HEALTH CARE REFORM IN THE 21ST CENTURY: A CONVERSATION WITH HEALTH AND HUMAN SERVICES SECRETARY KATHLEEN SEBELIUS

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HEALTH CARE REFORM IN THE 21ST CENTURY: A CONVERSATION WITH HEALTH AND HUMAN SERVICES SECRETARY KATHLEEN SEBELIUS

WEDNESDAY, MAY 6, 2009

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Committee met, pursuant to notice, at 10:10 a.m., in room 1100, Longworth House Office Building, Hon. Charles B. Rangel (Chairman of the Committee), presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
April 29, 2009

CONTACT: (202) 225–3625

Chairman Rangel Announces a Hearing on Health Care Reform in the 21st Century: A Conversation with Health and Human Services Secretary Kathleen Sebelius

House Ways and Means Chairman Charles B. Rangel (D–NY) announced today that the Committee will hold a hearing to welcome the Secretary of the Department of Health and Human Services Kathleen Sebelius. This is the fifth hearing in the series on health reform in the 111th Congress. **The hearing will take place at 10:00 a.m. on Wednesday, May 6, 2009, in the main Committee hearing room, 1100 Longworth House Office Building.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from the invited witness only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

The U.S. spends twice as much per person for health care as any other country in the world, and yet continues to lag behind other countries in terms of coverage and quality. There are nearly 46 million uninsured people in America, and millions more have inadequate coverage. The U.S. has lower life expectancy rates than all other industrialized countries, including Japan, Germany, Australia and Switzerland. Lack of health insurance coverage, rising costs and lower quality are intimately intertwined.

The uninsured crisis affects cost and quality for families with coverage, as well as those without. A recent report from the Institute of Medicine found negative "spillover" effects that occur for people with health insurance who are in communities with a large uninsured population. These effects for the insured include decreased access to both primary care physicians and specialists, strained emergency services, and less access to state-of-the-art treatments. Widespread lack of coverage also increases health care costs for providers, plans, and those with health insurance through cost-shifting.

President Obama has said that health care reform is both a moral and fiscal imperative. His principles for reform and the plan he proposed during the campaign envision a uniquely American system that assures affordable, quality health care for all Americans.

This hearing will be the first post-confirmation hearing before the Congress for Health and Human Services Secretary Kathleen Sebelius.

"President Obama has shown great leadership on health care reform," said Chairman Charles B. Rangel. **"Secretary Sebelius brings enormous expertise and wisdom to the table on these issues, and I look forward to working closely with her on health care reform and other health and human services issues."**

FOCUS OF THE HEARING:

Health and Human Services Secretary Kathleen Sebelius will appear before the Committee to discuss the President's principles for health care reform.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*Committee Hearings*." Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record*." Once you have followed the online instructions, complete all informational forms and click "submit" on the final page. ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Wednesday, May 20, 2009**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman RANGEL. The Committee on Ways and Means will come to order. Will staff, visitors, stakeholders please take their seats at this time.

This is, what, the fourth meeting that we are having on health reform, and we haven't finished yet. But this morning we will pause the hearing forum to welcome the new Secretary of Health and Human Services. We are just so pleased that she has been selected to guide us through what most all of us feel is one of the most historic and meaningful measures before this Congress: To make certain that all Americans have access to affordable health care.

For those of you that were fortunate enough to monitor her confirmation hearings, I am thoroughly convinced that, Republican or Democrat, we have been so impressed of the dedication almost all

of your life to public service and that the talents that you have acquired over those years are so very, very important to this Congress and to this Committee to reach the goals that the President has established for all of us.

I want you to know, Madam Secretary, that there are really sharp differences of opinion on this Committee as to how we achieve near-universal health care. But I also want you to know that Ranking Member David Camp and I have reassured each other that, to our constituents, there are no Democratic beneficiaries or Republican beneficiaries, there are just people in need of a solid health plan.

And because we try so hard to work together, I am asking you to use your good offices, since you have a history of working with Republicans and Democrats and coming up with legislation and programs that you and the people you work with can be proud.

You should know that, next week, Congressman Camp and I are working out a caucus just for Members of this Committee, so, without cameras and microphones, we can come together and see what differences we have and what differences can be worked out so that we can give you a bipartisan bill. So there may be a lot of good reasons why people would oppose this legislation, but it will not be because we have not attempted in good faith to work out those differences.

And so I would like to yield to the Ranking Member and publicly thank him, not for promising anything except an honest, good attempt to see what we can do in working together.

Mr. Camp.

Mr. CAMP. Well, thank you very much, Mr. Chairman. I appreciate those comments.

And welcome to the Committee, Secretary Sebelius, to the Ways and Means room. I think this is a place we will meet often. And as much as I respect this room and what happens within its walls, I think we both readily admit that the Leelanau Peninsula, an area I represent and I know your family has come to know, is a much nicer meeting place.

But I know your time is short, so I will get straight to the point. I have read your testimony and agree with much of it. And so I ask whether we will focus on developing a plan that features policies we can agree on—lowering costs for families, businesses, and the American taxpayer; insuring no family is bankrupted by their medical cost, choice of doctors; being able to keep your current coverage, among others—or will we focus on what divides us. And I think if it is the former, I think we can find a path to bipartisan health reform. If it is the latter, we may not be as successful. So I am hoping for success in that regard.

And, as we continue this conversation on health care reform, I ask that you make yourself available to this Committee, its Republican and Democratic Members, and that you and the President truly be open to our ideas and working across party lines to make health care reform a reality.

And since your time with us is short, I just want to make sure Members have as much time as possible to ask questions and discuss with you. And I yield back the balance of my time.

Chairman RANGEL. Thank you.

Madam Secretary, you will be given 5 minutes to present your remarks, and we are going to try to be extremely liberal in that. But I want you to know that I have been persuaded to convince Republicans and Democrats to reduce their questioning from the 5 minutes that we are used to to 2½ minutes. It may not seem like much to you, but I want you to know that is a big deal to us. And so we hope you will take that into consideration when we ask you to come back when your time is better, doing so.

At this time, I welcome you on behalf of the full Committee and the Congress, and I look forward to your testimony. You may proceed.

STATEMENT OF THE HONORABLE KATHLEEN SEBELIUS, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary SEBELIUS. Thank you, Mr. Chairman and Ranking Member Camp and Members of the Committee.

As the Chairman has already said, this is my first opportunity, outside of the confirmation hearing process, to have an opportunity to have a discussion in Congress and my first time before a House Committee. And I am pleased to be here with the House Ways and Means Committee and Members. And I know today is just the beginning of what I hope will be a robust and frequent conversation as we move toward the goal of health reform and health coverage for all Americans.

I am pleased that Ranking Member Camp has already recognized that, actually, I am one of his constituents. I pay property taxes, I might say too many property taxes, in your district. But I think it is an opening of bipartisanship demonstrated from the outset. I am not Chairman Rangel's constituent; I am Representative Camp's constituent.

Given the time shortage, Mr. Chairman, you have my printed testimony, and I am going to highlight a few things and then talk a little bit about a couple of the reports that I spoke about today with the Nurses Association because much of what is in the testimony this Committee is well familiar with: The need to provide health coverage, particularly because the costs of the current system are unacceptable and unsustainable for businesses, for families. What we have seen is the situation getting worse; costs continue to escalate, and more and more Americans lack coverage. I share the President's conviction that health care reform cannot wait and will not wait another year.

Many steps have been taken by Members of this Committee and others in the first 100 days to set a platform: Insuring 4 million more American children; providing resources in the Recovery Act for a variety of initiatives, health and wellness programs, funding the pipeline for new workforce efforts, making sure that the resources are there for implementation of health information technology, which can be an underpinning to moving the health system in a new direction.

I share the President's belief that reform must guarantee choice of doctors and health plans, including a choice between a public and private plan option, that no American should we forced to give up a doctor they trust or a health plan they like. And comprehen-

sive reform shouldn't force any Americans who are satisfied with their coverage to make changes. But covering every American, including access to high-quality health care, is so important.

The two reports that I am issuing today, as the new Secretary of Health and Human Services, I think highlight some of the underlying issues that we are facing. Today we are releasing the National Health Care Quality Report and the National Health Care Disparities Report.

Both of these reports underlie troubling findings about the status quo of our health care system. The disparities report, again, highlights that severe and pervasive disparities in care continue to persist in this country. Minority patients still receive proportionately poor care compared to their Caucasian neighbors. The quality report highlights that 40 percent, 4 out of 10 health care patients don't receive recommended care. And that is an ongoing situation.

And, again, prevention measures are too often lacking. Half of the obese adults and children who see a doctor are never given advice to exercise more frequently and eat a healthy diet.

And most troubling is the decline in patient safety measures, identified in the quality report, that have worsened every year for the past 6 years. When you look at the underlying causes, patient safety is down because the number of patients acquiring health-care-associated infections has gone up. Patients come to the hospital to get well, and unfortunately too many of them are acquiring potentially fatal infections.

It has become one of the top 10 leading causes of death in the United States. And the infections are thought to cause about $20 billion—$20 billion—a year in additional health care costs. So we are challenging the health care providers to work with us on attempting to fix this problem.

Thanks to your support, the Recovery Act now includes $50 million to help prevent health-care-associated infections. And, as of today, the Department is prepared to begin to release those funds. Forty million dollars is aimed at States to expand their infection prevention teams and educate and collaborate with patients and hospitals to keep patients safe. An additional $10 billion is supporting increased inspections of ambulatory surgical centers, which are all too frequently a site of these lethal infections.

We know that one particularly common and dangerous infection is the Central Line-Associated Bloodstream Infection. It strikes tens of millions of American patients every year, and that number increases year-in and year-out. But there is a relatively easy cure. Research has found that the hospital checklist protocol, if implemented uniformly and on a daily basis, dramatically reduces these results. Medicare has been studying this in 10 States. We want to expand that protocol to all States.

So today, Mr. Chairman, as part of this effort to begin to transform the underlying system, I am issuing a challenge to hospitals across America to commit to using the patient safety checklist in all hospitals and reduce the serious bloodstream infections in intensive care units by 75 percent over the next 3 years. That is what our data tells us can happen. If the checklist is used, infections will go down.

We want to include every hospital in every State. This morning I spoke to the Nurses Association and asked them to join in this effort. And we will be putting this challenge out to hospital administrators across the country.

So, Mr. Chairman, I know you and Members of this Committee share my concerns about the quality of care and the need for comprehensive health reform. I want to thank you in advance for the hard work that has already been done to set the platform for this historic moment. I want to assure you that I will do everything I can to work closely with this Committee and others here in the House and, across the Rotunda, in the Senate to make sure that we take advantage of this opportunity.

And, with that, Mr. Chairman, I would stand for questions.

[The prepared statement of Secretary Sebelius follows:]

Prepared Statement of the Honorable Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services

Chairman Rangel, Ranking Member Camp, Members of the Committee, thank you for this opportunity to join you for a critical conversation about health reform in America. Health reform has advanced thanks to your work and willingness to move forward together with other House committees. We appreciate your hard work to enact reform. It is urgently needed.

Health care costs are crushing families, businesses, and government budgets. Since 2000, health insurance premiums have almost doubled and health care premiums have grown three times faster than wages. Just last month, a survey found over half of all Americans, insured and uninsured, cut back on health care in the last year due to cost. And behind these statistics are stories of struggles for too many American families. Families who face rising premiums—now over $12,000, when it was $6,000 a decade ago. Parents choosing between health insurance and their mortgage because they can't make ends meet because their paycheck is standing still but health care costs are rising much faster than inflation. Today health care costs are the big squeeze on middle class families and these challenges are growing as the economic picture worsens. And on top of all of this, in the last 8 years an additional 7 million Americans have become uninsured.

And we know that during this recession, hundreds of thousands of people are losing health insurance as they lose their jobs.

Even families who do have some coverage are suffering. From 2003 to 2007, the number of "under-insured" families—those who pay for coverage but are unprotected against high costs—rose by 60 percent.

Still, we have by far the most expensive health system in the world. We spend 50 percent more per person than the average developed country. The U.S. spends more on health care than housing or food.

And the situation is getting worse. The United States spent about $2.2 trillion on health care in 2007; $1 trillion more than what was spent in 1997, and half as much as is projected for 2018.

High and rising health costs have certainly contributed to the current economic crisis. Rising health costs represent the greatest threat to our long-term economic stability. If rapid health cost growth persists, the Congressional Budget Office estimates that by 2025, 25 percent of our economic output will be tied up in the health system, limiting other investments and priorities.

