

November 5, 2009

The Honorable Nancy Pelosi  
Speaker  
U.S. House of Representatives  
The Capitol  
Washington, D.C. 20515

***Re: H.R. 3962, The Affordable Health Care for America Act***

Dear Madame Speaker:

Kaiser Permanente congratulates you and your colleagues on the progress you have made to date toward making health care reform a reality in the 111th Congress. We share your optimism that sound and comprehensive health care reform, including necessary and appropriate reforms of the health insurance market, can be enacted this year in order to improve the health and economic security of all Americans. Your leadership and that of your colleagues has brought us closer than ever to assuring universal access to coverage, and we stand ready to help you bring the process to completion in the coming months.

In that spirit, we would like to offer our views on what we believe are some of the many positive aspects of the Affordable Health Care for America Act, areas where we think the legislation can be improved, and some concerns we have that certain provisions may have unintended consequences that might undermine our shared goals of bringing reason and stability to the health insurance marketplace.

*Kaiser Permanente*

Kaiser Permanente's 14,000 physicians and 160,000 employees provide health care services for our 8.6 million members through the largest private integrated health system in the United States. Because we both deliver and finance health services, we have a unique perspective on health care reform. In 2008, our health care delivery system operated 35 hospitals and 431 medical office buildings, provided 36.7 million medical office visits, filled 129 million prescriptions, performed 547,338 surgeries, and conducted 1.1 million mammograms and 1.6 million colorectal cancer screenings for our members. Our electronic health record system, KP HealthConnect, is the largest civilian electronic health record in the world, and is designed to give our physicians, nurses and other caregivers the tools they need to provide high-quality, well-coordinated care.

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### Positive Features

#### *Extending Affordable, High-Quality Coverage for Most Americans*

In particular we are pleased with your commitment to extend high-quality affordable coverage to 37 million uninsured Americans, covering more people than any other proposed bill. We also applaud you for maintaining significant subsidies for individuals to make that coverage more affordable. We strongly support the establishment of guaranteed issue and the elimination of health status rating and pre-existing condition limitations when connected with a strong individual mandate. We appreciate the recognition in the bill of the necessity of these two policies operating in tandem to ensure affordable coverage for all Americans. We also appreciate your commitment to greater access for our most vulnerable citizens through the expansion of Medicaid through 150% FPL. An important component of ensuring greater access for this population is your decision to increase reimbursement for primary care in the Medicaid program to Medicare levels. This is imperative in ensuring that these individuals have access to a broader network of providers willing to provide services under this new benefit.

#### *Delivery and Payment Reforms for Long-Term Financial Stability*

H.R. 3962 would promote a more rational health care delivery system that focuses on quality over quantity of care and payment reforms that encourage individuals to seek preventive care, systems to better coordinate care and all systems to improve the quality of care. We must establish financial incentives to promote high quality, better coordinated, evidence-based care if there is to be long-term financial sustainability of our health care system. Specifically, we appreciate the inclusion of additional resources for the development of a national quality improvement strategy; the development of a Center for Comparative Effectiveness Research; the creation of pilot programs to develop and test Accountable Care Organizations and Medical Homes and efforts to strengthen the primary care workforce through shifts in reimbursement and training opportunities.

#### *Equitable Financing and Shared Responsibility*

The concept of shared responsibility in the financing of health care is crucial to sustainable health reform. Likewise, a reformed system must make significant strides towards changing the way we deliver and pay for care. To this end, we greatly appreciate the fact that the House legislation does not include certain taxes that would be inequitably applied and cause unintended consequences – such as the annual \$6.7 billion health insurer tax in the Senate Finance Committee bill. This tax would apply only to fully insured plans and not self-insured coverage, thereby discriminating against integrated delivery systems, small employers and individuals. We appreciate your leadership in assuring that health reform promotes new approaches to provider payment, rather than a continuation of the broken fee-for-service system that this insurer tax would lock in place. It is imperative that in financing health reform, we do not unintentionally add to the cost of care or accelerate the perverse financial incentives that exist in our system today.

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*Inclusion of Quality Incentives for Medicare Advantage Plans*

One very important addition to the health reform debate has been the inclusion of quality incentives for Medicare Advantage plans in both the House and Senate legislation. For many years, CMS has developed an infrastructure of quality measurement of private plans serving Medicare beneficiaries. We have long supported this effort as we believe it will make much clearer the relative performance of different types of plans, and we are eager to demonstrate the excellence that can be achieved when an integrated health care delivery system focuses its efforts on high quality service and improvement of the health of the entire population it serves. Using this infrastructure to provide financial incentives to successful plans, so that those plans can in turn provide beneficiaries with enhanced benefits, translates quality from a mostly theoretical concept for most beneficiaries to a meaningful economic choice among plans. At a time when there could be great disruption for integrated delivery systems that have long been the backbone of the Medicare risk program due to payment reductions in Medicare Advantage, these incentive payments could stabilize benefits for beneficiaries who rely on high quality integrated delivery systems for their health care needs.

