC is going to try to think through systematically, but let me offer some personal thoughts. We have got to make a lot of payment changes for all the reasons that have been discussed today. The changes that we need to make are sometimes operationally complex and uncertain in terms of their effect on cost and quality and so it stands to reason that we may want to do tests of them first. The fear that I have about the process that we have been using is that often the tests are small and so our ability to detect meaningful results is compromised. They are small projects that run for a few years and we are trying sometimes to affect things that will only materialize over a longer period of time. There is almost a bias in the design to finding no effect, and then we throw out the idea and say well, that didn't work and we will go on to something else when in fact it may be in part a function of the limits of the design.

A second issue is that even when things work, and I think you were pointing in this direction, then they have to come back through the legislative process for further consideration, maybe modification, in ways that might undermine whatever success we found in the demonstration. And so it seems to me that Congress may want to consider ways that we can accelerate that process, do more of what we have

referred to as pilots, large-scale tests that will be better able to find whether it works or not, and if it works according to pre-established standards, move immediately towards implementation as opposed to saying let us now go back through the legislative process again. So those are a couple ideas but I think we need to look at the whole process of innovation in payment and figure out where we can take out unnecessary steps and unnecessary resources and streamline that process. We have to get better way faster than we are right now.

Ms. {Baldwin.} You and I have had a chance to talk about this sort of pilot idea before. You would conceive of that under the auspices of CMS, and are there good examples of that working in the past or is this something that we would need to authorize?

Mr. {Hackbarth.} Well, the most recent example was in the disease management pilot. It was retitled, I think, Medicare Health Support or something like that, and the intervention that was being tested was having third-party disease management entities counsel patients, provide information, make sure they take their meds and whatnot. In that case, the intervention was pretty large scale. The test was pretty large scale and the finding was no effect, but the legislation had authorized the Department to go ahead and

implement program-wide it if had worked, and they found that it didn't so we didn't go down that path. We need to do more of that. I think that is a model worth maybe tweaking some but exploring for future projects, and bundling is an example that we have suggested a pilot approach.

Ms. {Baldwin.} Thank you.

Mr. {Pallone.} The gentlewoman from California, Ms. Capps.

Ms. {Capps.} Thank you, Mr. Chairman, and thank you both. I read your statements. I wasn't able to be here. But I have a question for each of you and I know I have 5 minutes, so we can base it accordingly. Both of you discussed the fact that we lack primary care coordination of and incentives for primary and preventive care.

Mr. Elmendorf, you mentioned in your testimony that the potential effects of initiatives where we might invest more now, which preventive care is all about, and not realize the savings until later. This would be certainly true in efforts to offer preventive care services but right now the CBO doesn't even allow us to account for savings, and as I have often said about a field that I care a great deal about, which is preventive health care as a public health nurse, there is no special interest group pushing for preventive health care. And so my question is, how do we integrate into

our proposals a way to realize that the savings later are what we are investing now for, and if you could give me your response to that. I have a different question for you, Mr. Hackbarth.

Mr. {Elmendorf.} So Congresswoman, CBO does not just as a blanket matter ignore the health effects of changes in policy. The tobacco example was raised earlier as a case where we very specifically look at the effects of higher tobacco taxes or tougher tobacco regulation and try to trace that through to the effects on spending, for example, in Medicaid, the number of premature infants that are born and the costs of that. So we are very actively looking for evidence to help us trace through the effects of changes in policies on health and then on federal and on private health spending later. So in no sense are we putting those issues to the side. We are focused on them. The problems that I mentioned are lack of evidence in many cases or very long-run effects in many cases and it is just more difficult to trace things out over several decades.

Ms. {Capps.} When you talk about tobacco smoking, it is a specific act, and when you talk about prematurity there is a specific entity surrounding it. I guess what I am talking about in the area of prevention some harder measures that may be more pervasive. Comprehensive health education for kids

in a school curriculum is a subject dear to my heart. There is no--most school curricula have no place for it today, and if we were to target things like that, maybe not that specifically, where it is general education but targeted towards preventive health care, are you looking to us or to some study group to measure the impact of the input and then some kind of impact and outcome?

Mr. {Elmendorf.} Yes. So we looked to outside researchers to guide us in the choices that we make in our estimating process. So on the tobacco front, there has been a wide range of research about the effects of tobacco on health outcomes.

Ms. {Capps.} How about obesity and diet and exercise?

Mr. {Elmendorf.} And I think that as well. I think on obesity, there are several steps of the prevention that have to work. So I think there is a good deal of evidence about the effects of obesity on health problems, less on how particular public policy changes will--

Ms. {Capps.} So that is what we need to work on.

Mr. {Elmendorf.} And that is what we look for.

Ms. {Capps.} And I hope there are some outside researchers listening who will help us take the ball. I want to turn to another topic, but that is one that certainly needs to be explored further, and I appreciate what you have

just said.

Mr. Hackbarth, in your testimony you alluded to the declining number of medical students pursuing a career in primary care. This has been well demonstrated. Could you please expand on how you do the correlation between Medicare reimbursement structure and this decline? And if I could just roll all my questions together, you will understand. Could you offer some suggestions on how we would need to restructure a payment system to incentivize primary care and how this would then spill over to private payers?

Mr. {Hackbarth.} So the first question, the relationship between payment levels and the decline in interest in primary care, I am not going to be able to point to particular studies off the top of my head but we could--

Ms. {Capps.} Maybe you could get back to us if you know of some.

Mr. {Hackbarth.} But certainly in talking to people involved in medical education including some of our commissioners and other people that I work with in other walks, what I hear from them over and over again is that medical students considering their career options often point to a couple things about primary care that make it unattractive. One is the income level relative to other specialties. Second is the demands, the lifestyle demands

that they experience in primary care as opposed to some of the other specialties.

Ms. {Capps.} Do you think the cost of medical school has anything to do with that? I am seeing a lot of people nod behind you.

Mr. {Hackbarth.} Yes, it certainly could. Obviously if you are making a salary or an income that is two or three times larger you can pay off those medical school loans a lot faster.

Ms. {Capps.} Exactly.

Mr. {Hackbarth.} And so the cost of medical education is not equal for all specialties but it tends to be a real problem for people concerning primary care. As far as what to change, we have made three types of recommendations. One, you are familiar with the process of establishing the fee levels, the relative value of scale, and we have identified what we think are some problems with how that process works. In particular we think the process focuses more on things that are undervalued and increasing values than things that are overvalued and need to be reduced. The net effect of that bias that we have seen in the system is to hurt primary care fees.

Ms. {Capps.} Exactly.

Mr. {Hackbarth.} And some steps are being taken to

reform that process that we are cautiously optimistic about. The second thing that we have recommended is what we refer to as a primary care modifier. It is basically a bonus for physicians and other clinicians who through their practice demonstrate that they are committed to primary care. So it would be a modifier. You would get your fee plus an increase of 5 or 10 percent if you are designated as a primary care clinician.

The third thing that we have recommended is a large-scale pilot of the medical home idea, a key element of which is to say for primary care because of the unique nature of the specialty, we ought to pay not just fee for service but on top of that pay a lump sum per patient to cover activities that are not included in the Medicare fee schedule, various counseling activities, following up on specialty referrals and the like, plus give primary care practices money to build some infrastructure including hiring staff that would allow them to more effectively coordinate care, especially for complex patients.

Ms. {Capps.} Has that proposal--

Mr. {Pallone.} We have got--

Ms. {Capps.} I know. I would like to follow up on that topic with you.

Mr. {Hackbarth.} I would be happy to talk more about

it.

Mr. {Pallone.} Thank you.

The gentlewoman from Ohio, Ms. Sutton.

Ms. {Sutton.} Thank you, Mr. Chairman.

Mr. Hackbarth, I understand you may have touched on this already but I would just like to expand it a little bit. In your testimony you mentioned that one way to cut costs from Medicare is to reduce payments for hospitals with relatively high readmission rates for select conditions. You go on to say that we know that some readmissions are avoidable and in fact are a sign of poor care or missed opportunity to better coordinate care, the premise being of course that keeping readmission rates down is critical not only for saving cost but for quality care. I am interested though in what criteria would be used to deem a readmission as unnecessary or avoidable. I mean, how do we know that are only penalizing hospitals for readmissions that could have been avoided?

Mr. {Hackbarth.} Let me just begin with a little bit of factual background. If you look at the rate of readmissions within 30 days, it varies according to the type of admission it is. The rate is higher for some things than others. Take a condition like congestive heart failure or chronic obstructive pulmonary disease, very common reasons for

admission among the Medicare population. You see as much as a fourfold difference in the readmission rates between the hospitals that are the best and those that are lagging. So we are not talking about small differences here. There are quite large differences. Our approach would be to look at the readmission rate and set a threshold and obviously this is policy judgment about how high to set that threshold but you could set it at quite a high level so that, you know, you are basically hitting institutions that are way, way above the mean, way above the average in terms of this performance on this dimension and we believe that with appropriate incentives, and it could be structured different ways that by focusing people's attention on it, we can improve performance, and there are models that they can look to. There are institutions. Don Berwick's organization, the Institute for Health Care Improvement has really started to focus on teaching hospitals the things that they can do to reduce their readmission rates. So you want an incentive coupled with support information on how to improve.

Ms. {Sutton.} Again, and this is an example in a way of those preventative measures we can take to reduce cost, what we don't want to do is though have an incentive that goes too far the other way and people who need to be readmitted aren't readmitted, so that is the balance there.

Mr. {Hackbarth.} Absolutely.

Ms. {Sutton.} Mr. Elmendorf, you know, I understand that in keeping with CBO's nonpartisan role you can't offer recommendations on any specific policy options, but do you think if we fail to enact some meaningful health care legislation in this Congress, that the cost to tackle reform down the road will be greater, and if so, in what specific areas do you see the foresee highest increase of costs?