This is why I share the President's conviction that "health care reform cannot wait, it must not wait, and it will not wait another year." Inaction is not an option. The status quo is unacceptable, and unsustainable.

We are already on our way to making health reform a reality. In just over 100 days, this President has made great strides to advance the goal of reducing costs, guaranteeing choice and assuring quality, affordable health care to all Americans.

Within days of taking office, the President signed into law the reauthorization of the Children's Health Insurance program. This program's success in covering millions of uninsured children is a hallmark of the bipartisanship and public-private partnerships we envision for health reform.

The President then signed the Recovery Act, which includes essential policies that will protect health insurance for the American people, support groundbreaking research, and make important investments in our health care infrastructure.

And just last week, Members of Congress passed a budget that includes an historic commitment to health reform.

Delivering on this commitment and enacting comprehensive health reform is one of my top priorities. The Obama administration is focused on passing health reform legislation that will end the unsustainable status quo and adhere to eight basic principles.

First, we believe that reform must reduce the long-term growth of health care costs for businesses and government. The high cost of care is crippling businesses, who are struggling to provide care to their employees and remain competitive. It is driving budget deficits and weakening our economy. We must pass comprehensive reform that makes health care affordable for businesses, government, and families.

Second, we must protect families from bankruptcy or debt because of health care costs. Today, too many patients leave the hospital worried about paying the bills rather than returning to health. They have reason to be concerned. In America, half of all personal bankruptcies are related to medical expenses. It's time to fix a system that has plunged millions into debt, simply because they have fallen ill.

Third, we will guarantee choice of doctors and health plans. No American should be forced to give up the doctor they trust or the health plan they like. If you like your current health care, you can keep it.

Fourth, we will make sure that Americans who lose or change jobs can keep their coverage. Americans should not lose their health care simply because they have lost their job.

Fifth, we must end barriers to coverage for people with pre-existing medical conditions. In Kansas and across the country, I have heard painful stories from families who have been denied basic care or offered insurance at astronomical rates because of a pre-existing condition. Insurance companies should no longer have the right to pick and choose. We will not allow these companies to insure only the healthy and leave the sick to suffer.

Sixth, we must assure affordable, quality health coverage for *all* Americans. The large number of uninsured Americans imposes a hidden tax on other citizens as premiums go up, and leaves too many Americans wondering where they will turn if they get sick. A system that leaves millions of Americans on the outside of the doctor's office looking in is unjustifiable and unsustainable.

Seventh, we must make important investments in prevention and wellness. The old adage is true—an ounce of prevention truly is worth a pound of cure. But for too long, we've sunk all our resources into cures and shortchanged prevention. It's time to make preventing illness and disease the foundation of our health care system.

And finally, any reform legislation must take steps to improve patient safety and the quality of care in America. Our country is home to some of the finest, most advanced medicine in the world. But today, health care associated infections—infections caught in a hospital or other settings—are one of the leading causes of death in our Nation. Ninety-eight thousand Americans die each year as a result of these and other medical errors—more than car accidents, breast cancer, or AIDS. These numbers are not acceptable for the world's richest Nation. We must sharply reduce the number of medical errors, keep patients safe and ensure all Americans receive high-quality care.

As we work to enact policies that adhere to these principles, the President is committed to hearing from people in communities across the Nation and on both sides of the aisle. In March, he held a White House health care forum and several regional forums in places like Michigan, Iowa, Vermont, North Carolina and California. There, bipartisan forums brought together people from all perspectives—across the political spectrum and representing all people with a stake in the system—to focus on solutions.

I look forward to continuing this bipartisan process and I am eager to work with this Committee and your colleagues in the House and Senate to deliver the reform we so desperately need.

Again, Mr. Chairman, thank you for the opportunity to participate in this conversation with you and your colleagues. I look forward to taking your questions.

Chairman RANGEL. Thank you, Madam Secretary.

First of all, for the most part, Democrats support the President's plan. We are anxious to have dialogue with others that have different plans. You may not hear it today, but we will be discussing

these things off-camera in the back room and trying to find out where we can publicly agree.

Having said that, and without them saying it, those who oppose the plan, it seems like one of the most controversial issues is the public plan. I know the President supports it, but I would hope that you will be able to share with us your views on why public plans should not be fearful that the government is going to undercut them and put the for-profits and public plans out of business.

It just seems to me that if we have a public plan, that this would monitor the private system, and the private system would look competitively at the public system, and at the end the standards of all of the plans would be the best ones to attract people who have no insurance.

People who have insurance and are happy with what they have will not be affected. But I think we are going to have to concentrate, and I will need your help, on the question of why do you and the President think that a public plan is so important in providing quality care at lower, competitive prices.

Secretary SEBELIUS. Mr. Chairman, as you are aware, part of my background is shared with colleagues in the Senate, where I was an insurance commissioner for 8 years in Kansas, and so my charge was to regulate the insurance market.

And what I am a believer in, and certainly the President is a believer in, is that competition often is a very healthy component of any market situation. And I think that competition helps promote innovation, it helps promote best practices, and also can help to lower costs. So, in the design of a health insurance exchange, which is really what we are talking about and what the President discusses, a choice of a variety of options is often critical.

In many parts of the country, including in my home State of Kansas, there are lots of areas in the State where there are not choices of private carriers for many citizens. And it is why, in our design of the State employee health insurance plan, for instance, we created a side-by-side public and private option so that it helped to promote a network. About 30 States have done similar things. I know in many States, in their design of the Children's Health Insurance Plan, a public plan is a side-by-side option with private carriers.

The underlying issues are: What are the rules? What are the actuarial issues going into the design of a plan? Is there a level playing field? I can assure you, Mr. Chairman, and some who have voiced opposition or at least, at best, skepticism about a public plan option that the President is committed to and I am committed to the fact that the design needs to level the playing field.

And it is on two fronts. First, a public plan option should not undercut the private market, tilt the playing field in one direction. The private market, on the other hand, should not be able to cherry-pick the least costly patients. So, getting rid of some of the preexisting medical condition barriers that allow a skewed marketplace I think is important.

But having an option for individuals, having a choice for the Americans who don't currently have coverage, and having competition to drive the best practices, the best cost-efficiencies, the best protocol, I think, can be very positive in the long run.

Chairman RANGEL. Thank you.

Mr. Camp.

Mr. CAMP. Thank you, Mr. Chairman.

Many have suggested limiting the amount of health insurance that can be excluded from an employee's taxable income as a way to lower the cost of health care, help finance reform, particularly to those at lower income levels for individuals and families.

And I would like to hear your views on the idea of capping or repealing the tax exclusion for employer-sponsored care to help address inequities in the health care system.

And then, second, is there any timetable for the Administration to release a specific legislative proposal on health care to the Congress? And if there is, could you shed some light on that?

Thank you.

Secretary SEBELIUS. Certainly, Representative Camp. I appreciate those questions.

As you know, the issue of the tax exemption for benefits was discussed in a robust way during the campaign season, and the President made it very clear that he did not support an elimination or capping of the benefit package. And I think a fundamental reason for that was the underlying fear that it could destabilize the private insurance market.

And, as the President repeated over and over again, he thinks a fundamental component of moving forward is to ensure Americans who are satisfied with their coverage, whose employers are currently providing coverage that is beneficial to themselves and their families, that they won't lose that. And with almost 180 million Americans in the private market, eliminating the tax writeoff, which was a component of encouraging employers to offer coverage in the first place, has a huge potential of destabilizing the private market and leaving more Americans uninsured.

Having said that, I do know that the President understands that that conversation is under way here in Congress. But it is not part of his proposal that he made during the course of the campaign. But he is willing to look at all serious discussions coming forward.

President Obama has made a commitment that he believes health reform has to engage the Congress in a meaningful way. I can tell you, during the course of my confirmation hearings, I met with a number of Senators who asked a similar question to your specific proposal question, believing that, there is a plan that has been written in great detail and eventually will be pulled out of the drawer and presented. What I can assure you is that does not exist, and it is not part of the President's plan moving forward.

What he hopes will happen—and it started, I think, in his early days in office, with the health care summit at the White House, a very bipartisan effort, not only among Members of Congress, but bringing in business leaders and providers and insurers, various stakeholders, and will continue through this process where the Senate Committees are very much engaged. The three primary House Committees are clearly very engaged in this dialogue. And his charge to me, as the new Secretary, is to work closely with Committees as proposals are being developed around the principles, frankly, that you primarily outlined in your opening statement. But the specific legislative language, the framework of ex-

actly what the benefit package ultimately looks like, what the exchange may or may not look like, will be a collaborative effort but primarily engaged in by Congress.

The President also, in his blueprint budget proposal, included a set-aside of $630 billion, which he sees as a downpayment for health reform, half of which are on the revenue side, half of which are on the savings side. And I think the recognition is that you can't fully cost out a plan until you know what you are paying for. So part of the effort going forward, in conjunction with Congress, is not only crafting the specific legislation, but also crafting the specific package to provide the revenue over a 10-year period of time to pay for health reform.

Mr. CAMP. Thank you.

Chairman RANGEL. Madam Secretary, you may not see Chairman Stark here, but we well know that he is monitoring these hearings, as he recuperates, on television, and he has all of his staff monitoring all of us.

So, Pete, everything is going okay.

I yield to Mr. Levin.

Mr. LEVIN. Thank you very much.

A special welcome.

Your reference to patient safety, Madam Secretary, I think will hit a very, very warm note in Michigan, which has been trying to tackle this issue, and I think with some success.

Let me ask a question, and maybe Pete Stark would ask it. With your unique experience as a Governor and insurance commissioner, why is it essential that we act this year?

Secretary SEBELIUS. Representative Levin, I think it is clear that the current situation is unaffordable, unsustainable, and unacceptable.

The costs of health care are crushing businesses and families. Our industries are becoming less and less competitive with their global partners and struggling under the high cost of care. Too many families are in dire financial straits because of a health-related incident that they did not have the insurance to provide coverage and a safety net system.

And way too many Americans, close to 50 million, have no access to the high-quality care that some of us enjoy in this country. And so they come in through the doors of emergency rooms with more serious conditions and end up with the least effective, most expensive care because they didn't get the preventive care, they don't have a health home. And all of us pay for that.

So I think that any economic prediction that is done underlies the fact that, unless we get a handle on health care costs, unless we can bend the cost curve—and one of the only ways to do that is shift the system toward prevention and wellness, make sure that all Americans have a health home, and begin to provide adequate coverage for all Americans, which provides a healthier workforce, students who can actually learn in school, making sure that they are ready to go as the workers of the future.

And now is the time to do that. As we are fixing the economy, we have to fix health care as part of that overall economic strategy.

Mr. LEVIN. Thank you. Well said.

Thank you.

Chairman RANGEL. The Chair would like to recognize Mr. Herger from California.

Mr. HERGER. Thank you, Mr. Chairman.

And, Madam Secretary, I want to thank you for your testimony.

I believe there is a great deal of potential for finding bipartisan common ground on the principles you and the President have outlined. One of them, which I very much agree with, is that people who like their current health care should be able to keep it.

We have heard testimony in this Committee that creation of a new government-run health plan could result in 120 million Americans losing their current coverage, partly due to increased cost shifting by providers that would drive up the cost of employer-based coverage. We have also heard testimony from a health policy expert who supports creating a public option but does not think people should be able to keep their current coverage.

Madam Secretary, are you concerned that proposals to expand government-run health care could run counter to the President's principle that if you like your current health care you can keep it?

Secretary SEBELIUS. Representative Herger, I think it is always a concern. And, again, it may have more to do with the overall plan design than the philosophical principles moving forward.

I can assure you that those two principles—Americans keeping their health coverage if it is satisfactory and serves them and their family well, and having a choice within an insurance exchange for a public plan option—are not mutually exclusive. It isn't either/or.

Mr. HERGER. How do they compete? How does a private plan compete with a government plan, which can be subsidized, which perhaps could start off innocently but be changed at any time to where a private plan could not compete? How could they ever coexist?

Secretary SEBELIUS. I think, Congressman, the examples of that, again, are in place across the country. Thirty of the States have State employee health plans where there is public option for State employees side by side with a variety of private openings, created largely to give those State employees in a State like mine, in Kansas, a choice. Because much of our State only had one private provider, and we felt giving employees a choice for themselves and their families, a competitive choice, was important.