Concerns

While these efforts represent major steps forward in the reform of our current health system, we would like to draw your attention to a few key issues in the current bill that do cause us concern.

*Medicare Advantage Payment Reductions*

We appreciate that many members of Congress believe that it is time to recalibrate Medicare Advantage payments so that they are more in line with the costs of fee-for-service Medicare. We are concerned, however, with the magnitude and timing of the payment reductions that would result from the implementation of the House legislation. In particular, moving to parity with traditional Medicare fee-for-service costs on a local basis, as the House policy would do, would go far beyond merely reversing the increases in payments that resulted from the Medicare Modernization Act in 2003. Prior to 2003, bipartisan majorities in Congress supported modifications to the Medicare risk payment methodology to assure that private plans would be viable in areas with very low fee-for-service cost levels, where highly efficient providers (often led by well-integrated health plans in the community) and lower-than-average fee levels set for local Medicare patients have created relatively low Medicare costs. Without placing a floor under payments in those areas, simply paying Medicare costs on a local basis penalizes enrollees and efficient providers in low cost areas.

We believe that if Congress decides to take an approach that moves payments back toward parity with fee-for-service costs (as opposed to one that, like the Senate legislation, moves to a system that sets benchmarks based on competitive bids,) it is important that Medicare beneficiaries in efficient, low-cost areas be protected. Without such an approach, payment levels for seniors in some parts of the country, including some of our regions, would be reduced by up to 40 percent over the three-year phase-in period. This would inevitably affect benefits for seniors and would impact our delivery system infrastructure because we have a unionized work force and tend to pay at levels that meet national rather than local standards in some areas.

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As noted above, we greatly appreciate the inclusion of the modest quality incentives for Medicare Advantage plans discussed above. We would recommend, though, that the incentive payments not be restricted by geographic factors, but that all plans meeting the appropriate level of CMS ranking be eligible. We hope that as the legislation moves forward, these quality incentive payments will be significantly enhanced and we believe that seniors will benefit everywhere as the quality of care is improved everywhere.

#### *Annual Rate Review Process*

The bill proposes that the HHS Secretary, in conjunction with the states, establish an annual rate review process, where insurers must justify any increase in premiums. We understand the desire to put in place a mechanism for cost containment, but rate review on health insurers is not an adequate substitute for addressing the rising cost of health care. As a nonprofit organization and an integrated delivery system, our margins are reinvested in our health care delivery infrastructure. We are particularly concerned that rate review has the potential to substitute the opinions of regulators for the judgment of our physician, hospital and health plan leaders in assessing the need for capital investments to our health care delivery system. For example, in the recent past we have been faced with the refusal by state regulators doing rate review to recognize the costs of implementing our important electronic medical record systems during the rate review and approval process in one of our states. At a time when we have the significant need to upgrade our facilities in states such as California (for required seismic-related upgrades or replacements and other reasons,) insensitivity by a rate reviewer to the need to invest in capital construction could create serious disruptions in care delivery infrastructure maintenance and the finances of our organization. Because rate review processes can tend to become formulaic over time and simply encourage "cost-plus" thinking by pure insurers, we are skeptical that rate review would meaningfully reduce the cost of care and we have real concerns about what standards would be applied. This would be further compounded if, as noted in the Manager's Amendment, our participation in the Exchange would rest upon the application of such standards.

#### *Community Rating Across All Group Sizes*

The bill currently would impose community rating across all group sizes without any restrictions on self-funded groups, and would establish a maximum 2:1 rate band. The bill would also allow entry into the Exchange in Year Three for groups of up to 100, with the goal of eventually broadening eligibility further. We are concerned that these provisions will negatively impact the integrity of the Exchange, will drive up rates in all market segments, increase subsidy costs for the government and undermine needed delivery and payment reforms.

Community rating in the individual and small groups markets is appropriate and will provide more equitable pricing in these two markets without the unintended consequences of driving groups to self-insure. Community rating that includes groups large enough to self-insure (without any new restrictions on self-insurance) invites aggressive risk selection against the Exchange by large employers and is not tenable. Larger groups with older or sicker populations are likely to choose to remain in the community-rated pool, which will drive the community rate

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higher. Large groups with younger, healthier populations will be more likely to self-insure, rather than cross-subsidize other purchasers with higher risk populations. This could create two significant problems: 1) the Exchange could be subject to significant adverse selection -- driving up both premiums and subsidy costs for people who seek coverage through the Exchange and 2) as more healthy large employers turn to self-insurance, the remaining insured pool will become unsustainable and disintegrate. It will be imperative to preserve the financial stability of the Exchange if, as the Manager's Amendment suggests, the intent is to open the Exchange more quickly to larger employers to provide additional affordable coverage options.