Mr. {Elmendorf.} Congresswoman, I appreciate your understanding of the role of CBO in this regard. Many analysts would agree that the changes in the health care delivery system that would be needed to improve the efficiency of delivering care will be changes that cannot be made overnight. As I said in my testimony, there are decades of experience following the rules as they have been laid down, the structures, the policies that have been created, and a lot of ingrained habits, and devising the rights sorts of incentives, collecting the right sort of information and then letting the health care professionals make the improvements in what they do is a task that will take time. So the sooner the process is started, the more unnecessary and ineffective care can be avoided. The longer that policymakers wait to create the incentives and help to provide the information, the more unnecessary and ineffective

will be given, and because the rising cost of health care imposes such a burden on the federal government and on the private sector, the more it will be necessary to make starker, more radical changes to balance budgets, to let employers and families pay for health care down the road, and starting sooner is a way to make the changes most based on evidence and the most effective way.

Ms. {Sutton.} Thank you.

Mr. {Pallone.} Thank you.

Mr. Murphy.

Mr. {Murphy of Connecticut.} Thank you very much, Mr. Chairman.

It is curious to me listening to people talk on this panel and in other forums about how we talk about this issue of rationing as if rationing is some futuristic, catastrophic development that is going to happen in our health care system when we know it happens every day right now. Medicare makes decisions on who gets care and who doesn't, this Congress makes those decisions, and in particular private insurers make those decisions, sometimes based on medicine but other times based on cost. And so I wanted to bring one particular difference that I see between private plan management and public plan management to your attention and get your thoughts on it.

When I was chair of the health committee in the Connecticut State Legislature, we brought in our insurers one afternoon to talk about a development that occurred in that the insurers had essentially stopped covering bariatric surgery across the board. Now, certainly there are a lot of abuses in bariatric surgery where it is more cosmetic than medical but we know that there plenty of circumstances in which it saves lives and reduces enormous costs later on in the system. The answer that we got from the insurers, not necessarily when they were all sitting together but privately was that because the average time that an individual spends on their particular plan is only two or three years before they switch to another plan, that it didn't make sense for them to pay for that enormously expensive surgery up front if they weren't going to bear the benefits of the person's extended health down the road. And it seems to me to be a particular handicap of a private insurance system where people now even if they stay with an employer or move from employer to employer are moving from plan to plan over a long period of time. It is a perfect example of the tragedy of the commons. If they all made the decision to cover bariatric surgery, they would all be benefited, but they don't because they are calculating that they are going to pay the cost and not receive the benefits.

And so in evaluating whether we--the question to you, Mr. Hackbarth, is how do you look at that particular problem as you weigh the benefits of public or private plans? And then to Mr. Elmendorf, in terms of looking at how you score a new system that is reliant on the existing system of private plan management or an expanded public option, is that an issue that gets considered in your cost estimates?

Mr. {Hackbarth.} A couple thoughts. Earlier I was talking about public plans and private plans, each have distinct advantages, and if you are a private plan and you are in a market where there is lots of turnover in your enrollee population, it would be surprising if they didn't make the sort of calculation that you were talking about; I am not going to have this patient in the long run, and that could influence their thinking. I don't think that is true of all private plans, however. There are some like Kaiser Permanente who take the long-term view, in part because they have pretty good stability in their membership but in part also because it is the right thing to do. So I wouldn't want to cast all private plans in the light of being, you know, calculating green eyeshade types that are just looking for short-term profit. Some are that way, others are not.

The last comment I would offer on this whole subject of rationing is that it has been characterized, well the haves

and the have nots. That is an important dimension of the debate but let us just focus on the haves for a second. I think we are all of two minds about the soaring cost of health care. If we are the patient or our loved one is the patient, of course is only natural that we want access to the latest, most innovative treatment that can help them get better. On the other hand, we are also all taxpayers and premium payers. You know, Mr. Elmendorf can correct me if I am wrong but I think this most recent economic expansion was pretty unusual in that the median income did not rise, and a big part of that was health care was taking the money out of people's pockets and a lot of Americans are very worried about that in addition to the possibility of losing their health insurance altogether. So, you know, I don't think this is a haves versus have nots. We have got finite resources as a society. We need to figure out how to use them most effectively to achieve all the things we want to achieve.

Mr. {Elmendorf.} To the extent that a public plan would provide more services now that would save cost down the road, that is something we would try to incorporate in our estimates. As I have said a couple of times, it is very difficult to track all of those effects but certainly something we would try to have in mind. The only thing I

would just add is that incentives can be created for private plans that would not otherwise do the sorts of preventive services that are important to do them. The government could pay for vaccinations, flu shots, things of that sort administered through private plans or through public plans so there are ways to work through the private plans to accomplish some of those objectives as well.

Mr. {Pallone.} Thank you. I think that concludes our questions, so I want to thank you very much. First of all, you raised some major new ways of doing things and looking at things and all the cost efficiencies. It was very helpful in terms of our trying to craft health care reform. So thank you very much.

I will ask the next panel to come forward. Let me welcome all of you and introduce everyone. Starting on my left is Jack Ebeler, who is vice chair of the Committee on Health Insurance Status and Its Consequences of the Institute of Medicine, and then is Alan Levine, who is secretary of the Louisiana Department of Health and Hospitals, and then we have Dr. Todd Williamson who is president of the Medical Association of Georgia, and finally Dr. Gawande--I hope I am pronouncing it correctly--who is associate professor of surgery at the Harvard Medical School and associate professor of the Department of Health Policy and Management at the

Harvard School of Public Health. Again, I want to thank you all and we will have opening statements for 5 minutes.

We will start with Mr. Ebeler.

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^STATEMENTS OF JACK EBELER, VICE CHAIR, COMMITTEE ON HEALTH INSURANCE STATUS AND ITS CONSEQUENCES, INSTITUTION OF MEDICINE; ALAN LEVINE, SECRETARY, LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS; M. TODD WILLIAMSON, M.D., PRESIDENT, MEDICAL ASSOCIATION OF GEORGIA; AND ATUL GAWANDE, M.D., ASSOCIATE PROFESSOR OF SURGERY, HARVARD MEDICAL SCHOOL, ASSOCIATE PROFESSOR, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, HARVARD SCHOOL OF PUBLIC HEALTH

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^STATEMENT OF JACK EBELER

} Mr. {Ebeler.} Thank you, Chairman Pallone, Ranking Member Deal, members of the subcommittee. I am pleased to present today the findings and recommendations of the Institute of Medicine Committee on Health Insurance Status and Its Consequences, which is funded by the Robert Wood Johnson Foundation and chaired by Larry Lewin. It is a particular honor to appear before this subcommittee which I once had the privilege of staffing.

The IOM presents its findings formally in rigorous and occasionally dense academic reports. Looked at another way, we present a simple and unfortunately logical three-part story about coverage of the uninsured. Coverage is trending

down. The evidence is better than ever before that health coverage matters for access and health, and even the care of the insured may be affected by high rates of uninsurance in the community and we strongly recommend action. Let me briefly review each area.

First, since 2000, we see an erosion in employment-based health benefits coupled with improvements in Medicaid and the child health program. The net result is that the portion of children who are uninsured has remained relatively stable at 11 percent while the portion of adults who are uninsured has risen from 17 to 20 percent. The principal cause of that eroding coverage: rising health care costs and premiums coupled with changes in the economy and the labor market. With premiums rising about three times faster than wages, employers are less able to offer coverage and employees are less able to afford it even if offered. Our committee concluded that these trends would not reverse without concerted action and the current recession will only make the problem worse.

Second, we find that the evidence is stronger than ever before that even with the availability of safety net services, uninsured Americans frequently delay or forego doctor visits, medications and other effective treatments and those deficits in care have consequences for health. We see

that in particular for those who are sick with serious health care needs, chronic and acute, for which medical intervention can be most beneficial. Again, there is a simple logic here. Coverage and access matter more as our health care gets better. For uninsured children, we see shortfalls in immunizations, in prescription medications, asthma care and basic dental care, missed school days and more preventative hospitalizations. Uninsured adults with chronic health conditions are more likely to have received no medical attention in the prior year and they experience more rapid declines in their health status. They are less likely to receive vaccinations or cancer screening services, more likely to be diagnosed with late-stage cancer and they are more likely to die prematurely.

Fortunately, we also found good news. When uninsured people acquire health insurance, they can experience improvements. Previously uninsured children who enroll in CHIP or Medicaid are more likely to have their serious health problems identified earlier, have fewer avoidable hospital stays, better asthma outcomes, fewer missed days of schools and more appropriate preventive services. Previously uninsured adults who become eligible for Medicare are more likely to receive appropriate care that improves their health and prevents costly complications. Their risk of death when

hospitalized for serious conditions is also reduced. We concluded that lacking health insurance reduces access to effective health care services and is hazardous to the health of children and adults. More importantly, we can now validate for you that gaining health insurance provider substantial health benefits to the previously uninsured.

Third, we report on a potential spillover effect. When community level rates of uninsurance are high, the insured population is more likely to report difficulties in accessing needed care and less likely to report satisfaction with that care. We also found that widespread vulnerabilities in local health care delivery including emergency care are sensitive to financial pressures that may be exacerbated by high rates of uninsurance. The committee concluded that the trends in coverage and the evidence of adverse health consequences are all too clear, and while we did not advance specific policy proposals we called for immediate action to address the coverage and cost problems. Stated formally, the Institute of Medicine recommends that the President work with Congress and other public and private sector leaders on an urgent basis to achieve health insurance coverage for everyone, and in order to make that coverage sustainable, to reduce the costs of health care and the rate of increase in per capita health care spending.

Thank you. I look forward to our discussion.

[The prepared statement of Mr. Ebeler follows:]

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Mr. {Pallone.} Thank you, Mr. Ebeler.