A number of States have constructed their CHIP programs, the health insurance plans for children, in exactly the same way, where there is a side-by-side option of a private provider and a public provider.

What I can assure you is that it can be done as a level playing field. It is about the rules that are established in the beginning. And the President and I are committed to working with Members on this Committee and Members in Congress to make sure that the playing field is level.

And, as I said, the private insurers currently have, in fact, I would say, a tilted playing field in way too many areas, where cherry-picking on the market is a strategy to make a profit, so that the ability to underwrite individuals' medical conditions to either make insurance unaffordable or unavailable is a current private-market strategy. I think that measure doesn't work well in a health insurance exchange any more than a measure which would

give government huge advantages and huge subsidies doesn't work well.

So I think if the rules are the same, so individuals who have lower income, who are not insured, have a subsidy benefit as they come into the health exchange and can choose between a public and private plan option with the same kind of rules, I think it can work as a very important competitive situation where it will help drive—where people will be competing, public and private will be competing, not on underlying price or on unfair government subsidies, but really on practice and protocol, on lowering overhead costs, on lowering administrative costs, and driving benefits to their incoming enrollees.

Chairman RANGEL. Dr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Welcome, Governor.

My Subcommittee handles unemployment insurance and foster kids and welfare, TANF. We will be back talking about that next year, but I want to talk about health care at the moment.

Wichita, Kansas, has 90 specialists per 100,000 people, whereas Boston has 180 specialists per 100,000 people. Everyone who has looked at these situations knows that that doesn't mean they have better health care in Boston than they do in Wichita. What it reflects is the lack of enough primary care physicians in the Boston area, which they found out when they started Mass-Care. They couldn't provide primary care physicians for everybody who was asking for one.

I have made a proposal that we have all public medical schools be free, with the requirement that the students, when they come out, would serve 4 years in primary care in the State.

And one of the things that the Dartmouth University study has shown is that there is clearly no connection between how many specialists you have and the quality of health care or anything except where people want to live, in terms of where they practice. Now, if you train them in Kansas and they move to San Francisco, the people of Kansas have nothing. Washington State is part of WWAMI, so we have Washington, Alaska, Montana, Idaho, and Wyoming. We train all the doctors in one medical school, but they doesn't necessarily go back to the rural areas.

With that kind of provision—and I hope that what will come out tomorrow when the President puts out his additional provisions is a commission that looks at workforce—a permanent commission for workforce planning. Right now, we have a graduate medical commission, but that only deals with specialists. It does not deal with the broader issue of how you get enough private practitioners to go into the whole area of primary care.

And I would like to hear your ideas, having been a Governor, delivered a State where you have operated way below the national average, actually one-half. There are only two cities that have less than Wichita: Sioux City, Iowa, and Mesa, Arizona. So I would like to hear how you did it.

Secretary SEBELIUS. Representative McDermott, I am not sure that that was a design strategy, to lower the number of specialists. But I can tell you there were a number of efforts at the State level to increase the number of primary care providers, recognizing that

the pipeline is very thin. And, certainly, as we look at 50 million additional Americans accessing a health home, having an opportunity to have regular preventive care, the pipeline issue is very important.

Congress made a major step, along with the President, when he signed the Recovery Act with a half-billion-dollar investment in workforce initiatives and more nurses, more primary care doctors. There is a proposal in the budget to increase the Commissioned Corps, again, providing health care providers in underserved areas. And one could argue that, in a lot of areas, primary care is underserved.

I share your interest in figuring out how we can encourage more medical students to actually look at primary care and preventive medicine as a choice going forward, because I want to make sure that, as we shift this system to a wellness system, we have providers that are capable of making that shift.

Having said that, I think it is important that we do not undercut the specialty initiatives that are so important. I mean, frankly, if I need neurosurgery, I would like to know that there is a neurosurgeon at least in the proximate area that I can call upon.

So I think there are ways to begin to shift payment incentives to more appropriately reward primary care doctors without disadvantaging the specialty care. If we begin to have payments based on outcomes, if we recognize that dollars spent on wellness pay huge dividends to lower health care costs on the other end, then I think we can have a system where more medical students—not only more people will be coming into medical school, but more medical students will be choosing general practice and primary care and family practice, as opposed to specialty care, as the way that they can be successful.

Chairman RANGEL. Madam Secretary, you are going to have to help us, because everyone wants——

Secretary SEBELIUS. Okay.

Chairman RANGEL [continuing]. At least to have some dialogue with you, and we are doubling up, notwithstanding the restrictions. So, I know it is difficult to give short answers to such complex questions, but since this is really just an initial introduction and we will be getting involved in those things, I ask you to help us out, too, as I recognize the hero of the Committee, Congressman Sam Johnson from Texas.

Mr. JOHNSON. Thank you, Mr. Chairman. I appreciate it.

Welcome aboard.

You know, I think our goal is to try to get Medicare or medical insurance to every individual in America. And I know it is something that Congresswoman Schwartz has inquired about in previous hearings, but do you think moving health care benefits from opt-in to opt-out with businesses might increase the take-up rate among employees, as it did for 401(k)s in the past?

Secretary SEBELIUS. Businesses moving to an opt-in strategy?

Mr. JOHNSON. That is what I wonder, if we should mandate that.

Secretary SEBELIUS. The sort of pay-or-play—I am not sure I understand the question. I am sorry.

Mr. JOHNSON. Well, the way it works is every individual who works for a company would have to take insurance, health insurance from the company, and the only way they don't is they opt out.

Secretary SEBELIUS. I understand.

Certainly, I think there is discussion under way for an individual mandate for health insurance. And it was not part of the President's proposal, except for parents who had children; they would be required.

But I think, as the proposals are developed here in Congress, that is one of the initiatives. Should everyone have a personal responsibility, whether it is through your employer or in the private market, to provide health coverage? And I look forward to working with Congress in figuring that out.

Mr. JOHNSON. Thank you.

And, second, I have talked a number of times about physician-owned hospitals, and it seems like everybody wants to torpedo them. And, you know, we have our best docs, our best nurses, and the best medicines in those physician-owned hospitals because they are specialty hospitals.

And I wonder what your thoughts are on that and whether you oppose their development or not. And, previously, CBO scored it differently from what HHS scored it, and I would like to know your feelings on that.

Secretary SEBELIUS. Congressman, The President and Congress have tried to clarify the hospital ownership exception currently in place. And it really is aimed, I think, at some troubling data about physician-owned hospitals producing numerous additional tests and additional protocol for patients that then directly benefit the owner/provider.

And I think that issue is one that is very serious, as we look at costs in the future. What Congressman McDermott may not know is Wichita, Kansas, has one of the highest per capita levels of specialty hospitals of anyplace in the country. I know Texas has a significant number.

So there are certainly some benefits to patients, but I think looking at the cost issues and certainly looking at the potential conflict issues are ones that are very serious.

Mr. JOHNSON. Thank you.

Thank you, Mr. Chairman.

Chairman RANGEL. The Chair recognizes Mr. Lewis.

Mr. LEWIS. Thank you very much, Mr. Chairman.

Madam Secretary, thank you for being here today.

I agree with you, very much so, that we cannot wait any longer before we pass comprehensive health care for all of our citizens. I happen to believe, as so many others, that health care in our country is a right and it is not a privilege and that all of our citizens and every person that dwells in America should have adequate and affordable health care.

I would like to know from you, is the President committed to passing health care reform this year?

Secretary SEBELIUS. Yes, sir.

Mr. LEWIS. That is all I need to know.

Thank you very much, Madam Secretary.

Thank you, Mr. Chairman.

Chairman RANGEL. Thank you, Mr. Lewis.

Mr. LEWIS. Less than 2½ minutes.

Chairman RANGEL. You are good, you are good.

The Chair recognizes one of the rising stars of our Committee, Mr. Ryan.

Mr. RYAN. What?

Chairman RANGEL. Unless you want to yield to him.

Mr. RYAN. Well, no, but Mr. Brady is in front of me, so I thought——

Mr. BRADY. Go right ahead.

Mr. RYAN. And I would submit Mr. Brady is also a rising star.

Mr. CAMP. That is right. He has already risen.

Chairman RANGEL. The seniority system is alive and well.

Mr. RYAN. He is in front of me.

Mr. Brady, really, you are in front of me, so you should go.

Mr. BRADY. Okay. My ego has taken a huge hit this morning.

Madam Secretary, thanks for coming here.

You just got on the job, but have you had a chance to examine the way we reimburse physicians under Medicare?

It is truly a mess. We drive good doctors out of the system, away from our seniors. And it is embarrassing to have to have them come up here every year to beg for a 1 or 1.5-percent increase in their reimbursements when their nursing costs have gone up, technology has gone up, operations have gone up.

Have you had a chance to take a look at the way we do that?

Secretary SEBELIUS. Well, Congressman, I haven't had a chance to do the global examination in the budget, but I certainly am aware of that situation, having been in the State of Kansas.

Mr. BRADY. I would encourage you to examine it, to weigh in on a truly sustainable fix for reimbursement. I would encourage you to take a look at if you can administratively remove the part B drug costs from that formula. They don't belong in there, and I think it creates a false cost within that system.

And, finally, the reason I encourage you to take a look at it, one of the reasons many of us are scared about rationing of health care under a government-run system is that the physician payments are a prime example of how we ration care today. Physician cost-of-living increases aren't determined by what the cost of providing those services are within their office. Basically, MedPAC takes an accumulation of physician practitioner services, estimates what that amount should be, and then, if actual services are above that, they lower the reimbursement. That is why doctors face a 21 percent cut in reimbursement. When you take a number, ration the care and the reimbursement from it, you get bad results. That is an area that produces it.

Madam Secretary, if you get a moment, I think that would be an important thing for you to weigh and, I think, important as we go forward.

Secretary SEBELIUS. Representative Brady, let me assure you, that the 21 percent cut that is looming right over the horizon is totally unacceptable. And nothing could be more disruptive to the health system and that will underpin moving forward on health reform is losing providers. When people talk about choice, they are

not talking about choosing their insurance company; they are attached to their doctor and their health care provider.

So I share your concern. Let me assure you that the Administration and I look forward to working with Congress to address not only the current crisis that is right around the corner, but a long-term sustainable coverage to make sure that seniors and our most disabled population who rely on Medicare services keep the doctor that they want and need and keep the health services vital.

Mr. BRADY. Thank you, Madam Secretary.

I thank the Chairman.

Chairman RANGEL. The Chair recognizes Chairman Richard Neal.

Mr. NEAL. Thank you, Mr. Chairman.

Madam Secretary, childhood obesity, I think we all acknowledge that it is growing more common in America. And it is being diagnosed in more people at a younger age, as well.

Great emphasis in this plan is going to have to be placed upon the whole notion of prevention. And would you maybe outline for us some of the thoughts that you have about how some investments in prevention and wellness might change the entire health care system? It seems to be a recurring theme in our discussions.

Secretary SEBELIUS. Thank you, Congressman Neal.

There are, I think, a couple of strategies that can work together. First of all, the expansion of the CHIP program, 4 million more American children, is a piece of that puzzle. We have to do that well. We have to make sure that we drive a wellness message, along with expanded coverage.

In addition, in the Recovery Act, the Department of Health and Human Services was given a billion dollars to focus on wellness and prevention. And that discussion is well under way with providers and experts across the country to determine what is the best possible strategy for not only using our resources but leveraging those resources with some private-market care.

There are a number of efforts that we know are successful. Working, as we did in Kansas, with school groups on everything from vending machines to more PE in school to doing a body mass index for every child and driving that information home to parents is an effective strategy.

But I share your concern that we have the first generation of American children who may actually have shorter lifespans than their parents, ever in history. That is a pretty frightening place to be. And even if you just look at it as a workforce issue, we need every child to be healthy and acquire the skills they need to be competitive in the future. So this is an issue which is not just a health care issue; it is a huge economic crisis looming in this country.

Mr. NEAL. Thank you, Madam Secretary.

Thank you, Mr. Chairman.

Chairman RANGEL. The Chair yields to Mr. Ryan, unless he wants to yield to——

Mr. RYAN. No, I am good now. I thank the Chairman.

Nice to see you, Madam Secretary. This is the first time I am having a chance to meet you.

The rhetoric coming from the Administration sounds good; it sounds familiar. If you like what you have, you can keep it. We are going to have more choice and more competition in health care. Those are the principles I think most of us all agree with.