The bill would require completion of a study in advance of the onset of the new rating rules that will examine the possible impact on the market, self-funding and the possibility of adverse selection. While this is a positive addition, we are concerned that it directly address the fundamental policy problem or allow sufficient time to make adjustments to the requirements of the law to ensure a stable, well-functioning market.

#### *Pharmaceutical Policy*

While we believe there are positive elements in the legislation related to prescription drugs, we are concerned with several issues. First and most concerning is the inclusion of a generic biologics provision that would inexplicably provide brand name manufacturers with an additional 12-year monopoly on biotech drugs. The Federal Trade Commission clearly analyzed this subject and concluded without ambiguity that such a new monopoly was unjustified and unnecessary to assure strong innovation. At a time when biotech drugs are driving virtually all of the cost inflation in the pharmaceutical sector, and when the cost of and access to prescription drugs is of great concern to many Americans, it is surprising that Congress would propose to add to these problems rather than simply assuring that a workable pathway existed for generic drugs once the biotech innovator's 20-year patent has run its course.

It has been noted that innovation requires two incentives: first, strong patent protection to assure that investors and inventors are rewarded for their valuable efforts; and second, a certain and absolute end to their monopolies to assure that they continue to provide true innovation and not simply rest on their laurels. This provision works against both of those goals and is out of balance. It should be significantly revised.

Separately, while we believe the increase in the minimum Medicaid rebate to 23.1 percent is a move in the right direction, we are concerned about the unnecessary continued reliance on the "best price" element of the Medicaid drug rebate program. This provision has severely undermined competition in the drug markets since it was established in 1990, and we have long recommended substituting a budget neutral flat percentage rebate. This would allow private organizations to negotiate lower prices, and the benefit of that would carry over to Part D plans and the entire market as well.

We are also concerned about the extension of "best price" to private Medicaid plans. We support the notion that rebates should be paid based on utilization within Medicaid plans, but providing those plans, in effect, with the fruits of others' negotiations is not appropriate and further confounds the prescription drug market.

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### *Grandfathered Coverage in the Individual Market*

While grandfathering of existing coverage is an appropriate way to ensure that individuals who currently have such coverage are able to keep it, we are concerned that if there is a gap in time between the date of enactment of health reform legislation and the end of the grandfathering period, some plans will attempt to increase enrollment of relatively healthy people in “non-conforming” coverage during the interim. We recommend that existing coverage be grandfathered as of the law’s enactment date, rather than before the effective date of the individual mandate. This will prevent a race to market non-conforming plans in the run up to the effective date, and will promote plan competition based on quality and affordability, rather than risk selection.

### *Administrative Simplification*

While we support the establishment of consistent standards for electronic transactions, we are concerned that the proposed process for developing companion guides and operating rules for each standard would follow a one-size-fits-all approach. This would result in rules that do not allow the flexibility to accommodate delivery systems, such as our integrated system, that function primarily using salaries instead of claims payments to pay for care. It is important that the legislation account for the kinds of administrative transactions that make sense in a capitated and integrated environment, as opposed to a fee-for-service, claims-payment environment. We urge that the process for developing companion guides and operating rules steer clear of a one-size-fits-all approach to implementation, so long as the end results still meet the goals of administrative simplification. We also hope that Congress will direct the administrative agencies to assure that proposed interim companion guides and operating rules be subject to the same formal rulemaking as is proposed for the standards themselves, following an open, transparent, collaborative process with opportunities for public comment.

### *Strengthening Compliance with the Individual Mandate to Ensure Affordability*

As noted above, we appreciate your acknowledgement of the necessity of guaranteed issue and an enforceable individual mandate to ensure affordable coverage for all Americans. Securing compliance with the mandate will be essential to keeping coverage for individuals and subsidy costs for the government affordable. In addition to the measures outlined in the Act, we would suggest consideration of the following additional measures for individuals who do not initially comply with the mandate: specified waiting periods; access to only the basic plan when first entering the market; access only to guaranteed issue products during an annual open enrollment period for individuals after the initial offering; and for those who did not qualify for an affordability exemption, a surcharge on the premium to account for late enrollment (very similar to the approach used in the Medicare program.)

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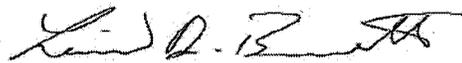
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We believe that our perspective is aligned with yours as it is necessarily focused not only on the fiscal sustainability of health care coverage in an environment of significant health care inflation, but on the need to constantly improve the quality and value of care that we provide. It is from this perspective that we offer our thoughts on the Affordable Health Care for America Act. We share your commitment and interest in covering as many Americans as possible. We need universal coverage for our country and salute your commitment to that goal.

Thank you for your consideration of our concerns. Please do not hesitate to contact me at any time with questions or concerns.

Sincerely,

A handwritten signature in black ink, appearing to read "Laird Burnett". The signature is fluid and cursive, with a prominent "L" and "B".

Laird Burnett  
Vice President, Washington DC office  
Kaiser Permanente