Mr. Levine.

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^STATEMENT OF ALAN LEVINE

} Mr. {Levine.} Thank you, Mr. Chairman. I am here today to support systemic reform of health care in our country and to advocate that every American have access to affordable health insurance. However, covering the uninsured by simply expanding government programs like Medicaid and Medicare without structural reforms that focus on early identification of people with chronic disease and prevention is not a solution and may in fact make the problem worse, particularly from the perspective of the States. Let me explain.

In Louisiana, we are proud of the fact that 95 percent of our children have insurance. Most are covered through Medicaid, and while they have coverage, only 39 percent accessed a dentist last year. Only 55 percent of our infants zero to 15 months received their recommended well-child visits. Our infant mortality rate is the second highest in the Nation. Our death rate among children is the second highest in the Nation. We have one of the highest rates of insured children but the real question is, does that alone, does the Medicaid one size fee for all system provide the access, proper diagnosis and coordination of needed services. Structurally, we argue it doesn't. Considering that 56

3569 percent of our Medicaid population is African-American and
3570 nationally 56 percent of the Medicaid population is minority,
3571 we are literally as a matter of practice institutionalizing
3572 the very disparities that we all want to address.
3573 Who is accountable for the fact that 30 percent of what
3574 we are spending does nothing to improve health outcomes, and
3575 what industry would a purchaser accept paying a 30 percent
3576 premium for services that don't add value? Medicaid and
3577 Medicare were originally designed simply to pay claims, a
3578 financial process, at its worst breeding waste, corruption
3579 and fraud, and at its best supporting payment policies that
3580 incent legal but unnecessary and sometimes even harmful care.
3581 Many argue the low administrative cost of Medicaid and
3582 Medicare are reason enough to expand a government solution.
3583 I argue it doesn't cost anything to simply pay claims. The
3584 comparison simply isn't a fair comparison. The hidden cost of
3585 the inefficiencies caused by not coordinating care, not
3586 managing chronic illness and chasing fraud costs tens of
3587 billions of dollars each year that is not counted toward the
3588 administrative costs.
3589 To quote Dr. Emmanuel, special advisor to the President
3590 on health care reform, the health care delivery system is a
3591 fragmented, fee-for-service arrangement emphasizing delivery
3592 of more services rather than the right services. I couldn't

agree more. Why is the C-section rate 12-1/2 percent in Minneapolis but 26 percent in south Florida? Why does Louisiana have the highest Medicare cost per capita but the worst health outcomes? Just last week, three more physicians in south Florida were arrested for infusion therapy fraud. In 2005, providers in two south Florida counties submitted more than $2.2 billion in claims for infusion therapy, 22 times the total filed by the rest of the country combined, even though only 8 percent of the HIV/AIDS population lives in south Florida. We will never catch up with fraud or inefficiency if our system is designed to pay claims first and then ask questions later. It is simply difficult to manage.

Even States are forced to resort to gimmicks in Medicaid to optimize federal funding, a persistent source of frustration for Congress, the executive branch and for the States. We believe the solution is a structural reform that provides each American with access to health insurance, harnessing the resources and infrastructure of the private sector and government. Consumers should have a choice with government acting in its proper role of ensuring transparency and providing the system with proper oversight.

I again agree with Dr. Emmanuel, the President's advisor, who has said the advocates for a single-payer system

3617 fail to recognize the very organizations with the
3618 infrastructure necessary to coordinate care and implement the
3619 technology to develop rational payment models are the very
3620 insurance organizations they disfavor. Opportunities exist
3621 to correct the tax code to eliminate the bias against
3622 individuals, particularly low-income individuals. Rather
3623 than segregate the poor into government programs like
3624 Medicaid where they are confined without choice to poor
3625 outcomes, low-income Americans could be provided with premium
3626 assistance and be permitted to choose their own certified
3627 health plan that meets stringent requirements. The premiums
3628 should be risk adjusted and align the financial incentives
3629 with early identification of people with chronic conditions
3630 so they can be properly managed. Each plan should be
3631 measured publicly on key performance metrics, particularly
3632 for children, and we should focus on things like management
3633 of chronic disease, engaging consumers in their own
3634 behaviors, and I will tell you, the evidence as I will talk
3635 about during the Q&A shows that these models work. They have
3636 worked in California, they have worked in New York, they have
3637 worked in Arizona, they have worked in States all over the
3638 country, and we have shown actually that avoidable
3639 hospitalizations were reduced by 30 percent for minorities in
3640 California by using this model.

I look forward to answering your questions, particularly as it relates to the medical home model. We think that has to be the heart of any reform as well as investment in creating more primary care physicians and dealing with the medical liability system.

Mr. Chairman, I appreciate the opportunity.

[The prepared statement of Mr. Levine follows:]

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Mr. {Pallone.} Thank you.

Dr. Williamson.

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^STATEMENT OF M. TODD WILLIAMSON

} Dr. {Williamson.} Good afternoon, Chairman Pallone and Ranking Member Mr. Deal and members of the committee. My name is Todd Williamson, and I want to thank you for the opportunity to speak to you today on an issue that is vitally important to my profession and my patients.

I am particularly pleased that you have included on this panel an actively practicing physician who sees patients on a daily basis. I am a medical doctor, board certified in neurology, and practice in Lawrenceville, Georgia. I also have the privilege of serving as the president of the Medical Association of Georgia and am testifying on behalf of six State medical societies representing more than 35,000 physicians.

Medical care in America became the best in the world because of the patient-physician relationship and the right of a patient to select his or her own physicians. Patients have the right to privately contract with the physician of their choice. Decisions regarding care and the cost of care were made as part of this coveted relationship. This relationship and the profession it fostered served patients well and attracted bright young men and women into a

rewarding field of service to their community. Clearly now something has changed. The private practice of medicine, once the backbone of America's medical care system, has become nearly untenable. Many newly trained physicians do not have the option of going into private practice because of large educational debt and high practice startup costs. This is especially true for primary care specialties. In many communities, only older, established practices are feasible and new physicians are rare. In my home county of Gwinnett, the population has nearly doubled during my practice tenure but the number of full-time practicing neurologists has remained nearly constant. The number of primary care physicians has not kept pace with the population and the number of general surgeons has actually declined. This means that it is more difficult for patients to see the doctor of their choice.

How did this happen? The answer lies in examining how we pay for our medical care. Initially, health insurance was a mechanism for distributing risk, not a means of paying for all medical care services. Soon after, third parties began paying for medical care and they began controlling the delivery of medical care. Medical decisions have become the business of third-party payers causing delays in the delivery of care. Our patients have lost the ability to choose where

they receive care and physicians are faced with take-it-or-leave-it contracts offered by large health plans. As the impact of third-party payers increased, administrative burdens were placed on physicians. When I started practicing nearly 15 years ago, my office of four doctors employed one person to submit insurance claims. We are now down to three doctors but we have three full-time employees just to manage insurance issues. These added administrative costs divert funds that could be used for patient care. Simultaneously, Medicare and Medicaid rates have not kept pace with the cost of providing care, and in many instances are below the cost of delivering the care. Private payers have reduced payments dramatically using federal payment levels as guidelines.

We all know the payment system is broken. How should it be fixed? I believe the way to heal our payment system is to restore the patient-physician relationship by ensuring that patients have the right to privately contract with the physician of their choice without onerous penalties regardless of the presence of a private or government third-party payer. The importance of this point cannot be overstated. Medical decision making would once again be in the hands of patients and their physicians. This will enhance patient choice, heal the ailing payment system and once again restore the best medical care system in the world.

We hear a lot about the high cost of medical care in our country. Please consider the difference between medical care costs versus medical care expenditures. While the cost of many specific procedures and therapies is actually lower today than in years past, we now expend much more for care because more patients have access to more tests and therapies that simply were not available in years past. We can significantly reduce health care expenditures by enacting proven, effective medical liability reform measures that will eliminate the need for so-called defensive medicine.

As an early adopter of electronic medical records, I will caution you not to overestimate the savings from advances in health information technology. We must continue to guarantee patient privacy and ensure that medical records are kept confidential. However, regardless of whatever reforms are enacted, we can preserve patients' access to quality medical care only by ensuring the rights of physicians and patients to privately contract for care.

I appreciate this opportunity to present the views of a practicing physician to you today, and I am happy to answer any questions you may have. Thank you.

[The prepared statement of Dr. Williamson follows:]

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Mr. {Pallone.} Thank you, Dr. Williamson.

I just want everyone to know, we have three votes. We are going to hear from Dr. Gawande and then we will break and come back right after the votes for questions, so we will ask the panel to stay.

Dr. Gawande.

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^STATEMENT OF ATUL GAWANDE

} Dr. {Gawande.} Chairman Pallone, Ranking Member Deal and distinguished members of the subcommittee, it is an honor to be speaking to you today about repairing our ailing health care system. As a clinician and observer, this is what I see. Our health system is failing in cost, coverage, safety and value because health care itself has become so immensely complex. I will try to explain.

The new edition of the International Classification of Diseases identifies more than 68,000 different diagnoses that we now know a human being can experience, and science has given us beneficial remedies for most of them with more than 4,000 different procedures and 6,000 different drugs, but the remedies are rarely simple. Each involves different steps care, risks and uncertainties, often expensive technologies and complex coordination. This extreme complexity has produced failures of coverage and of execution with large numbers of patients experiencing inappropriate treatment, avoidable infections and other forms of costly harm. These failures reveal that the structure of our health system is not suited to what we have learned is required for good care. It has three main problems. Human beings need preventive and

acute care throughout our lives including costly medications, procedures and hospitalizations yet most Americans lack coverage for significant stretches of time. The system doesn't measure its successes or failures. And third, the system has no reliable mechanism for deployment of practical knowledge for ensuring, in other words, that important discoveries actually reach the average American.