But when you look at what is being advocated here, in particular the public plan option, it just seems to me that actuarially speaking you are embracing contradictory principles. You are embracing faulty premises that collide with one another.

And what I mean when I say that is, if the public plan option will reimburse at Medicare rates, as it has been advocated, as most of the plans that are out there already do, and as your budget rests upon, then how do you escape the conclusion that reputable actuarial firms, like The Lewin Group, suggest 120 million people will lose their private health insurance and be thrust upon the public plan option? Seven out of 10 workers who get health care from their jobs will, in fact, lose that as they go into the public plan option.

That is question number one. Since we are short, I will just put it all into a question now.

Question number two is, where are you going to pay for all of this? The budget carves out $646 billion. About half of it comes from provider cuts, from Medicare, MedPAC recommendations, things like that. The other half comes from revenues. Chief among that is the limit on charitable deductions, which I think will have a hard time passing here, or at least in Senate Finance.

You have already said that the Administration is opposed to capping the exclusion, which I think that ought to be revisited. There is an issue there, I think, that both sides would agree needs to be addressed.

But where are going to come up with the money, number one?

Number two, looking at these plans, it is going to take you about another $600 billion on top of what you have already put in the budget, and that has been acknowledged by the Administration, as well. So if we are going to have about a $1.2 trillion or $1.3 trillion plan, you have already identified $646 billion—some of that which probably won't materialize—where is the other $600 billion-plus going to come from to make this work?

And how do you escape the conclusion that if you have a public plan alongside the government plan, the way I see it, it is kind of like my daughter's lemonade stand competing against McDonald's. It is having the referee, the government, also be a player in the same game. And, actuarially speaking, it is almost impossible to make that a fair game.

Secretary SEBELIUS. Again——

Chairman RANGEL. Unfortunately, Mr. Ryan has used up the time allotted for you to answer in his question. However, I am certain——

Mr. RYAN. Go figure.

Chairman RANGEL [continuing]. That you will be able in writing to give some response to his very complicated but interesting inquiry.

And the Chair would now like to recognize Mr. Becerra, who is not here.

Mr. Doggett.

Mr. DOGGETT. Thank you, Mr. Chairman.

Madam Secretary, thank you.

Three issues to ask you to respond to at once.

First, our colleague, Debbie Wasserman Schultz, has an excellent bill based on the experience she has had in a struggle with breast cancer that so many Americans face that would focus on education of young women. And I hope that it can be included in any health care reform legislation. It is supported by the Komen Race for the Cure and a number of other groups.

Second, I applaud the bipartisan cooperation that the Administration has sought, to get all stakeholders at the table. But I think that some of those who have successfully blocked health care reform for decades have not changed their goal to thwarting reform, only their tactics. And I think it is vital that any reform offer the uninsured the option of a public insurance plan and that our goal must continue to be getting access to health care for all Americans, not getting all to agree to a plan that will not provide access to all Americans.

Third, I believe that health care reform must address the soaring cost of prescription drugs. One report I saw on a particular class of drugs last year showed an increase in 1 year of 3,000 percent on the cost of some of the drugs. Those soaring costs bankrupt individual families. They can present great problems to us in trying to have the taxpayer pay for it. And we know what to do about that, but Congress hasn't had the political will to deal with it.

Could you respond?

Secretary SEBELIUS. Congressman Doggett, let me assure you, I look forward to working with you and with Rising Star Ryan on the issues that you have outlined.

Chairman RANGEL. Madam Secretary, your response, because of the length of the question, will be limited to 40 seconds.

Secretary SEBELIUS. I just responded, Mr. Chairman, to both.

Chairman RANGEL. It is embarrassing for me, as Chair, to do this, but the Secretary has gone out of her way to make certain that the first Committee that she reports to is our Committee. And we graciously accept that. But, rest assured, Mr. Camp and I have reason to believe the Secretary will have more time to spend with us, and we appreciate that.

So I guess most of us want you to hear how bright we are, and we will then get responses to make certain that we are correct in our thinking.

And if you yield back, then the Chair will recognize Mr. Linder for 2½ minutes.

Mr. LINDER. Thank you, Mr. Chairman.

Thank you for being here, Madam Secretary.

When President Johnson gave his "Great Society" speech, he said, "We know from using easily quantifiable user statistics that, by 1990, Medicare will cost us $9 billion and Medicaid will cost us $1 billion." But he was wrong, it was $108 billion and $76 billion respectively, because people overuse something they think someone else is paying for.

We are proposing to increase the number of consumers in health care by 17 percent. And we are increasing the number of doctors

per year by 1 percent. And the number of nurses has been flat for 5 years in its increase, just flat.

Who is going to treat these people?

Secretary SEBELIUS. Congressman Linder, I think that is a huge issue, and the looming shortage of providers—particularly nurses, but primary care doctors are shortly behind the nurses—is huge. States have been trying to work on the pipeline issue for a number of years.

I was pleased that, in the Recovery Act, there is a half billion dollars for workforce issues. And I look forward to working with those of you here in Congress on a long-term strategy. It has been suggested that we have an ongoing workforce commission.

We need to focus payment—we need to shift payment to appropriate protocol. A lot of people, frankly, overuse the system because it is often recommended that they have procedures that aren't necessarily the best health outcome, as our quality report, issued today, will indicate.

So I think there are ways to address this from the workforce system, but also to begin to shift the payment system to look at outcomes and not necessarily contacts with a health provider.

Mr. LINDER. And we are going to have bureaucrats make those decisions?

Secretary SEBELIUS. Ideally, the health providers make those decisions with informed information about best practices, which currently are in place in some parts of the country but are not uniformly driven throughout the system.

Mr. LINDER. Thank you.

Chairman RANGEL. Thank you.

The Chair recognizes Earl Pomeroy.

Mr. POMEROY. Thank you.

And, Madam Secretary, I know I speak for Senator Ben Nelson and Senator Bill Nelson, both former insurance commissioners like myself and you, in acknowledging at least someone in the former insurance regulatory ranks has gone on to make something of their lives, and we congratulate you.

The White House this week had a roundtable on rural health care, in particular, and released a report called "Hard Times in the Heartland," reflecting that in rural areas you have higher rates of poverty, mortality, uninsurance, and limited access to primary care providers.

As former Governor of Kansas and insurance commissioner of Kansas, you have seen the difficulties of keeping proximate access to care in sparsely populated areas. It is excruciatingly difficult.

I believe part of our rural health care system is being under-reimbursed by Medicare. You see Medicare reimbursement at half per capita rates reflecting more urban areas. That also includes much higher utilization trends in urban areas, but also, I believe, underpayment for rural services.

I am wondering about your thoughts, as you assume your new responsibilities, relative to this unique dimension of America's health care, in rural areas.

Secretary SEBELIUS. Congressman Pomeroy, as you said, you and I share a lot of background, not only in our insurance commissioner days, but in dealing in a very rural State.

So this is a huge issue. The disparities in Medicare reimbursement is a big issue. I just want to assure you that I look forward to working with Congress to reduce those disparities.

Part of it is a shift toward outcome and away from geography. So we look for protocol that will reward outcome and begin to have the Medicare system focus more on prevention and wellness, which reduces cost.

But it is an issue I take very seriously and one I look forward to working on.

Chairman RANGEL. The Chair recognizes Mr. Nunes.

Mr. Tiberi.

Mr. TIBERI. Thank you, Mr. Chairman.

As the only Ohioan on this panel, Madam Secretary, I want to give you a Buckeye welcome——

Secretary SEBELIUS. Thank you.

Mr. TIBERI [continuing]. From your native State and wish you well in your job. As Ranking Member Camp said earlier, the principles that you outlined I think we all agree on.

In my district, in Columbus and central Ohio, we have a Medicare Advantage plan called MediGold that is very, very popular, that I have had family members actually talk to me about the popularity of it. Anyhow, a very popular, very well-defined program in my district. And I have talked to many, many seniors that enjoy that program.

MediGold's principles are very similar to what you outline in terms of the principles that you see going forward with respect to health care reform. How do you see their plan, MediGold, their Medicare Advantage plan, playing out with respect to your proposals and the Administration's proposal on health care reform?

Secretary SEBELIUS. Congressman Tiberi, first of all, I appreciate the Buckeye welcome.

I know that there are some very popular and well-run Medicare Advantage plans, and there are some that I think have not provided the additional benefits that would be estimated to be provided with a 14 percent additional payment over traditional Medicare.

So I think what is important going forward is to make sure that, again, there is a kind of level playing field that we are paying for the benefits and the outcome, and that the information provided to seniors, the numbers of plans—I mean, there are literally dozens and dozens of Medicare Advantage plans which have a very small number of enrollees, which are very confusing, in my experience for seniors to try and identify what the best plan is. But I think in the situation that you have described, the health reform plan ideally will not tamper with the kind of coverage and benefits that your family is currently enjoying.

Mr. TIBERI. Thank you. Look forward to working with you. Yield back.

Chairman RANGEL. Because there is such an outstanding number of Democrats, Majority Members waiting, I will now try to do two of them at a time to try to level this off, and recognize Mike Thompson of California.

Mr. THOMPSON. Thank you, Mr. Chairman.

Madam Secretary, congratulations, and thank you for being here.

I, too, want to chime in on your rural experience and how important that is for someone with a district such as mine. I think a lot of our success in health care reform hinges on providers, making sure we have the number of providers necessary, especially in rural areas where it is so hard to get not only primary care, but all the specialties. I don't think we can do it unless we address that issue. And at the same time, we have to do it in a way where it is affordable to small businesses, and that is something that I hear about constantly. And so I appreciate your experience in this regard, and look forward to working with you on those two areas in particular. If you have something you want to add, fine. If not, I yield back.

Secretary SEBELIUS. Look forward to it.

Chairman RANGEL. Thank you so much for your cooperation. Believe me, we will make up for this embarrassing moment.

Mr. Becerra.

Mr. BECERRA. Thank you, Mr. Chairman.

And, Madam Secretary, great to see you here. Thank you. We look forward to further opportunities.

Without spending time on it, because we don't have time, I would like to mention that I appreciate that you mentioned the reports that you are issuing, especially the one on disparities. I would love to follow up, because as we know that there are disparities in the quality of health care dispensed to Americans. I hope that you will take a look at your agency, your Department, to make sure that there aren't disparities within your own personnel ranks when it comes to being able to meet the needs of all Americans. And you have a diverse workforce that can address those disparity issues that we have in America.

On health care, you said some interesting things, and I want to follow up on them, and perhaps later on we will have an opportunity to discuss them more fully.

In response to the question about whether or not a public health insurance option could really compete, this notion that there is no way the government could compete, I appreciate that you mentioned that today we have a track record of public health insurance options competing, and competing on a playing field that is level through the 30 States that currently do that.

I think it is also important to note that Medicare, which is, in essence, a public health insurance plan, offers 48 million seniors in America the options and the opportunity to have health care coverage. And by the way, 95 percent of all of America's doctors participate in Medicare. And so, clearly, it becomes obvious that you have quite a bit of choice within a public health insurance option in terms of doctors if 95 percent of today's doctors participate in Medicare.

And I am wondering if it is your sense, as you said before, that a level field can be created in this health care reform so that we can remove any doubts that any type of option that gives Americans the most choices can be constructed so that at the end of the day what we have done is we have left consumers with the option and the choice of what plan they will use, and not have the government or private insurance companies make the choices for consumers.

Secretary SEBELIUS. Representative Becerra, I think you have just outlined and articulated very well the strategy of a public plan. Clearly, you could have a situation where it would be unfair and lack the competition element for private insurers. But I can assure this Committee that the President and I believe strongly that we want to stabilize the private insurance market, not undermine the private insurance market, because millions of Americans rely on their private coverage and feel it is very satisfactory for themselves and their families.

So the rules of a public plan within a health insurance exchange are to offer choice, offer competition based on what are the best practices, how to lower costs, not with an unfair advantage, but who is doing the best job for their patients, because wellness, frankly, costs less than sickness does. So keeping patients healthy is part of the competition we are eager to have plans engage in.

Mr. BECERRA. Thank you, Mr. Chairman.

Chairman RANGEL. Mr. Davis of Kentucky.

Mr. DAVIS OF KENTUCKY. Thank you Mr. Chairman.

Madam Secretary, one question that I would like to ask, or follow a request. I would like to submit two questions regarding community pharmacy efforts to get detailed answers in writing that I am sure will exceed the 2½-minute limit here. We will provide those to staff.

But the question that I have, and it concerns me greatly, on the national connector model. We have tremendous local solutions that are being developed. In particular, a gentleman named Chris Goddard, who runs Healthpoint, a community health center network in northern Kentucky, developed a plan working with small businessowners that will remove the majority of our uninsured or underinsured in northern Kentucky entirely off the grid of the Federal system, providing a physician home, providing preventive dental and medical services and some acute care, not catastrophic, but at the cost of about $50 per employee per month. And I would like to hear your thought on having solutions like that that are locally driven, have the accountability in the network that is key for success in health care, as opposed to the one-size-fits-all plan that we have heard so much about over the last couple of months.

Secretary SEBELIUS. Congressman Davis, let me assure you, there is no one-size-fits-all plan. There is no national health plan that has been developed or written. In fact, the more strategies that are successful at the local and State level, the more people will have coverage that they enjoy and benefits themselves and their families, then the more provider support there will be. The effort for health reform is aimed at stabilizing just that market, so if you have a strategy that is working in Kentucky that is insuring previously uninsured folks, I think that not only will it not be disruptive, but, hopefully, will help lower the additional costs that those individuals, those Kentuckians, are paying for the uninsured care that is currently coming through emergency room doors and stabilize that market.

This effort is primarily aimed at either those individuals who are paying out of their own pocket for catastrophic coverage, have no prevention care, for those 50 million Americans who have no access

to health insurance at all, and for a system, frankly, where the costs continue to rise.

Mr. DAVIS OF KENTUCKY. I think in that case, Madam Secretary, it will be well served both for the country and I think would be illuminating. I would like to invite you to personally come to northern Kentucky, to Covington, and to see some creative solutions that have been developed out of that old saw, the greatest source of inspiration is desperation.

Secretary SEBELIUS. I would be glad to do that. And, you know, Cincinnati is my hometown, birth town, with my dad and sisters still there, so any opportunity to visit Covington provides a trip home.

Chairman RANGEL. The Chair would like to recognize Mr. Lawson and then Mr. Blumenauer.

Mr. Lawson.

Mr. LAWSON. Thank you, Mr. Chairman.

Chairman RANGEL. If I could interrupt. The record will be open for those people that would want to submit questions to the Secretary.

Chairman RANGEL. Mr. Lawson.

Mr. LAWSON. Thank you, Mr. Chairman.

Again, thank you, Madam Secretary, and thank you, with very little notice, and having just been confirmed, to come before a joint caucus conference of the House Democrats and House Republicans last week to address H1N1, commonly referred to—but Mr. Etheridge won't let me say it, so I won't. So I want to thank you for that.

I just have one question I would like to follow up with you on, and especially given your experience as an insurance commissioner, in your estimation does the current private health insurance market do an adequate job of providing affordable health insurance? And what do we need to do to improve access and create affordable coverage?

Secretary SEBELIUS. I think, Congressman, there are certainly lots of Americans who have coverage that they think is terrific, and it is very good. Others, I think, are really struggling with underinsurance or struggling in a situation where they have been underwritten because of a medical condition or are limited where the cost is exorbitant because they have recovered from a heart attack or have diabetes. So there are the best and the worst, if you will, currently in place. And I think working on the strategy moving forward, getting rid of some of the rules which allow insurers to make health decisions instead of providers—I know there is a lot of talk about not having bureaucrats make health decisions, but I think it is equally important not to have private insurance companies make health decisions overruling protocol recommended by health providers. And part of health reform is to change those underlying rules, to have major insurance reform along with this effort.

Mr. LAWSON. Thank you, Madam Secretary.

Chairman RANGEL. Mr. Blumenauer.

Mr. BLUMENAUER. Thank you, Mr. Chairman.

Madam Secretary, coming from one of those low-cost, high-quality regions in Oregon, I hope to work with you on fundamental payment reform that encourages the outcome we want in one specific

area, end of life, where most of us spend most of our lifetime supply of health care dollars, and we are finding that people are too often unprepared. And Medicare doesn't even recognize a consultation with a patient and their family to be able to deal with these complex choices that they face to help guide them through as worthy of a specific reimbursement.

Now, I introduced some legislation to try and remedy that on a specific area, but I wonder if you see this counseling initiative, end of life empowerment of patients and families, as an area to be dealt with in comprehensive reform, and maybe even something that we might be able to make some adjustment sooner to give patients and families the support they need at this difficult time.

Secretary SEBELIUS. Congressman, I can assure you on a personal basis I share your concerns. I am not familiar with your specific legislation. But my mother spent the last 10 weeks of her life in three different hospitals and an army of health providers, and frankly, the help and support needed by families to not only make medical decisions, but end-of-life decisions is really essential and something I take very seriously. So I look forward to working with you on strategies moving forward to not only lower what are often exorbitant costs that are not necessarily as patient-friendly or direct the patient outcome, but to help family members make tough decisions at an earlier point.

Mr. BLUMENAUER. I appreciate that, and I appreciate your emphasis. Yes, it may end up saving us money in the long run, but, most important, it is giving the sort of tools so that families' needs are met. And I appreciate your words and look forward to working with you.

Thank you, Mr. Chairman.

Chairman RANGEL. Thank you.

Mr. Reichert, you may inquire.

Mr. REICHERT. Thank you, Mr. Chairman.

Welcome, Madam Secretary.

My background is in law enforcement, so I am really interested in fraud, waste and abuse and safety, and you have touched on the safety issue. I am glad to hear that you are a proponent of the safety checklist, which will save lives.

I am going to try to run real quickly here two questions together. GAO has estimated that Medicare wastes $13 billion a year. It has paid out to $92 million just this year in part B providers who have deceased, are deceased.

Then I want to shift real quickly to interoperability, so that waste, fraud and abuse kind of shifts over to interoperability; $35 billion in the stimulus package ready to go out the door. I don't think we are ready for it. Health providers have said they don't need it yet. They don't know how to spend it yet. There aren't providers that they believe are interoperable and that it can work with now. There is no national standard. I am afraid we are going to be wasting some money here if we don't have a plan in place.

Secretary SEBELIUS. Let me try to first assure you, I very much am interested in waste, fraud and abuse. Every dime stolen from the health care system is money we can not apply to appropriate care and quality care for Americans. So that is an effort I will look

forward to working with you and the Committee on cracking down in any way we can.

On the interoperable standards, as you know, Dr. David Blumenthal has now been appointed. He is charged with the kind of protocol that you are suggesting. There is a Committee at work right now to develop a national platform. I couldn't agree more that having—just shifting our paperwork onto computers doesn't save any money and is totally ineffective unless our technology can talk to one another. So protecting privacy on one hand and moving forward as rapidly as we can with a system that eliminates paperwork, eliminates the duplication, lets health care providers not fill out dozens of forms, but focus on medical care is what the shared goal is, and that is very much on the way. But dollars are not going to leave before there is a platform ready to go.

Mr. REICHERT. That is good to hear. Thank you.

Chairman RANGEL. Thank you.

Mr. Kind and Mr. Pascrell.

Mr. KIND. Thank you, Madam Secretary. Thank you for being here. And I agree with the President. I think that health care is one of those reforms, is one of those building blocks that we have got to get done at the end of the day if we are going to have prolonged, sustainable economic growth in the country.

Here are my concerns. At the end of the day, we have got to figure out a way of how we bend the cost curve in all this, but we also need to figure out a way to deal with the affordability of health care for small businesses, family farmers throughout the country.

With the cost curve issue, I, too, come from one of those low-cost, low-reimbursed, high-quality care areas of the country in western Wisconsin, a lot of innovation taking place. That is why I am a big believer in the importance of HIT buildout, but also comparative effectiveness studies. As you said, best practices, I think, are going to show us the way for greater cost savings, while improving outcomes and quality of care at the end of the day.

The Economic Recovery and the Investment Act had about $1.1 billion in there to go forward on comparative effectiveness studies. I know you are relatively new to the position, but I am wondering if you gave any thought about whether that money is going to be sufficient to get us where we need to go, or if it is just the beginning of more of what needs to be done to find out what works, what doesn't, so we can, as Mr. Blumenauer indicated, revamp the reimbursement system so we are rewarding quality at the end of the day, as opposed to more quantity or just more consumption in the health care system.

Secretary SEBELIUS. I think that the effectiveness research, comparative effectiveness research is a strategy that we know can help inform providers, empower consumers, and drive best practices. That is the goal at the end of the day. It is prohibited by law to use that research to make Medicare cost decisions. But certainly, empowering and driving best practices and highlighting what we know works is an effective strategy. And as the quality report says today, we know 4 of 10 Americans do not receive the care that is recommended, so that bends the cost curve.

Mr. KIND. And I am a small business friend. Tomorrow I am going to be introducing a bipartisan bill called the SHOP Act, which establishes purchasing pools for small businesses, family farmers, with ratings reform, administrative fees, tax incentives that Senators Durbin and Snowe have been carrying on the Senate side, too, and we think this could be a commonsense piece to the overall health reform that addresses needs in the small-business community and family farmers throughout the country. So we will look forward to supplying some more information to you and your team over there to take a closer look at the SHOP Act. Thank you for being here.

Mr. PASCRELL. Madam Secretary, just one quick question on the end of life. Would you consider a mandatory—that all Medicare recipients must have an end-of-life directive?

Secretary SEBELIUS. Congressman, it is something that I certainly would be glad to take a look at. I am not quite sure what that means in terms of individual mandates.

Mr. PASCRELL. I want to continue what my good friend from Wisconsin was talking about, and that is cost. We have got to get folks on the Hill, as well as the folks, our constituents, to understand that the costs of health care have to be contained, or else we cannot come up with enough money to sustain a universal health care plan. I don't care what anybody says. There isn't enough money out there. If that is true, if you accept that premise, that we can't continue to do business as we are doing—otherwise I guess we wouldn't be here, would we—what policy options hold the greatest promise for systemically slowing the growth of health care costs? And as part B of that question, would you prefer to pay for performance, a value-based purchasing system and/or a public plan option? If you had to make a choice amongst those three, what would you do?

Secretary SEBELIUS. My sense is, Congressman, we do all of the above.

Mr. PASCRELL. So they are all possible.

Secretary SEBELIUS. Absolutely. And I think that part of what is happening in America is that we pay more than any country on Earth, and our health results are poorer than many of the countries who have coverage. So we clearly don't have to substitute quality for cost. They are not paying for quality right now. We need to begin to pay for outcomes.

Mr. PASCRELL. If we don't do these things, Madam Secretary, will we have to begin to ration health care?

Secretary SEBELIUS. Essentially it is going on right now; 50 million Americans have rationed care. We have people who, because of their gaps in their coverage, are cutting their pills or not taking their protocol that is recommended. Hospital stays are often cut short, not because it is the provider's recommendation, but because the insurance plan only covers a limited stay. So we are essentially in a situation where providers' recommendations are often compromised by what dollars are available.

Mr. PASCRELL. Thank you, Madam Secretary. Good luck to you.

Chairman RANGEL. Mr. Boustany from Louisiana.

Mr. BOUSTANY. Thank you, Mr. Chairman.

Welcome, Madam Secretary.

As a heart surgeon with over 20 years' experience clinically, and as somebody who has deep concerns about quality and cost in health care, I have to say that I have concerns, and I am certainly well aware of the problems in the private insurance and in current existing government health care programs. But I would like to ask you, if we can build off the current insurance system, private insurance system, make it truly competitive, make it truly accessible for coverage, are you willing to entertain this, or are you purely wedded to a government option?

In other words, I mean, are you—is this an exclusionary foregone conclusion that the Administration wants a government option at the expense of real bipartisanship to solve a very complex problem?

Secretary SEBELIUS. Congressman, I would say that the Administration is committed to working with Congress and has every hope that this will be a bipartisan effort, and hopes that all serious ideas are on the table from both sides of the aisle, that it isn't exclusionary on one side or the other. So as we move forward, what I know from my experience is that if the public plan option is opposed because it is seen as uncompetitive, it is seen as the way to drive private insurers out of the market, there are plenty of examples around the country to indicate that that is not the case.

Mr. BOUSTANY. Reclaiming my time, I would submit to you that some of the biggest culprits with regard to lack of emphasis on prevention, screening, early detection are our existing government programs.

Secretary SEBELIUS. And I would certainly share that notion that we have to change that. One of the building blocks for health reform is the assets, frankly, the programs run right now in the Department of Health and Human Services, both Medicare and Medicaid. And changing our system, our underlying system, and the dollars that are already available in the public program and focusing more on prevention and wellness is a huge part of this effort.