The result is a troubling mismatch. We are an industry of highly skilled and extraordinarily hardworking individual professionals but we work in a structure where no one is aware of, let alone responsible for, the overall effects of what we do, whether for our patients or the economy as a whole.

This reality, I want you to know, comes home to me weekly. Recently I helped care for a critically ill woman in her 60s with severe abdominal pain. Insurance coverage troubles may have played a role. She had not seen a doctor in 15 years and had multiple preventable problems. To save her, I operated to repair her ruptured colon, a cardiologist treated her subsequent heart attack, intensivists managed her pneumonia and a vascular surgeon tried to rescue her foot, which had become gangrenous and would have to be amputated. She didn't make it. It was all too much for her. But there was a moment when we thought she would pull through, and as

we contemplated it and considered that when she went home she would be unable to work, unable to eat for months and have a large open wound, someone asked, who is going to be her doctor, who is going to take care of her. The silence was deafening. The answer, of course, was that we all needed to be her doctor. Each of us would see this woman in our clinics for one of her problems but we had no real mechanism, let alone incentives, to work as a team and ensure that nothing fell between the cracks, that we all worked in a common direction for her.

The great satisfaction of medicine is to have skills that help people and to be rewarded for using them but there is also a constant demoralizing recognition that one is but a white-coated cog in a broken machine. Our present structure of health care with its gaps in coverage and value has set us up for failure. A better health system requires a few new capabilities. For one, it must provide coverage for people without it, a kind of lifeboat for those left out or dropped from care, and over the next few months we are going to be hearing you argue until we are all blue about whether that lifeboat should be a public program, a private program or both, but the key is that the coverage must be there and it must be adequate. We must simply take that step. Just having an insurance program, though, will not make health

care better, safer or less costly. We must also outfit the system to measurably reduce failures and increase success in health care delivery and thereby increase the value of our immense investment in health care, and that requires doing three new things.

Number one, we have to measure national statistics. We must measure in real time the results and value of care nationally, how many Americans suffer hospital infections, die from surgical complications and other basic indicators. Our current data measurement is inadequate, uncoordinated and at least 3 years out of date. This is one-sixth of our economy, and not having these measures is like not knowing our unemployment or inflation rate.

Second, we have to support discovery of practical know-how. We spend $30 billion a year seeking new scientific discoveries but little to identify how hospitals and doctors' offices can put them all into effective use. This is vital, lifesaving reach. My team at Harvard and at the World Health Organization, for example, devised a 90-second safe surgery checklist that was found to reduce surgical complications and deaths by more than one-third. We need more solutions like these, basic team checklists for everything from heart attacks to infectious outbreaks, and we also need investigation of the complex solutions you heard about today

such as how to organize and bundle payments for teams to be more effective for care and wellness and measure what is happening with them.

And third, we need to coordinate deployment. At present, new knowledge like that safe surgery checklist, takes more than a decade to reach most Americans because no one is responsible for ensuring dissemination. A reformed system must therefore support active deployment.

I would like to see this work coordinated in a national institute for health care delivery but it can be done through existing agencies like the National Center for Health Statistics, the Agency for Health Care Research and Quality, and insurers like Medicare or a coverage program for the uninsured. The debate about how we will do any of these things will be fierce but we must do these things if we want a better health system and the goals are achievable. By 2013, we can virtually eliminate personal bankruptcies due to health care debt. We can make health care measurably more effective including reducing the number of infections picked up in hospitals by 50 percent, by becoming the first country in which cardiac disease is no longer the number one cause of death, and by reducing major complications and deaths from surgery by at least a fourth. We can improve the ability of clinicians to do their jobs by reducing the burden of

insurance paperwork by at least 50 percent, and we can cut overall health inflation by at least half by 2013 and ensure no business has to spend more than 15 percent of payroll on ordinary health coverage.

Health reform is not going to produce a utopia but we can have transformation, which is to stay we can do more than just catch up to other countries. If we follow through on this work, we will have the most effective health care system in the world. I thank you.

[The prepared statement of Dr. Gawande follows:]

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Mr. {Pallone.} Thank you. You went over, but your optimism makes me feel good.

What we are going to do is, we have about half an hour approximately for votes and then we will come back, so we ask you to stay here and then when we come back we will have questions. So we are in recess.

[Recess.]

Mr. {Pallone.} The committee will be called to order. Myself and Mr. Deal are the first questioners so we might as well get started and then I am sure the others will start coming in. I will recognize myself for 5 minutes.

I wanted to ask Dr. Gawande the first questions. During the health summit, and I keep harking back to that, the consensus was clearly that we weren't looking to make radical changes with the system. You know, we really were just looking to improve the current system, and I mean, politically certainly that is going to be the easiest way to go, and of course, you know, from my perspective, when we talk about the current system, I divide it into three parts. One, existing government programs like Medicare, Medicaid, SCHIP and how we can improve those, and then the second thing would be employer-sponsored care, which I think Mr. Ebeler stated, you know, has been drastically reduced because of

rising costs over the last few years, the percentage of Americans that get their health care through their employer is down, and then finally of course, there is this area of creating some kind of a health market or national insurance pool that the government would regulate in some way either with totally private insurers or possibly with a government option for those who now can't get a government program because they are not eligible or they don't get it through their employer and they have go on the private market. So when I talk about building on the current system, I mean those are the kinds of things that I talk about.

But you say, I think, Dr. Gawande, that we can't simply expand coverage and leave it at that. In other words, you know, we hope that we can reduce costs and reduce growth and come up maybe with a new funding source, as the President has in his budget, but that is all part and parcel of the ability to expand coverage. In other words, we are going to hopefully expand coverage by using some of the cost savings but if all we do is expand coverage, that is not going to be good enough.

And I also wanted to hark back to what Mr. Ebeler said because I was thinking of my staff person in my office. You said that with high levels of uninsurance may undermine health coverage for the insured population, and in the

previous panel I used the example of my staff person in New Jersey who has, I think, Blue Cross/Blue Shield, works for me, but he couldn't get a primary care physician so he ended up in an emergency room. So I guess my fear is, you know, we want to build on the current system, we want to expand coverage but at the same time we have to make sure that it is done in a way that improves the system and creates cost efficiencies. So I guess I would like to know from Dr. Gawande, how do we achieve these goals? I mean, can you walk me briefly through and show how it is achievable to cover everyone and use cost savings to pay for a good percentage of it and still have a quality system? I mean, you could talk for days but--

Dr. {Gawande.} So the short answer is that it is going to have to happen on a path that takes a step-by-step process. So imagine on January 1, 2011, what can we do. Within weeks we could cover an entire population of people. We could start with people under 25, for example, and have them in coverage by saying that we would enroll them in a plan and it can build on the experiences we have. It could be one that is based on something like the federal employee benefits plan which offer a range of private options. It could be an option that is a public option building off of Medicaid or Medicare. But that coverage part can be done.

The second part of it is whether you are able to begin to include the kinds of proposals that people proposed earlier in that first panel. Do you begin to include, for example, in Medicare and other kinds of programs medical home and other models which start to make primary care better, just better organized. But we have work to do on our side in medicine as part of reform as well, and I think that includes being able to now test ways to structure care that make it more cost effective but more important better in safety and better in quality.

Mr. {Pallone.} Let me ask you this, and I am not trying to cut you off, but include for me your opinion about whether there should be a public option and whether or not we should be expanding employer-sponsored care, for example, by providing tax credits or, you know, making it more affordable using federal dollars for that.

Dr. {Gawande.} Well, the debate over the private-public option is a bit baffling to me. I think the question people are asking is whether the existence of a public choice undermines the ability of the private sector to succeed, and we live in a world that looks like that as it is. We live in a world where we have Medicaid, we have the VA, we have Medicare and we have private insurance. We have a kind of flotilla of ships that provide our health care system with a

big gap because you have 15 percent dumped off of these ships into the sea without coverage and so what we are talking about is what is the makeup of this ship that would be a lifeboat for the people who are left out. As a clinician, I don't have any strong preference about a private plan. Dealing with private insurers is as ugly to me as dealing with Medicare. I have, just like Dr. Williamson laid out, I have a full-time person who has to manage just dealing with insurance rejections and referral numbers and everything else and so I think a fundamental part of this is that we include research work for the practical know-how of cutting that insurance paperwork and that private insurance administrative costs for us down. I think there is a burden that I see as both a citizen and as a physician where I wonder what is the added value of paying more for some of those private insurance costs that I am absorbing and I do think there is a burden to prove that value in being able to coordinate care and improve the value of our end results.

Mr. {Pallone.} Okay. Thank you.

Mr. {Deal.} Well, this is a difficult onion to peel. First of all, I would like to ask the two doctors here, both of whom are specialists, when we start talking about concepts like medical homes, obviously your practices depend on referrals from someone below you in the chain of delivery.

Do you have concerns about medical homes becoming the proverbial gatekeepers that maybe absorb more responsibility than perhaps we would anticipate? Is that a concern?

Dr. {Williamson.} That certainly was a concern I think back in the 1990s. I think what we saw is that the gatekeeper model really didn't work for anyone. It added delays, it added extra costs. I do agree that anything that would serve as a gatekeeper function is concerning to specialists and it should be concerning to patients. As I understand the medical home concept as it has been presented, it is not fundamentally a gatekeeper as that term was initially introduced. So yes, I am concerned about any gatekeeper scenario but my understanding of the medical home scenario as is being put forth now doesn't include that as a significant consideration.

Dr. {Gawande.} And I would agree. The medical home concept, as I understand it, and it does shift a bit but the general idea is that the only way the primary care physician is paid is if you are physically with the patient in your office, and compensating them for all that time they spend on the phone, on e-mail, coordinating care with other specialists should be done and that is a major part of what primary care physicians do and we should make that more attractive and better structured, and I think that would make

the specialty care better as well. The way I think of it is, we should have a medical home but there are going to be specialists in the neighborhood.

Mr. {Deal.} Well, I agree with the concept as long as it plays out the way the both of you have talked about.

One of the other concerns I have is that we are talking about reform but invariably we come back to wanting to use our current programs as a model or a basis for expansion, and as somebody, several of you actually have pointed out, we currently face the crisis of SGR every year. The complaints that we get from both Medicare and Medicaid, from the provider community continue to grow, and to anticipate we are going to dump 47 million people into government programs that already have their problems without structurally reforming those programs I think is not feasible. Now, we talk in terms of being able to save half or whatever of the ultimate cost to pay for this expanded coverage from efficiencies within the current system but then that means there is another half that comes on top of that.

Mr. Levine, I also have a concern of, for lack of a better term, the woodworking effect. We recognize that there is always a woodworking effect once you have coverage of expanding the utilization. Do you have a concern about that?

Mr. {Levine.} Thank you, Mr. Deal. I would think that

anything that we do to expand government programs can potentially have the unintended consequence of allowing people the opportunity to leave their private coverage and come into the public program, and, you know, the difficulty from the States' perspective as it relates to Medicaid is, if that starts to occur, if you see Medicaid rolls increase dramatically, we can't serve the population we have now. Providers, because of the rates paid in Medicaid, it is very difficult to get specialists and even primary care. So I would be concerned about what we call the crowd-out. So I think States really need to be consulted on that before that decision is made.

Mr. {Deal.} Dr. Williamson, you mentioned the question of defensive medicine practices and the necessity for medical malpractice reform.

Dr. Gawande, do you agree that that is an element that ought to be addressed in this overall discussion?

Dr. {Gawande.} I have actually written a great deal about what I consider to be a problematic medical malpractice system. It doesn't work for patients, it doesn't work for doctors and it is excessively costly. One of the most--from some of the research work we have done, though, the most valuable thing we can do for malpractice is have universal coverage. Other countries that have universal coverage have

4070 markedly lower malpractice costs, primarily because the
4071 payouts for the medical costs are no longer in the legal
4072 system and that is the majority of what is paid out in the
4073 costs. So physicians could have a markedly reduced premium
4074 for their malpractice expenses in a universal coverage system
4075 simply because that system now guarantees the coverage for
4076 universal coverage and it doesn't end up in that legal
4077 expense.

4078 Mr. {Deal.} I don't quite follow the logic of that.
4079 Let me say from the perspective of what I just heard you say,
4080 is that if we get more people into the public system, that
4081 the doctors don't need to worry as much about the cost of
4082 medical malpractice. It would seem to me that they would
4083 have even exponentially more reason to worry about it.

4084 Dr. {Gawande.} So if I get sued and I have to pay $1
4085 million for a malpractice suit, most of that money is future
4086 medical expenses for the patient who was harmed and left
4087 disabled. In other systems, because that person's disability
4088 and their medical expenses are covered in a national health
4089 system, that doesn't enter the court system and so the costs
4090 for medical malpractice are massively lower, much lower than
4091 you would achieve with a cap, much lower than other kinds of
4092 approaches, and a universal coverage system is hugely, hugely
4093 beneficial for us as physicians in helping decrease that

malpractice cost.

Mr. {Deal.} That would require some substantial changes of State and perhaps federal law as well, I think to be able to discount the cost of future medical as a compensable factor in medical malpractice.

Dr. {Gawande.} It is just that every other country that has a universal coverage system is able to do that because they have health coverage.

Mr. {Deal.} Okay. Thank you.

Mr. {Pallone.} Ms. Christensen.

Ms. {Christensen.} Thank you, Mr. Chairman.

Mr. Levine, I clearly support Medicaid and like the chairman, you know, consider that building upon Medicaid, SCHIP and others as part of extending coverage but I do share some of your concerns about the ineffectiveness of the care and the poor outcomes but don't you think we can fix Medicaid without throwing the baby out with the bathwater? I mean, there are other factors like lack of providers, facilities, services in poor neighborhoods.

Mr. {Levine.} I agree with you. I am not suggesting necessarily throwing the system out but what I am saying is that expanding it without fixing it will be perilous for us. I will tell you, I look at, for instance, in California. When California implemented the coordinated care model and

they allowed consumers to opt out of the fee-for-service system into a managed Medicaid model, unique to California, the rate of avoidable hospital admissions for African-Americans decreased by 36 percent, Hispanics by 37 percent. When we talk about proving out prevention--because what went along with that was, looking at, for instance, in New York, cervical cancer screenings went from 39 percent to 71 percent using a coordinated care model, diabetes testing went from 32 percent to 76 percent. What you find when you move towards a coordinated model is, you will spend more on physicians, particular primary care physician services, you will spend more on pharmaceuticals for things like diabetes maintenance drugs and things like that, but you will spend much less on institutional services that cost more. And that data is out there. There is compelling data over 20 years to support that claim.

So I think that fundamentally before you look at any expansion into public programs, into public fee-for-service programs, I would argue that you should fix the structure so it does three things. Number one, it is geared towards risk adjustment of premiums so if somebody is chronically ill, there are more resources that follow them. Number two, it also incentivizes people to identify people with chronic conditions and it also encourages chronic disease management,

and then finally engaging the consumer in their own behavior, particularly if they have a chronic disease.

Ms. {Christensen.} Thank you. I am going to try to get two more questions in. Thank you for the clarification.

Dr. Gawande, you mentioned one of the reasons for having the problems within the system that decision making not being as consistent or reliable as people deserve. Now, in looking at that decision-making problem, have you seen any racial, ethnic, economic or gender basis for this or is it across all lines?

Dr. {Gawande.} No, and just as Mr. Levine pointed out, the ways in which the insurance coverage plays in affects the disparities in the care and then also in the decision making that occurs and we have seen some very powerful studies that show, for example, that people presenting with the same complaints about chest pain end up having very different care. One of the striking things from being able to implement our work in making surgery safer is we have done it from rural Tanzania to top hospitals in places like Seattle, and the striking thing is that you are taking places that are hugely disparate and even with that degree of resource changes, we were able to reduce their complication rates and bring them all up the bell curve and reduce the disparities considerably, and if we can do that from India and Tanzania

and Jordan to London and Toronto and Seattle, we can do that between, you know, my hometown in rural Ohio and a place like here in D.C.

Ms. {Christensen.} Thank you.

Dr. Williamson, could you elaborate on your statement in your testimony that you caution us not to overestimate the savings from advances in health information technology?

Dr. {Williamson.} Yes, I can, and that is made purely from a perspective of a practicing physician. I was one of the first 4 percent of physicians in Georgia to implement an electronic health record as well as electronic billing services, and that one item was the single largest purchase in my practice in its 25-year history, and maintaining it is enormously expensive every month. Once you buy it, you have got it. Changing it is prohibitive. So you are pretty much locked into a certain cost of maintenance month by month. It is a fantastic tool and it allows you to do things that you simply cannot do otherwise. Unfortunately, saving money is not one of the immediate advantages that I have found. Now, I know many practicing physicians that have bought systems like this and actually abandoned them and just called it a loss. I know other physicians that feel like it has added to the productivity of their office. It is not a slam dunk though, and it shouldn't be, I don't feel, viewed as a way to

instantly save money across the board.

The other concerns that I have about health information technology going forward, although certainly it could make us more efficient, is that protecting patient privacy be paramount in that because a patient is much less likely to come to the doctor if they know that their medical records are instantly going to be on the Internet somewhere, and we have got to keep that in mind going forward. You are talking about something that would keep patients out of the doctor's office. That definitely would. So I strongly encourage you to keep that in mind as we go forward, protecting patient privacy in health information technology.

Ms. {Christensen.} Thank you, Mr. Chairman. I would like to just ask unanimous consent to enter a statement for the record submitted by AARP for this hearing.

Mr. {Pallone.} We have seen it, so without objection, so ordered.

Ms. {Christensen.} Thank you.

[The information follows:]

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Mr. {Pallone.} Mr. Burgess.

Mr. {Burgess.} Mr. Chairman, before I do questions, may I just take a moment for a point of personal privilege? I wanted to add to your optimism after Dr. Gawande testified and he gave you great hope. I have a young constituent here from Texas, Wen Chin, who is a student at the Texas Academy of Math and Sciences at the University of North Texas. This is where young high school students are taken into a college environment and allowed to flourish, and Mr. Chin has done exactly that and he has developed a new system called pulse plasma deposition, which lays down a layer on plastic, silicone, metal and a variety of other substances which inhibits the growth of bacteria and therefore could one day reduce our hospital-acquired infections with a very inexpensive process that he has developed. So Mr. Chin, stand up and take a bow. As I understand it, he has won a scholarship from Siemens Westinghouse for $100,000 and he is a finalist for an Intel scholarship, so congratulations. I wanted to add to your sense of optimism that there are indeed new breakthroughs on the horizon that are not going to break the bank. Thank you, Mr. Chin, for your indulgence.

Now, I am going to ask you a question. This is really mean to do it but I am going to do it anyway because I have

been sitting here all day, and you don't have to answer, but let me just go across the board here and if you have health insurance today, would you swap that one for one for Medicaid coverage? Mr. Ebeler?

Mr. {Ebeler.} I am in a policy box here because I am representing the IOM committee and we did not speak to that, so my only advice to you is that health insurance coverage matters, it is important for everybody to have it. We have no judgment on that question.

Mr. {Burgess.} Very good evasive answer.

Mr. Levine?

Mr. {Levine.} Would I trade my coverage for Medicaid?

Mr. {Burgess.} Yes.

Mr. {Levine.} No.

Mr. {Burgess.} Dr. Williamson?

Dr. {Williamson.} No.

Mr. {Burgess.} Dr. Gawande?

Dr. {Gawande.} No.