Mr. BOUSTANY. Thank you, Madam Secretary. We certainly hope you will work with our side of the aisle on those very difficult issues. Thank you.

I yield back, Mr. Chairman.

Chairman RANGEL. The Chair recognizes on our side Mr. Crowley. He is not here.

Madam Schwartz from Pennsylvania. Thank you. I am so sorry. Ms. Berkley.

Ms. BERKLEY. I thank you very much, Madam Secretary, for joining us today. I know there is a great deal resting on your shoulders. This is such an important issue. I believe that Congress and the Administration have a once-in-a-generation opportunity to make important reforms to our country's health care system. We have done quite a bit already with the SCHIP program and our health IT infrastructure, bringing it into the 21st century, increasing COBRA benefits for those who lose their jobs. I also would like to see us increase health care and provide health insurance for the 50 million of our fellow citizens that do not have health care or health care insurance.

I was very, very pleased to hear you emphasize prevention and wellness programs. I have often said in these hearings that the

way we deliver health care in this country is "bass ackward." We spend a fortune in end-of-life care, not enough money in early detection and prevention of illness.

Also, the fact that we need to educate our fellow citizens. We contribute to our own sicknesses and illnesses. If we would moderate our liquor consumption, moderate exercise, watch our diets and stop the cigarette smoking, I think we would be much healthier, and we would save billions of dollars.

I am concerned about the lack of enough health care providers that currently exist in this country, including, as we all know, we don't have enough primary-care physicians. Coming from Las Vegas, I can tell you we don't have enough specialties either.

There are things we can do, and I am wondering what your opinion is on increasing the GMEs and better distribution of them so some of the States in the Western United States could take advantage of that program.

Also, loan forgiveness. My own stepdaughter started practicing primary-care medicine in September with a $190,000 debt.

And also SGR. I know the President's budget provided for a permanent fix, but we are hearing from the other side of the dome in the Senate that they are more willing to kick that problem, that can down the road. That would be a disaster. What do you think?

My time is up.

Secretary SEBELIUS. All of the above.

Chairman RANGEL. I hope that you share your answers with all of us, because those are questions that she asked that we are all concerned with.

Congresswoman Schwartz from Pennsylvania.

Ms. SCHWARTZ. Thank you, Madam Secretary. Congratulations and welcome. You have a very full plate, and I wish you well. I know you are well positioned to be successful.

There has been a lot, two issues I wanted to raise. One you have heard a good bit about, so I will—and you have answered, so I won't—it is just to say that I do have a bill I am introducing tomorrow to create incentives for primary-care physicians and nurses. And I would just ask you to take a look at that. It addresses many of the issues that you have heard today, and I would ask you to take a serious look at that.

And I also know that you have been looking at market reform, and I am also working on legislation. A number of these pieces have been talked about, both by the insurance companies, the Insurance Federation. Of course, many of us have been looking at them for a number of years. One is, of course, ending the preexisting condition exclusions, getting to a guaranteed issue, being able to go to community rating, stopping gender discrimination in rating as well has been talked about, ending waiting periods for employees are all important.

I did want to follow up on Mr. Johnson's reference to legislation I am working on that he is in agreement on, which is nice to have a bipartisan start, and that is to really do what we did under 401(k) plans, which is to just change the way employees opt in. And basically what I am saying is that they should be presumed to be in the health benefits package plan that their employer offers. They can opt out, but instead of potentially failing to sign up and

then never being able to sign up even if you are employed for years seems really unconscionable in this day and age.

So we really want to make it easier. We think that there has to be transparency to make sure the employee knows what they are doing, but would ask you to take a look at that and see what you think is a way to encourage those who do have available insurance coverage to take it. So I wanted to have your reaction to that, and just say I look forward to working with you on all of these issues so that we do actually get to coverage for all Americans in an affordable way for the government and for them.

Secretary SEBELIUS. Congresswoman Schwartz, I look forward to working with you. And I know that the kind of autoenrollment strategies that you are talking about are often looked at as in many cases as effective and in some cases more effective than mandate strategies. So I look forward to looking at your legislation and moving forward.

There are lots of people who have eligibility right now in a variety of programs who, for one reason or another, are not enrolled, and I think we need to take that very seriously as an underpinning to cut down on the number of uninsured Americans.

Ms. SCHWARTZ. Actually that is a great point. I know we saw that in CHIP, for example. Thank you.

Chairman RANGEL. Mr. Heller.

Mr. HELLER. Thank you, Mr. Chairman, and Governor, thanks for being here. Look forward to working with you. I have noticed a theme from both sides, and that is talking about rural care and the concern that we have for rural care. I represent a district that is 105,000 square miles, and if you live in central Nevada, and you need a blood test taken, in most cases—or you can't find a primary-care physician, needless to say you obviously can't find a specialist either. So your choice is to travel 200 miles to Reno or another 200 miles the other way to Salt Lake City. And I just want to emphasize my concern for that.

Veterans that Need Help, which is another government-run program, find similar accessibility problems in rural areas. Those that are on Medicaid and Medicare have accessibility problems in the rural areas.

I guess my question for you is, how would another government-run program like we are discussing today solve these accessibility problems?

Secretary SEBELIUS. Congressman, first of all, I don't think anybody is talking about a government-run program. I think the goal is to have most Americans without health coverage in a health insurance exchange run by the private market to stabilize the current private market where we see employers, frankly, dropping coverage every day because they can't sustain the cost of insuring their employees. None of that solves the workforce issue that you are addressing, and particularly the underserved rural areas that are very common.

There is a proposal by the President to double the Commissioned Corps. That will provide some incentives. There is a half billion dollars in the recovery plan to help fill the pipeline for nurses and doctors. I think there are a series of strategies, frankly, using health technology, and at least it has been my experience in our

State that health providers are more likely to choose and stay in an isolated and more rural area if they have access to specialist consultation through telemedicine, if they can tap into advice and consult and support.

So I think there are underpinnings of this underway. I don't have all of the answers of the workforce issue, but it is huge, and I think looking at incentives, looking at forgiveness of medical loans, a variety of strategies that, frankly, have been proven successful at the State level, are things we should examine at the Federal level.

Mr. HELLER. Look forward to working with you.

Chairman RANGEL. Mr. Davis of Illinois and Mr. Etheridge of North Carolina. Mr. Davis, you may inquire, and the time, as you may have heard, is 2½ minutes.

Mr. DAVIS OF ILLINOIS. Thank you very much, Mr. Chairman.

Madam Secretary, welcome. A few minutes ago you and Representative McDermott talked about the need and desirability of increasing primary-care providers. My question is, would you see increasing community health centers and networks with built-in home visiting programs as a way of doing that?

And in the Recovery and Reinvestment Act, there are provisions for some hospital-based physicians to receive incentives, but then the act specifically states that some will not be eligible.

Could you tell us how you would go about looking at or determining which ones would be eligible and which ones would not?

Secretary SEBELIUS. Congressman Davis, you make a great point about the community health centers. And again, the Recovery Act had resources to double the number of health centers, and that will certainly provide a health home to millions of Americans who currently don't have that health home. There also is an expansion of the Commissioned Corps for providers who work in underserved areas.

And I think what we have to look at is a series of strategies. Incentive payment is one. Shifting the payment to reward outcome and not contact with doctors is another. Looking at the ways that Medicare can be an innovator and an opportunity to lead the way in terms of how the payment system can begin to incentivize additional primary care docs is something that again, I know is a major challenge and look forward to those of you who have worked on this issue for a number of times, and having some dialogue and figuring out ways that we can use the Department's assets to move in the right direction.

Mr. DAVIS OF ILLINOIS. Thank you very much. And I would just like to say I also have a great deal of interest in long-term care and the needs of people with disabilities, and look forward to working with the Department on those issues.

Chairman RANGEL. Bob Etheridge from North Carolina.

Mr. ETHERIDGE. Thank you, Mr. Chairman.

Thank you, Madam Secretary for being here.

And coming from a State that has some great hospitals and institutions, but in North Carolina, in the past 2 years, the uninsured has jumped 22.5 percent, the biggest increase in the Nation. Nationwide about 22 percent of adults do not have insurance, and in my home State, that is now about 25 percent of adults, and an additional 9 percent are underinsured. And that is being compounded

by the fact that our unemployment rate has more than doubled in the last year, making us the fourth highest in the Nation.

And I set that stage to say a lot of the people who had insurance have lost it. Those who don't have it are looking for care. And so they are moving to the community health centers, who are stepping in to help fill some of these gaps.

So my question is this: Following Congressman Davis' question, CACs in turn are seeing their reimbursement rate stretched because of the people who are coming to them, and they are really stretched hard.

As we work to reform health care, I ask you to consider, and if you have time to comment on how we are going to make sure that the rural areas, and really some of our low-income areas, many are more in rural areas, have access to quality care because I think that is a critical piece in this whole issue.

Secretary SEBELIUS. Congressman, just let me assure you, it is a piece I take very seriously, and stabilizing the existing system where it is effective. I think community health centers have been very effective in delivering care. So we don't want to destabilize, by either lack of resources or overdemand, any piece of this system. So figuring out strategies to make sure that the community health system continues to serve the population it is serving effectively right now is something I look forward to working on.

Mr. ETHERIDGE. Thank you.

Thank you, Mr. Chairman. I yield back.

Chairman RANGEL. Mr. Roskam of Illinois.

Mr. ROSKAM. Thank you, Mr. Chairman.

Madam Secretary, we have seen eight dot points that have come out of the Administration, and the fifth one is really the one that folks are tending to focus on today, the public plan, and the assurance and confidence that there is not an erosion of the choice for folks.

It is interesting to me, there are two groups that are out there, or two entities that are out there that think you are wrong or sort of think you are wrong.

Secretary SEBELIUS. I am sure there are more than that.

Mr. ROSKAM. Right. But sort of wrong in the underlying premise. And you have demonstrated a certain amount of humility on we have got to get it right, and I respect that. But it is interesting, the Lewin Group, in a study that I am sure you are familiar with, says it is not going to happen, and 120 million folks are going to be out of that public—out of a private plan.

And the other is one of my colleagues from my delegation, Representative Jan Schakowsky. Let me read a quote, and I am interested in how you reconcile these two views in the brief time that we have.

This is Representative Schakowsky's quote on April 18 speaking to a group of single-payer advocates. She said, "I know many of you here today are single-payer advocates, and so am I. And those of us who are pushing for a public insurance don't disagree with this goal. This is not a principle fight. This is a fight about strategy for getting there, and I believe we will." In other words, this part of the plan is part of a prelude toward ultimately a large single-payer plan.

Can you debunk that? Can you reconcile those?

Chairman RANGEL. That is very difficult, Madam Secretary, for you to respond to a statement attributed to a Member, but I am certain that the question could be reframed without responding to a Member and asking whether or not she believes that this is the beginning of single-payer. But I don't think it is fair, since the Congresswoman is not here, to say whether or not she ever said it.

Mr. ROSKAM. Okay. That is fair enough.

Is it a prelude?

Secretary SEBELIUS. I don't think so, Congressman. Again, I would point to the fact that these competitive strategies are effectively in place across the country. They are not a prelude to anything other than offering consumers choice and driving competition based on practice models. So it is determined by the plan design.

Can you construct an unlevel playing field with a public option unfairly competing with private options? You bet. Is that the intention of the Administration or the Majority in Congress when they talk about it? I don't think so at all.

So it can be designed any number of ways if you have the right actuarial support. If you design the rules so there really is a level playing field that private insurers don't have the advantage of cherry-picking the market, and the public plan doesn't have the advantage of undercutting the costs and driving everybody out, it can work very effectively and does work very effectively across this country.

Chairman RANGEL. Ms. Sanchez of California will be followed by John Yarmuth of Kentucky.

Ms. Sanchez.

Ms. SANCHEZ. Thank you, Mr. Chairman.

And thank you, Madam Secretary for being with us this morning.

I have been a strong supporter of employer-based coverage, and for those who have union jobs or a college education or work for big corporations, the employer system, based system, works quite well, and people generally, according to surveys, are satisfied with their plans if they are lucky enough to have them through their employer.