Mr. {Burgess.} The reason I ask is, I offered an amendment during the SCHIP legislation so that members of Congress could get a better idea, and Mr. Levine, you have alluded to it, that provider rates are different in Medicaid. Of course, it varies from State to State. It may be different in different States but it is typically hard to

find a doctor if you pick up the phone and call and say will you take my Medicaid. And then of course for the doctors who do, it is very difficult if you need a cardiologist or an ear, nose and throat specialist or whatever, it is hard to find a specialist to take that care. So I offered an amendment to get members of Congress to give up the FEHBP, the Federal Employee Health Benefit Plan, and switch to Medicaid so we could live that life for a while and see if we couldn't be more creative about offering better solutions, and I didn't get any votes. So just like you all, you are not unique in that. But I didn't poll the IOM and maybe next time I need to do that.

Now, Mr. Levine, you have brought up some very interesting concepts about Medicare being simply a bill-paying organization and therefore the overhead, when we hear overhead comparisons between Medicare and other private sector plans that that is perhaps a false comparison, and we also all know that we never calculate the cost of capital. Medicare has a huge unfunded liability and if any of us were to construct a business plan and carry liability we would have to have interest payments on that liability going forward. But would you care to speak to that just a little bit more?

Mr. {Levine.} Well, there are a couple of things, I

think two things, first, about the administrative costs of Medicare and Medicaid and then two, relating to rates. Let me answer the second part first. You talked about rates. Let us be clear about how Medicaid sets rates. It is different from Medicare. Medicaid sets rates based on how much a State can afford generally in the aggregate and there is no rationale behind the rates. If you are a neurosurgeon in Lake Charles, Louisiana, and you are a neurosurgeon in Baton Route, you are getting paid 90 percent of Medicare, and by the way, I understand that is a good pretty rate compared to other States.

Mr. {Burgess.} Very good.

Mr. {Levine.} So come to Louisiana if you are a doctor. But irrespective of the market conditions, we pay the same thing. That is not a way to deal with the shortages that we have, and in fact, I have a case right now, a woman with a brain tumor that literally was told by her primary care doctor who lives in Lake Charles, you have a brain tumor, there are no neurosurgeons taking new Medicaid patients, drive to Shreveport, go to the ER, tell them you have a brain tumor and you will get to a neurosurgeon. That is how Medicaid operates, and there are stories like that in every single State, so it is not a unique anecdote.

As to the administrative costs, understand, and I am

4305 going to refer to the American Medical Association. They
4306 have done their own analyses of administrative costs between
4307 public and private programs. First of all, when you measure
4308 the administrative costs of Medicare and Medicaid,
4309 fundamentally all they are really doing is paying claims and
4310 then chasing the claims afterwards when they go after fraud
4311 and abuse and overbilling. But they don't even count
4312 administrative costs the same. In the Medicare program, and
4313 this is according to the AMA, premium collections by private
4314 payers is counted but not by the government when they count
4315 their own administrative costs. Medicare outreach, customer
4316 service, OIG auditing, contract negotiations, these things
4317 are not added the same, and what administrative costs also
4318 don't count in the public paying systems is, like for
4319 instance in Medicaid, people that are very sick, very chronic
4320 that are in the Medicaid fee-for-service program as a
4321 percentage if you are measuring the cost as a percentage, of
4322 course they are going to be lower because the per-unit
4323 billing, the per-person cost is substantially higher.
4324 Mr. {Burgess.} I need to move on to one other thing.
4325 GAO did a report 2 years ago that suggested within the
4326 Medicaid system that Medicaid becomes the primary payer when
4327 in fact it should be the secondary payer and this occurs
4328 roughly 15 percent of the time, different in different

States, as low as 11 percent in Texas, 25 percent in Iowa, and I suspect this is a problem because of the difficulty with collecting across States lines if a patient changes addresses and changes locations. Is there a way that we can deal with that problem of Medicaid going from a secondary insurance to a primary insurance when a private insurance should in fact be covering that patient?

Mr. {Levine.} We do have recruitment processes but typically again, as I mentioned earlier, we are paying and then chasing afterwards. I need to do some more research on that for you.

Mr. {Burgess.} I will get you the link to the GAO report and I would be interested to get your thoughts on that.

Thank you, Mr. Chairman. I will yield back.

Mr. {Pallone.} Thank you.

Ms. Capps.

Ms. {Capps.} Thank you, Mr. Chairman, and thank you to these witnesses and for your perseverance and staying as long as you have. I want to turn first to Dr. Gawande and then Mr. Ebeler for the last half of my precious 5 minutes.

Dr. Gawande, I appreciated your testimony very much, as I told you, and I am very interested to learn more about your idea for a national institute for health care delivery. As

we develop a strategy to improve our health system overall in that big picture, clearly clinicians are the most integral players, and I would like to ask how you foresee a national institute for health care delivery or something like that working and how we could get that information to clinicians, how actually you would see that implemented?

Dr. {Gawande.} So a good example would be to break down our services that we provide into several buckets. We do 3-1/2 billion prescriptions, we do about a billion office visits, we do 120 million ER visits, and if you had a national institute of health care delivery, it would focus on asking why do the ERs not work, what are the tools they need to get rid of diversion, to deal with organizational problems, to stop the waiting times in ERs, to divert the group who are getting, you know, non-urgent care that should be in other places. They would invest in programs that we don't invest in, for example, experiments with how do you triage people correctly so they go to the right place safely and get quality care and save money. NIH does not pay for that work. I spent 3 years trying to say that we know how to make surgery have fewer complications but there was no funding in the government to get it. I got the funding to carry out an American study from the World Health Organization. In the end it only took about $100,000. I

made sure we tested it in eight countries, and I showed here at home that we could reduce our complications with a 90-second checklist that costs, you know, nothing at all, and so that is the kind of work I can imagine coming from a national institute for health care delivery service by service, in the ER, in dialysis, in operating rooms and in offices and clinics. What is it we need to make those places organize all of these drugs and technologies we are trying to deliver.

Ms. {Capps.} Thank you very much. I would like to follow up with that.

Mr. Ebeler, some of the testimony that has come forward today during this hearing argues that we should look at private arrangements, that sort of sacred physician-patient relationship in the private context or others have argued that our health care problems can be solved through a tax code alone, in other words, leave those decisions in that other sector. Your research seems to indicate another direction and maybe you would elaborate on why this might not work according to some studies that you have access to.

Mr. {Ebeler.} Let me say what we found, and it is not--we are not speaking particularly to different options that the subcommittee and committee have for reforming system. Our message and our research really hones in on the fact that people who have no coverage are getting less than they need,

they are suffering worse outcomes, and that relates a little bit to Mr. Deal's question, very good research that when you add coverage, whether that be children becoming eligible for CHIP or adults becoming eligible for Medicare, for folks who were previously uninsured you see very positive results of that. So that is the way to go. So the message we have for you is the need to proceed, the need to make sure that those uninsured patients get coverage so that they can have a connection with a physician. The flavor of that approach of the different options in front of you, we don't have a view on that at this point.

Ms. {Capps.} Your basic discovery, if you will, sort of makes sense too, that if you don't have a regular path to some provider that you use for small things, that when you are forced because of the drastic nature of your symptoms to seek health care, you are not going to have as good an outcome, and you have documentation to show that too, so which kind of care it is that we pursue with some kind of goal of everybody getting coverage some way, is it less important to you than the difference between not having coverage and having coverage?

Mr. {Ebeler.} Correct.

Ms. {Capps.} Anyone else? I have 16 seconds left if anyone has a final thought on that topic. I appreciate that

very much. I think it gives us a good starting basis from which to--I mean, I hope we can all agree as a result of this day that we spent with you that it more important to have some access to care than not to have any, even though there is care available in the community.

Mr. {Ebeler.} That is an important point, because these studies--the simple reality is, the uninsured are getting some care and there is a safety net out there and there are doctors and nurses and hospitals trying to help every day, but the simple reality is, when you adjust for all the things you need to adjust for, they are not getting the clinically appropriate care and they are suffering worse outcomes.

Ms. {Capps.} I yield back. Thank you very much.

Mr. {Pallone.} Thank you.

Mr. Gingrey.

Mr. {Gingrey.} Mr. Chairman, thank you, and I will direct my first question to Dr. Gawande.

Dr. Gawande, when Ranking Member Deal was talking to you about medical malpractice and that sort of you and you were saying under universal coverage it would be much less expensive. When you referenced universal coverage, were you meaning the same thing as this phrase national institute for health care delivery? Is that basically the model that you were talking about?

Dr. {Gawande.} No. So a national institute for health care delivery would be more like a research organization like we have with the National Institutes of Health, which does new discovery of technologies and this looks at the side of how do we make sure those--

Mr. {Gingrey.} Okay. Then I understand that. But basically I guess when you said universal coverage, you were referring to universal health care, a single-payer system?

Dr. {Gawande.} No, that is not true. Any system in which--so, for example, in Switzerland, they don't have a single-payer system, they have multiple private insurers that provide coverage for the entire population. They don't have a public insurance--

Mr. {Gingrey.} Reclaiming my time. The reason I asked you that question, because I really do believe that a lot of people get confused about universal coverage and universal health care, and I think it is important to understand that members on this side of the aisle and even on the other side of the aisle, we are in favor of universal coverage without question. I think those 47 million people ought to be insured and I think that would be good for our country, good for our economy and certainly good for them, for the individuals. But universal health care when it means a single-payer system or national health insurance program, and

I think that was the thing that seemed to be a little bit confusing when Representative Deal was asking you about the cost of malpractice coverage and he was a little confused, and clearly I think it would not be cheaper just because you had universal coverage. But anyway, I am going to move away from that. I wanted to ask the other witnesses a couple of questions.

Real quickly for Mr. Levine, in regard--you run that Medicaid system in Louisiana. Do you feel that we should get away from the Medicaid system and very likely put everybody in a managed care Medicaid sort of program, maybe through a connector where you have insurance companies that are going to bid on this business?

Mr. {Levine.} I am for consumers have a choice of what model they want. I think it is very difficult for States--we process 54 million claims a year. We spent a lot of our time just really chasing fires as opposed to trying to put these integrated systems together that we need to. There is a variety of different models out there. I think philosophically where we are at is a coordinated system of care where consumers can choose from different networks, which network they want based on transparent outcomes, which one has the best patient satisfaction, which one has the best provider satisfaction, best compliance with well-child

checkups, and let a consumer choose that plan that works best for them. I think in that model the consumers win because fundamentally everyone is going to react to the most powerful force out there, which is--

Mr. {Gingrey.} Reclaiming my time because I do want to get to my colleague from Georgia with the last question but I tend to agree with you on that, Mr. Levine.

Dr. Williamson, I thank you for your testimony, and, you know, like every aspect of our economy, health care and its costs are also a function of supply and demand. I think you brought that out in your testimony, and obviously when we are discussing our health care system, demand is the need for medical services by the patient and supply is very much contingent on the quality and quantity of doctors and other medical providers in the market. I am wondering if you can tell us from your perspective what obstacles potential medical students of the future may face when considering entering the field of medicine? I am talking about education costs, years of schooling, cost of liability insurance and practice overhead, if you could in the few seconds remaining.

Dr. {Williamson.} It is a significant endeavor to start down that road, and you just listed, I think, all the major items. Students, as you know, now face enormous debt when they finish medical school. The numbers are way into six

figures. I have heard a lot of figures thrown around. But that amount of money is easily equal to a mortgage, easily, and I remember when I first finished residency I felt like I should be looking for a retirement community rather than a job, but I had to go out and find a job, and that basically is a starting-over point for residents that finish their training after a 13-year or so depending on what specialty you are in, tenure and you have accumulated quite a lot of debt, made very little money and spent a decade and a half, and I am concerned that bright young men and women like the gentleman that was introduced so eloquently earlier aren't going to pursue the profession of medicine if they don't see it as a viable way to take care of their families and their debts, and that is a very real problem that we have now. It is not just attracting bright young men and women to the field but it is keeping them.

Mr. {Gingrey.} Real quickly, because my time has run out, do you feel like if we go to a single-payer system, national health insurance and that these bright young men and women realize that they indeed will be working not managed by the government but for the government that they would disincentivize them even further from choosing medicine as a profession?

Dr. {Williamson.} I believe that is correct, and we

have data in Georgia that bears that out. We have survey data that practicing physicians have said in a majority that they do not feel that increased government involvement in financing health care is going to be a good thing for the profession, so I think you are right. I think larger government involvement in health care in general is going to dissuade bright young men and women from entering the field of medicine.

Mr. {Gingrey.} Thank you, Doctor.

Mr. {Pallone.} Thank you.

Mr. Sarbanes.

Mr. {Sarbanes.} Thank you, Mr. Chairman. Thank you to the panel.

Dr. Gawande, I have to say your response to the malpractice question is kind of like a heat-seeking missile. I thought that was very good. I am sure it is going to generate a lot of follow-up research and inquiry. But I wanted to ask another question because I am so focused on this issue of the physician shortage, particularly in the primary care arena, and also how it gets linked to new and more innovative delivery models or taking some of the existing delivery models that we have and expanding them. The term I use for this is sort of place-based health care, so for example, school-based health clinics. That is where

the kids are. That is where they spend most of their day. There should be a health center in every school and you are going to need pediatricians to staff those. There is a concept called naturally occurring retirement communities, which are where people are aging in certain neighborhoods so you can look at the whole neighborhood like you would like at a senior living community so you could argue that a place-based clinic with an emphasis on geriatricians in a NORC, a naturally occurring retirement community, would make sense. The concept of clinics in places of employment, I mean, if you walk down the hall there is a health clinic, you know, a health suite right down the hall here to make it easy for people who work here on the Hill to go get health care. So I don't know how much you have thought about that but I would love to get your perspective on that in terms of informing the kind of delivery model we are trying to move towards and where you would base a lot of these new primary care providers like geriatricians and pediatricians and others once we get them in the pipeline.

Dr. {Gawande.} My immediate reaction is that what are you honing in on is that we have had half a century now of lost innovation with how primary care is created and delivered because we haven't provided the incentives for people to put them anywhere else other than in offices that

might be from 9 to 5 with very limited evening hours, very limited weekend access and so on. The idea of putting them in places closer to where people actually need their care if there was more incentive for those physicians to be entrepreneurial, it would be--you would see those cropping up and you would see that come into place. I think the creation of ideas like medical homes starts to give people incentives for organizing their groups in places where they can do that work most effectively and get to their patients that they are looking for and so I think that is an important point.

The second thing is that on physician shortage, your earlier comments and then coming again here to say that we have this looming aging population without adequate primary care and then a world where if we create universal coverage will provide increased demand for basic services. We have seen that in Massachusetts where we have coverage now and primary care physicians can finally see people but because there weren't enough primary care physicians around we still have insured people, as the chairman mentioned, going to emergency rooms and so I think that work that you are interested in is very fundamental.

Mr. {Sarbanes.} And of course, that will be the critique, right? If you get the coverage and you don't have the providers in place, then people are going to have to

wait, you know, weeks and months to see somebody, and that is the refrain you get from those who don't want us to move to coverage--

Dr. {Gawande.} It is the chicken and the egg problem. You can't create those physicians sitting there with their offices open without knowing whether there are going to be people coming, and you see it in plenty of places that expand coverage that you see a growth in those models. But what you are going to have happen over time is that we also have to learn how to take care of an enormously growing aging population. We are going to double the number of people over 65 in the next 20 years and our health workforce isn't going to grow much to keep up with that no matter what we do. And so our models have to evolve. An example is at Intermountain Health Care in Utah. Brent James, who leads that program, was able to take care of their entire diabetic population with just two endocrinologists by being creative and they are getting better quality results than almost anywhere in the country.

Mr. {Sarbanes.} The concept of medical home is one that we typically think of in terms of an individual, but I think what we are also discussing here is the potential to think of a medical home for a community, and that is what a clinic in a school is. It a medical home for that school community.

It is what a clinic in a naturally occurring retirement community is. It has a staff of geriatricians. It is a medical home for that community so we can look at it both in terms of the individual and in terms of the community.

Mr. {Pallone.} Thank you.

Ms. Schakowsky.

Ms. {Schakowsky.} Thank you, Mr. Chairman. I think the need in this discussion as we go forward in time to use accurate data is going to be very important. I talked about the myth that I think Mr. Ebeler has talked about in his studies that there is a difference between getting access to care and then getting access to care you need. You can go to an emergency room but obviously insurance is very important, and this notion that somehow we have absolutely the best care system in the world and no one in the United States goes without health care really begs the question of the negative effects of not having insurance. We also need to talk about Canada. If you ask the question, would Canadians swap with the United States on their health care system, I think we should get that data about what is really going on in a country is pretty satisfied with their health care. And finally, the issue of students not wanting to go into health care if there were a national system. I have talked to plenty of doctors who say not having to deal with billing and

if we had a really good system of public health that it would be more satisfying.

But I wanted to ask Mr. Ebeler, a previous IOM study found that the lack of insurance resulted in 18,000 premature deaths annually in the United States. I am wondering if you have updated that at all or how your new study contradicts the notion that we are all accessing the care we need.

Mr. {Ebeler.} Thank you. The report I am presenting today is sort of an update of a very extensive six-part IOM series that was presented between 2001 and 2004. We did not update that particular study on 18,000 deaths. We did again look at the literature very clearly and the evidence is even better than was available to that committee when it met that it absolutely does matter to have health insurance, it matters for the access of children and adults and it matters for the health outcomes, and the likelihood of premature death is higher for those who have no health insurance. We didn't follow up and quantify that though.

Ms. {Schakowsky.} Mr. Chairman, the Institute of Medicine study, has that been inserted into the record, or at least the report brief? Has the Institute of Medicine study been put into the record already? If not, I would like to--

Mr. {Pallone.} I am a little concerned about the number of pages.

Ms. {Schakowsky.} Well, how about the report brief?

Mr. {Pallone.} Yes, that is fine. We will put that--

Ms. {Schakowsky.} Okay. With unanimous consent--

Mr. {Pallone.} Without objection, so ordered.

[The information follows:]

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Ms. {Schakowsky.} I also wanted to ask Mr. Levine, I was interested in your statement and agree with much of it, but you said that Medicare and Medicaid are not innovators in quality and you mentioned the importance of medical home model, which I support. In Illinois we began the primary care case management medical home initiative in the fall of 2006. We have enrolled 1.6 million Medicaid and SCHIP beneficiaries in 5,300 medical homes, and a May 2008 memo from the National Academy for State Health Policy mentions medical home models in Pennsylvania, in Arizona. I think there were other States, I think including Mississippi, that were doing well. And by the way, that memo also talks about State Medicaid innovation in health IT. So Louisiana could undertake similar initiatives, could it not?

Mr. {Levine.} Well, in fact, Louisiana is doing a lot of those things. We have a primary care case management program where 700,000, 800,000 of our residents that are in Medicaid have a--we pay an enhanced fee to the primary care doctor, $3 per member per month, and frankly, our results haven't been--in some instances have been good in terms of reducing ER visits but when you compare us with the national measures with other States, we perform poorly, and so we are looking to improve that system. We have 37, I believe,

medical homes that were just certified by the NCQA just last week and I think we are the second State in the country to have a hospital certified as a hospital-based medical home. So, you know, we are embarking on that. You know, we are a State that has 23 percent of our children in poverty, you know, we are a State that I think is still going through rebuilding from two hurricanes in 2005 and now again two more in 2008, and so we are engaged and we have submitted a waiver request to CMS to allow us to dramatically transform our Medicaid program to get to what you are talking about, allowing consumers to choose between different coordinated care networks, and we are still going through what the complexion of those networks will look like, but at the end of the day--and I think the doctor said it right. He said we shouldn't stop with a discussion about the medical home. You really have to consider the neighborhood. You have got to have specialists. You have to have institutional support. You have to have home-based services. So I think that is the model, and I think Medicaid programs all over the country are going to have to transform to that model.