But those who are not as satisfied with the current system include not only those that don't get coverage through their workplace, but also those who lose coverage when they lose their job. And I routinely get letters from constituents. A constituent recently wrote me about the struggles that she has gone through as a cancer patient after losing her job and the health insurance that went with it. And I know that COBRA coverage exists, and for some people that is an option, but for a lot of unemployed people, they can't even afford COBRA, so they can't afford to extend their health care benefits.

I am interested if you could please share with us a little bit about how we might reform the system so that losing a job doesn't mean that you lose high-quality, affordable coverage, even if we retain the current employer-based system. For example, how we might—the newly unemployed access the health insurance exchange to obtain or maintain their health insurance benefits.

Secretary SEBELIUS. Those are great questions. I think that the Congress appropriately recognized in the Recovery Act that unem-

ployed Americans can't afford COBRA. It is hard for unemployed folks to have COBRA coverage because you are suddenly paying 100 percent of the cost, 103 percent, as opposed to having an employer contribution. That is really the issue. And if you have lost your job, there is no way you are going to be able to come up with a 100 percent benefit. So the Recovery Act provided additional Federal assistance as a stream of money so people could afford COBRA.

I share your concerns about stabilizing the current system. The opportunity, though, in a reform of the future would be you would have a system where that individual who has lost his or her coverage through the job would, first of all, be able to continue coverage in an exchange program, would not lose coverage based on job loss. I think that is one of the issues facing way too many Americans today.

Ms. SANCHEZ. Thank you.

I yield back, Mr. Chairman.

Chairman RANGEL. Mr. Yarmuth of Kentucky.

Mr. YARMUTH. Thank you, Mr. Chairman.

Welcome, Madam Secretary.

We have heard, I think, pretty much what—a broad acceptance of the fact that we are all trying to find a way to insure every American. Although we haven't specifically heard that from some people here, I think everybody on our side of the aisle and certainly the President has expressed that. As far as I can tell, there are three ways of doing it. One is to create a single-payer plan, one is to create the hybrid plan that is under discussion with a public option, and the third way is to rely strictly on the private insurance industry.

Mr. Ryan earlier gave an assessment as to the budgetary problems that might be inherent in developing a coverage for everybody using the public option. Could you give an assessment of what the budgetary implications would be of trying to shove everybody into the private system without a public option? Would that be more or less affordable than doing it with the public option?

Secretary SEBELIUS. I think that the current system is unsustainable in terms of cost. What we have to look at is not only transforming the underlying payment incentives, but changing what the payment incentives do. I think this will help encourage different kinds of behavior. So if we want a wellness and prevention system, we have to pay differently at the end of the day. And I think both public and private plans can be effective doing that.

We have to change the underlying Medicare directives and opportunities for provider incentives, and they can be a leader in this. We can shift the system around. I don't think it is can this work in either the public or private; it has to work in both places. And dismantling the private market and having an entirely public option, the single-payer system, I think, is not something that the President supports. He supports moving forward and filling the gap, not disrupting the entire marketplace.

So we have got to stabilize the private market with a different set of rules, hopefully, that will make it more accessible to more Americans, and encourage competition moving forward.

Mr. YARMUTH. But my question, I guess, was in relation to Mr. Ryan's statement earlier. The budgetary problems inherent in insuring everyone who is right now—every citizen—are not going to be diminished by relying strictly on the private sector.

Secretary SEBELIUS. I would say that is fair.

Mr. YARMUTH. Thank you very much.

Chairman RANGEL. Thank you.

It looks like we have made the deadline. We have Congresswoman Brown-Waite, who has been patiently waiting to inquire, and then we will be followed by Mr. Tanner, Mr. Higgins and Mr. Davis of Alabama.

Congresswoman Brown-Waite.

Ms. BROWN–WAITE. Thank you very much.

Welcome, Madam Secretary. I look forward to working with you on health care reform that I think all Americans do want. I think we may differ in how it is formulated, but we look forward to working with you. And congratulations again.

Representative Anna Eshoo and I introduced a bill on additional funding for pancreatic cancer research. The bill number is H.R. 745. We have 130 cosponsors. And last year I found out, tragically, how quickly pancreatic cancer can take a life because my husband finally succumbed to it 6 months after he was diagnosed.

The bill also addresses other hard-to-find cancers that have a very—that, once diagnosed, people have a very short lifespan. So it is not just about pancreatic cancer. I would certainly welcome your views on it and your support. We are gathering more and more cosponsors every single day, and I would appreciate your support on that bill.

I think we agree—and this is on another subject—I think that we agree that we should get individuals involved, everybody who is eligible for Medicare, Medicaid and SCHIP. How do you propose that we enroll the 11 million Americans who are currently eligible for these programs, but are not yet enrolled in Medicare and SCHIP?

I know hospitals tell me all the time that parents bring children in for care, and when they go over the fact that they don't have insurance, many of them are eligible for SCHIP or Medicaid. So how do we encourage those individuals to sign up for the programs already in effect? I look forward to hearing your views on that.

Secretary SEBELIUS. Thank you, Congresswoman. First of all——

Chairman RANGEL. Madam Secretary, you have 30 seconds to respond, and the rest of your response we will be glad to receive in writing.

Secretary SEBELIUS. We need to look for best practices of enrollment. It is very clear that there are strategies out there, and some States have had huge success. We did pretty well in Kansas with SCHIP. Other States haven't begun to do that. So best practices.

Working with you on cancer initiatives is certainly something I will look forward to, and I am sorry for your loss.

Ms. BROWN–WAITE. Thank you very much. And I yield back my time.

Chairman RANGEL. We have five Members left, Madam Secretary. We recognize that you have extended your time here. So I am going to ask Mr. Tanner, Mr. Higgins, Mr. Davis of Alabama, Mr. Van Hollen and Mr. Meek of Florida to greet you and to share with you how grateful they are that you committed yourself to attend our Committee first, and they will be submitting questions to you. And we know you will respond.

But since they are here, I am certain that they would want to greet you. And so, Mr. Tanner, say hello to the Secretary.

Mr. TANNER. I understand that, Mr. Chairman. You called on probably the Member who can talk as slow as anyone here. So I will just say, Madam Secretary, it is great to see you. I have a couple of questions about rural delivery of health care with regard to competitive bidding of durable medical equipment and the pharmacy requirements for the surety bond and the accreditation. But we will talk about that later. Thank you.

Chairman RANGEL. Mr. Higgins of New York.

Mr. HIGGINS. Thank you, Madam Secretary. I am just interested in the issue of the cancer treatment and cancer drug reimbursement. And my concern is that the reimbursement paradigm hasn't kept pace with the science. And I think we are at the dawn of a cancer treatment revolution with smart drugs, Avastin for lung cancer, Herceptin for breast cancer, and there are so many smart drugs that are in the pipeline toward discovery, and I would just hope that the Administration would take a very serious look at cancer drug reimbursement within the context of health care reform.

Secretary SEBELIUS. That is a great point.

Chairman RANGEL. Mr. Davis of Alabama.

Mr. DAVIS OF ALABAMA. Thank you, Madam Secretary. And obviously, I have to be brief, too, but I would just invite you to personally take a look at an issue that has been affecting my State and could have significant consequences going forward. The 10-second version of it is we have been embroiled, the State of Alabama been embroiled, in a decades-long dispute with CMS over how we finance our Medicaid system. As a former Governor, you know that the issue of intergovernmental transfer has been a very important one. And unfortunately, unless there is a change in course in CMS' current position, unless there is a change in course, Alabama could have to make dramatic cuts to its acute care services, and potentially many of our safety-net hospitals could have to literally close their doors; not cut back services, but literally close their doors. I would urge you, as the new Secretary and as a former Governor who knows these issues intimately, to personally engage this question and to look at a resolution on behalf of my State.

Chairman RANGEL. Mr. Van Hollen from Maryland.

Mr. VAN HOLLEN. Thank you, Mr. Chairman.

And congratulations and welcome, Madam Secretary. We all look forward to working with you and the President to get health care reform done this year.

We have talked today about some of the ways we can both reduce costs and improve quality of care. One of the areas I think we need to look into within the Medicare system is changing the incentives with respect to multiple chronic diseases.

Right now under Medicare there is really no incentive to better manage those diseases. You have people going to individual specialists, and, again, payment is made just on number of contacts, and there are very few incentives within the system to better manage that care to, number one, to get a better health care outcome, but also to drive down an area of costs in an area where we have lots of payments and costs. So it seems to me that is an area that is ripe for again meeting our twin objectives of improving care and reducing costs. And I look forward to working with you in that area. Thank you, Mr. Chairman.

Chairman RANGEL. Mr. Meek of Florida.

Mr. MEEK. Thank you, Mr. Chairman.

Madam Secretary, again, congratulations, and looking forward to working with you.

My line of questioning was going to go along the future. And in a State like Florida, right now we are one of very few States especially under a 2006 waiver as it relates to Medicaid. We have a senior population and an issue of uninsured, especially among service workers, a very, very important issue to us, and also the utilization of community health centers. And I look forward to talking with you and working with your Department as we move forward.

Florida, as you know, we are special in many ways. And when it comes down to health care and delivery of health care for seniors and for indigent and for giving some relief to small businesses, incentivizing best practices so that they don't have a mountain of health care issues is paramount. So I look forward to talking with you in the future. Thank you.

Chairman RANGEL. Madam Secretary, I want to thank you for giving this Committee the courtesy of your first congressional hearing.

I want to apologize to the Members for curtailing their ability to follow through in their questions. And I want to thank you also for making yourself available to us, if not necessarily in hearings, but when we have our Democrats and Republicans together, that you would come in an informal way and try help us out with some of the questions.

We again congratulate you for your appointment. We look forward to working with you. Thank you so very, very much. And the Committee stands adjourned, subject to the call of the Chair. Thank you so much.

[Whereupon, at 12 p.m., the Committee was adjourned.]

[Questions for the Record follow:]

Congress of the United States
U.S. House of Representatives
COMMITTEE ON WAYS AND MEANS
1102 LONGWORTH HOUSE OFFICE BUILDING
(202) 225-3625
Washington, DC 20515-6348
http://waysandmeans.house.gov

May 20, 2009

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, D.C. 20201

Dear Secretary Sebelius:

As a follow up to the 5/6/2009 Full Committee hearing on Health Reform in the 21st Century, please provide answers to the following questions for the record:

Questions from Representative Tanner

1. As you know, the Bush Administration pushed forward and tried to implement a competitive bidding program for durable medical equipment. The bidding program was suspended by Congress in 2008 because the roll-out of the program was disastrous and flawed and many of us believed that the rule should have been totally rescinded. However, CMS has recently announced its intent to move forward with the competitive bidding program. Many Members, including me, were very disappointed in that announcement because we are convinced that competitive bidding for DME will actually reduce access and patient choice. Madam Secretary, what assurances can you give us that a competitive bidding program for DME will actually preserve competition and maintain quality and access for Medicare beneficiaries?

2. In recent years, CMS has undertaken numerous initiatives to combat fraud, waste, and abuse in the area of durable medical equipment (DME) under Medicare Part B. Programs include: competitive bidding, accreditation of DME suppliers and, more recently, a final rule requiring a surety bond in the amount of $50,000 per location. I commend the agency for taking steps to reduce the number of fraudulent suppliers in the Medicare program. However, I am also concerned that these initiatives could have the unintended consequence of driving legitimate providers from Medicare if complying with these requirements becomes too burdensome or costly. For example, many Medicare beneficiaries in my state rely on their local pharmacy for diabetes testing supplies and

other durable medical equipment. These pharmacies are state-licensed and heavily regulated by their state boards of pharmacy. They also typically have long standing relationships with both the Medicare and Medicaid programs. Nevertheless, every pharmacy location will be required to spend thousands of additional dollars to comply with these new programs if they wish to continue to provide services to Medicare patients. I am concerned that some of these pharmacies will be unable to afford to continue to provide durable medical equipment to Medicare beneficiaries, and these patients will have trouble accessing the health care products and services they need.

How can we pursue efforts to combat fraud, waste, and abuse without overburdening legitimate providers, such as state-licensed pharmacies, and potentially create access issues for patients?

Questions from Representative Thompson

1. As you know, recent CMS regulations require pharmacies to comply with accreditation requirements. Seventeen types of state-licensed medical professions were exempted from these requirements by CMS with the announced plan to later tailor accreditation requirements for each type of profession. It seems appropriate that retail pharmacies would be subject only to the same reasonable accreditation requirements as other state-licensed medical professions. Would you consider modifying the current accreditation requirements for retail pharmacies so they are more narrowly tailored to pharmacies and their practice?