Ms. {Schakowsky.} Thank you.

Mr. {Pallone.} Before I go on to the next member, we have entered a number of executive summaries here and I have one more. This is the economic impact of private practice

physician offices in Georgia. I am going to put in the executive summary and then reference the website for the full document. I am going to do that with each of the ones that we have had today. And then in addition to that, your article, Dr. Gawande, from the New Yorker, ``Getting There from Here: How Should Obama Reform Health Care,'' I would ask unanimous consent to put that in and the Georgia document. Without objection, so ordered.

[The information follows:]

********** COMMITTEE INSERT **********

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Mr. {Pallone.} And next is Ms. Castor.

Ms. {Castor.} Thank you, Mr. Chairman.

Thank you, gentlemen, very much for your testimony. Health care in America is such a patchwork. You know, you have Medicaid for folks in poverty, primarily children and pregnant women, then Medicare if you are 65 and over but sometimes seniors, sometimes nursing home under Medicaid and Medicare and then SCHIP, and private health insurance is the bulk of it, of course, but Mr. Ebeler, in your testimony you point out it is practically impossible for a hardworking family now to access insurance if they don't get it through their employer and they are working hard so they are not going to qualify for Medicaid, they are too young for Medicare, and I think the latest estimates for a family it would cost over $12,000 a year to access it and that is if they don't have preexisting conditions. If they do, they will meet the hand.

In my community in Tampa, Florida, in Hillsborough County we have a model program that we set up over a decade ago to kind of fill those gaps for folks that don't have health insurance from any other source, and I think it is one of those models that we need to be looking at, and then I am going to ask if you all can identify other models from around

the country. What the Hillsborough health care plan does, it is kind of like what Mr. Sarbanes was discussing and Congresswoman Capps, a more expansive community clinic system, not just community health centers but they are an important piece of it. We have developed a neighborhood clinic system in conjunction with our hospitals and doctors, private hospitals and private doctors that do this, because a decade ago we were having our property taxes going to indigent care in the hospitals. So instead we said let us get these folks out of the ER and into neighborhood clinics. It has worked very well and we are able now--we have built in programs like smoking cessation and prevention and they have that medical home in their neighborhood. It might not be as close as Members of Congress have right down the hall but they recognize the doctor, they recognize the nurses in their community. They are part of their community. They are their neighbors.

Can you all identify other models like this? Mr. Levine, you are familiar with this because of your experience in Florida. Is this something that we need to--a model we should be looking at and can you identify other models across the country where we should focus in and learn some lessons?

Mr. {Levine.} I think first of all, I am familiar with the Hillsborough Health Plan. As you might know, I used to

run South Bay Hospital and Sun City Center. And they operate it as an insurance plan. Basically once you meet qualifications, you effectively have a medical home, and it does operate well for the people that fall through the cracks and don't have other forms of coverage, whether Medicaid or private coverage. Healthy Palm Beaches is another one that operates. They actually offer an SCHIP insurance plan, as you know. Almost every child in Florida is covered through-- every child in SCHIP in Florida is covered through private insurance and Healthy Palm Beaches is operated as a private insurance plan, even though it is a public plan. The North Carolina model is a medical home model that seems to be working well in North Carolina. Arizona uses models. There are 40 States that are using different variations of integration of care all the way from straight managed Medicaid all the way to various forms of enhanced primary care case management. And I think each State related to Medicaid has to do what works for that State and really what drives that is the provider community, what does your provider network look like, how robust is it, and can your model work. But I think there might be other people can answer as well.

Mr. {Ebeler.} Actually I am familiar with those where I used to work at the Robert Wood Johnson Foundation which--

Ms. {Castor.} Yes, and the Robert Wood Johnson Foundation recognized them.

Mr. {Ebeler.} Let me talk about it briefly from the perspective again the relatively constrained lane I am from the committee. It reminds me a little bit of the lexicon issue that Mr. Gingrey raised when people hear everybody covered or universal coverage. From the perspective of our report, that is an open issue of how one achieves that so, you know, these different models of how one gets to everybody getting coverage is the key variable that we are here reporting to you.

The second thing is the models you are describing connect to another piece of our recommendation and I think what many committee members have been discussing, which is you can't--everything relates to everything. You can't get to coverage without cost, which is why we have recommended action on both. You can't get to cost without attention to deliver. You can't get to delivery without quality. You can't get to those two without primary care. So the idea of looking at models that do not just coverage but other approaches to reforming delivery, producing the high-performance system that you are talking about a very positive direction to go.

Ms. {Castor.} Thank you.

Mr. {Pallone.} Thank you.

Mr. Scalise.

Mr. {Scalise.} Thank you, Mr. Chairman. I appreciate extending the courtesy.

As we discuss the importance of health care reform, obviously there are a lot of different options, a lot of different ways we can go, and I am sure on this committee there is going to be a whole lot of discussion on what the different routes are. I know I have some real concerns about a socialized health care model and I think we have heard some of the problems with Medicaid specifically and how just spending money doesn't necessarily yield better health outcomes, and Secretary Levine, if you can touch on the medical home model that Louisiana is pursuing and how this provides more options for people on Medicaid to maybe use the money smarter in essence to yield better health outcomes with the money that is being spent.

Mr. {Levine.} Louisiana faces a problem not unique. It is faced by almost every State, and that is first in 2004 our Medicaid budget was 10 percent of our State budget and now it is 22 percent of our State budget just 5 years later, and so we clearly have to do something to maintain the sustainability of Medicaid. And so we started looking at the cost of our program. We realized that we need to focus our

effort on, number one, early identification of people with chronic conditions so that we can properly manage the condition before it becomes acute and we wind up spending money. Our State has the highest rate of avoidable hospitals in the United States, which is one of the drivers for why we have such an expensive system with poor outcomes. So our proposal, which we have submitted to CMS, creates a medical home model. Everybody in Medicaid would have a patient-centered, NCQA-certified eventually medical home. We actually require the coordinated care networks to share any bottom line results if there is a positive bottom line at the end of the year related to the coordinated care network, they must share the savings with the primary care physicians. That is something that I don't know that any other State is doing right now. So there are some unique tenets to our proposal we would ask people to look at and we certainly are going to try to get CMS to approve it.

Mr. {Scalise.} How long has it been since the application to CMS?

Mr. {Levine.} The application was submitted in the end of December and there has not been any formal action by CMS yet, I anticipate because of the transition. It might speed up one there is a secretary and an administrator in place.

Mr. {Ebeler.} Just briefly, at the risk of defending

Medicaid, again, our view of this is no coverage is the wrong amount one wants to move to coverage, and we are open about the various tools at your disposal to do that, one of which is Medicaid, one of which is improving Medicaid, and I guess the only thing I would point out is that if we were a random draw of five males at this table from the community, it is likely that one of us would be uninsured, and the choice of no coverage and Medicaid might be viewed differently than sort of the currently insured. So it is--again, the IOM report has no particular policy option that is preferred. My only message is to urge you to keep various options on the table as you deliberate and make your choices.

Mr. {Scalise.} Right, and I think earlier when everybody was asked to go down the table and respond to whether or not you would be willing to trade your health policy for Medicaid and nobody responded that they wanted to do it, I think that said a lot about the problems but I will say, you know, we have experienced this in Medicaid populations, not just in Louisiana, but you have seen a shrinking number of doctors that accept Medicaid patients because of some of those problems, and especially with this last SCHIP bill. I think the concern a lot of us had was that as you go to a much higher level of bringing more people in that otherwise in some cases are on private insurance

because the lure might sound good, that you are paying for private insurance now, you can get on SCHIP and you don't have to pay, many of those people are experiencing that many doctors don't take Medicaid and so you get a decreased list of options as a parent. I would be curious to hear your take, Dr. Levine, about the problems with Medicaid as we are talking about physicians, we want to attract more physicians and a big challenge is in getting enough doctors, people to come into the profession. If it looks like we are doing something, creating policies that replicate more of a Medicaid model, how would that help attract more doctors when in fact many doctors don't want to take Medicaid today?

Mr. {Levine.} I think any model, particularly in Medicaid, historically Medicaid has achieved its financial goals by pushing down provider rates. That is pretty much the only weapon we have to try to fight the growth in Medicaid. And as we have done that, it has been a self-inflicted wound in that we wind up with fewer particularly specialists that will take new Medicaid patients and then that creates a serious access problem and obviously it drives ER utilization and we know what the consequences are. And I think the problem is the spiral that we are in is if we don't--if we expand Medicaid, if we use Medicaid as the vehicle by which we expand access to coverage and we call

that a victory, we have not solved this problem. We have given people a card for a system that may not be able to serve their needs.

Mr. {Scalise.} And we may in fact have made it worse, and I know my time is expired but I appreciate your comments and hopefully we can get CMS to approve that application, the waiver.

Thank you, Mr. Chairman.

Mr. {Pallone.} Thank you. We are done with our questioning but I want to thank all of you. You may get additional questions in writing from us over the next few days, so we would appreciate your getting back to us about that, but again, this was our first hearing today and I appreciate your participation. We obviously have a long way to go but we are determined to deal with this issue of health care reform.

So thank you again, and without objection, this meeting of the subcommittee is adjourned.

[Whereupon, at 3:45 p.m., the subcommittee was adjourned.]