2. In addition, a significant number of pharmacists are already in the process of complying with accreditation requirements but might not meet the September 30th deadline. Unfortunately, small independent pharmacies have limited staff resources to take care of their accreditation process. A recent national survey of independent pharmacists conducted by National Community Pharmacists Association showed that of those that have completed an accreditation application but have not been surveyed, 73% will need an extension to meet the accreditation deadline.

Would you at least consider extending the September 30th deadline for pharmacies already involved in the accreditation process to ensure timely and accurate compliance with the CMS regulation?

3. The requirement for Durable Medical Equipment (DME) suppliers to obtain a $50,000 surety bond was an important step to protect the integrity of the Medicare program and beneficiaries. However, CMS appropriately realized that the surety bond requirement isn't necessary for certain providers. CMS has exempted physicians and non-physicians, such as certain physical therapists and occupational therapists, from the requirement to obtain a surety bond. Although the statute does not specifically mention pharmacies, CMS would seem to have the authority to exempt those providers from the requirement. Do you believe that CMS has authority to exempt pharmacies from the surety bond requirement? If you believe that CMS has that authority, what is your rationale for not acting on that authority?

Questions from Representative Van Hollen

Under the Bush Administration, CMS promulgated a regulation in 2008 that would phase out the budget neutrality adjustment factor (BNAF) in the hospice wage index over a three-year period. This regulation would reduce Medicare hospice reimbursement by more than $2 billion. The American Recovery and Reinvestment Act (P.L. 111-5) placed a one-year moratorium on the phase-out of the BNAF. Yet CMS issued a proposed FY 2010 hospice reimbursement regulation on April 21, 2009, that would phase-out the BNAF over a two-year period. An independent 2007 Duke University study showed that patients receiving hospice care cost the Medicare program about $2,300 less per patient than those that did not, amounting to an annual savings of more than $2 billion. Has the Administration reviewed this study? Does it agree with conclusions of this study? If not, why not?

Health care costs are spiraling out of control and, according to the CBO, are only projected to get worse. There are a number of initiatives that have been proposed and discussed as possible solutions to reign in health care spending and improve the delivery of care. One of those initiatives is to improve the management and coordination of care of Americans with chronic diseases. What is the Administration's view on improving the management and coordination of care of those with chronic diseases? What is the best approach to accomplish this goal? Which provider would be best to manage and coordinate the care of an individual with one or more chronic diseases? What incentives need be created so that providers do a better job in managing and coordinating care?

Questions from Representative Davis (AL)

Alabama is involved in an ongoing dispute with the Centers for Medicare & Medicaid Services (CMS) regarding the State's conversion from intergovernmental transfers (IGTs) to certified public expenditures (CPEs) at the insistence of CMS in 2005. It has been more than 3 years since the State agreed to CMS' request that it switch to a CPE-based methodology after lengthy consultations with CMS and CMS consultants. However, it now seems that the mutual understanding reached between CMS and the State, specifically, that the conversion would be at the very least budget neutral, is not being honored. By not honoring this understanding, CMS is imposing hundreds of millions of dollars in retrospective liability. It has also prevented Alabama from financing its Medicaid program on a going-forward basis under its previously approved methodology.

Specifically, in reconciling the State's claiming of federal funds for fiscal years 2006-2008, CMS is utilizing a definition of "cost," which results in approximately $400 million less in federal funding than was expected. Among other things, with respect to uninsured costs, CMS insists that "costs" do not include hospitals' uninsured costs if the hospital receives any amount of insurance reimbursement. The use of CMS' new definition would result in acute care services being paid approximately 50 percent of the actual cost of services which would lead to the closure of Alabama's safety-net hospitals.

CMS' actions and the departure from the mutual understanding with Alabama Medicaid have caused extreme instability and have jeopardized Alabama's ability to provide services. Will you and your Administrators be willing to work with the State to resolve this ongoing IGT/CPE issue without reducing the quality of care for Alabamians?

In recent years, CMS has proposed regulations which narrowly define uncompensated care within the Medicare and Medicaid payment rules. Hospitals and physicians are experiencing an increasing volume of people who cannot afford their co-pays and deductibles for services they have received. Given this trend, why wouldn't CMS consider those bad debts as uncompensated care components?

Questions from Representative Sanchez

I am very concerned about the uninsured. Under our current patchwork of programs—which do not really constitute a system—we know that at least 47 million of us go without: accessing healthcare, if at all, only in emergency rooms.

But even under a reformed system, one that included employer-sponsored insurance, an individual mandate to buy insurance, a health insurance exchange, and even a public plan, there would still be those who would fall through the cracks. For instance, homeless families, those only casually connected to the labor market, and new arrivals to the US are just a few of the identifiable populations who would experience periods of uninsurance because of their disconnect to health insurance access points. Moreover, the length of time that such disconnected families would go without health insurance is difficult to predict.

Unless we have a truly universal plan that reaches everyone present in the U.S. regardless of ability to pay, an outcome which seems unlikely given political realities and the need to compromise, we must have a plan to care for the uninsured that does not overburden full service hospitals, bleed community health centers dry, or unintentionally leave people out in the cold.

It is universally acknowledged that emergency room care is the most expensive kind of care there is. And, as the current swine flu outbreak demonstrates, infections do not ask about insurance status.

I would like to hear your thoughts on how we might build a **real** safety net that consists of **more** than just the local emergency room. I would also like to offer to work with you to construct a plan that can help the disconnected to access real healthcare—to manage their chronic conditions and get preventive treatments: a plan that would not bankrupt hospitals, drive away providers due to inadequate reimbursement rates, or leave struggling families without quality care.

Questions from Representative Higgins

1. One of the critical components to any health plan is a plan's quality of coverage. A plan's quality is a measure of both its breadth of benefits and the depth of its coverage, and the degree to which those benefits meet the reasonably foreseeable needs of the beneficiary. For cancer patients, their reasonably foreseeable needs are costly and sometimes unpredictable, and both the breadth and depth of coverage often does not keep up with what most beneficiaries would consider as "quality". An April 15th, 2009 New York Times article highlighted this problem in the context of reimbursement for intravenous, injectable, and oral treatments for beneficiaries. That article discussed how some insurance plans do not reimburse for oral treatments at the same rate as intravenous and injectable treatments, and how that affects the quality of care delivered for patients. Are you aware of this situation, and would you be willing to discuss the issue of cancer drug coverage parity as you work with President Obama and Congress on health reform?

2. One of the confounding notions with the difference in reimbursement between intravenous/injectable cancer treatments and oral pill treatments is the issue of which treatments are more effective and how authoritative the evidence is for one treatments being more effective than another. Research being done at our nation's most advanced cancer research institutions, all of whom receive significant funding from your Department, study and compare the effectiveness of these treatments, albeit usually on a targeted basis depending on each researcher's goals. As cancer treatment becomes more personalized to the patient, this type of research will become more important to improving patients' quality of life. The widespread dissemination of the results of such research will improve the quality of treatment received by all cancer patients, regardless of their circumstances. Do you see a role for this type of research in the context of the Department's comparative effectiveness research efforts authorized by the American Recovery and Reinvestment Act, particularly when assessing cancer treatments?

3. For cancer patients who are Medicare beneficiaries, the problem of reimbursement for cancer treatments can also be complicated. Anti-cancer drugs covered under Medicare Part B that can be administered in both intravenous/injectable form or orally with a pill are reimbursed equally. It is my understanding that some newer treatments, particularly oral chemotherapy "smart" drugs that do not have intravenous/injectable conduits are covered under Medicare Part D. Because these treatments fall under Part D, patients are subject to co-pays and the "doughnut hole" payment issue. Many of these drugs are classified into "specialty tiers" as part of the drug plan, making them more expensive for beneficiaries to receive than other treatments. My concern is that as more smart drugs come to market; this gap in coverage could grow as a determinative financial disincentive to Medicare beneficiaries to take them, as most Medicare beneficiaries are on fixed incomes, and thus lead to a marked decrease in quality of life. Has the Department made any recommendations on this issue? How could Congress be helpful in providing guidance to address this issue?

Questions from Ranking Member Camp

Secretary Sebelius, during the hearing, Congressman Herger asked you if the creation of a government-run health plan that could result in 120 million Americans losing their current health coverage ran counter to the President's stated principle that "if you like your current health care, you can keep it." You responded that there are examples "in place across the country: thirty of the states have state employee health plans, where there is a public option for state employees side-by-side with a variety of private options. …A number of states have constructed their CHIP programs—the health insurance plans for children—in exactly the same way: there is a side-by-side option of a private provider and a public provider."

Can you please tell me how many of these 30 states you referenced have opened up their state employee health plans to any resident of the state? We were able to identify only one state that allowed such outside enrollment – Kentucky. Does Kentucky still permit outside enrollment? If not, why was this enrollment option terminated and for what period was outside enrollment permitted?

How many of the 30 states you referenced are actually running and operating the day to day activities of their state employee health plan (from paying claims, to forming provider networks, to providing consumer and provider support) versus contracting with a third-party administrator for those functions?

Questions from Representative Ryan

Secretary Sebelius, thank you for your testimony today. After reviewing the President's budget submission and the proposals advocated by organizations that have testified before this committee, I have strong reservations about a so-called "public health care plan." We have heard testimony that under this scenario, providers would be reimbursed using Medicare's current reimbursement methodology. Reputable actuarial firms such as The Lewin Group have estimated this would result in 120 million people loosing their private coverage and instead enrolling in a public plan. I would like to know how you plan to resolve this issue and whether it is the Administrations intent to use Medicare's payment policies as the framework for determining reimbursement rates for benefits provided under a public using Medicare's current payment systems?

My next question relates the amount of new spending the Administration plans to pursue in order to enact health reform legislation. Health care currently consumes 16 percent of our overall economy and is one of the largest expenditures in the Federal budget. It is widely accepted that the unfunded liabilities of Medicare and Medicaid are currently driving our Federal budget into ruin. Indeed, the Medicare Trustees recently reported that the Medicare trust funds will become insolvent by the year 2017 absent any changes in health care spending. The President's budget carves out $646 billion in new spending for health care reform. About half comes from provider cuts, from Medicare and MedPAC recommendations, while the other half comes from revenues, such as limiting the deduction on charitable contributions. Will you please elaborate on the rationale

behind spending additional money on health care yet requiring no changes in the Medicare program?

Finally, it has been widely reported that $646 billion falls well short of what a health care reform proposal will cost. I would like to know if additional funds will be spent health care reform outside of what was proposed in the President's budget and where those funds will come from?

Questions from Representative Davis (KY)

1. As you know, recent CMS regulations require independent pharmacies to comply with costly and burdensome accreditation requirements. Seventeen types of state-licensed medical professions were exempted from these requirements by CMS with the announced plan to later tailor accreditation requirements for each type of profession. Retails pharmacies were not exempted by CMS. In order to avoid duplication with pharmacies' existing licensing requirements and thereby eliminate unnecessary costs, would you consider modifying the current accreditation requirements for retail pharmacies so they are more narrowly tailored to pharmacies and their practice?

2. A significant amount of independent pharmacists are already in the process of complying with accreditation requirements, but still might not meet the September 30th deadline. A recent national survey of independent pharmacists conducted by the National Community Pharmacists Association showed that, of those that have completed an accreditation application but have not been surveyed onsite by the accreditation organization, 73% will need an extension to meet the deadline. Most small independent pharmacies do not have adequate administrative personnel to handle the accreditation process. Would you consider extending the September 30th deadline for pharmacies that have already started the accreditation process, but haven't been able to complete it yet due to time and capacity constraints?

Question from Representative Roskam

Recently, speaking to a group of single-payer advocates, Rep. Jan Schakowsky articulated the notion that a "public option" health insurance plan is merely a stepping stone toward a single-payer system:

"And those of us who are pushing for a public health insurance option don't disagree with the goal [of single-payer healthcare]. This is not a principled fight. This is a fight about strategy for getting there, and I believe we will."

We're told that a "public option" will foster enhanced competition in the health insurance marketplace. However, the Lewin Group predicts that 120 million Americans would lose their current health insurance under a government-run plan, and we know from experience that a government subsidy distorts the marketplace and provides an unfair advantage to the recipient. Given the expressed wishes of some Congressional

Democrats, how will President Obama work with Congress on healthcare reform in a way that guards against a single payer system and doesn't discourage a vibrant marketplace through government distortions?

HOUSE COMMITTEE ON WAYS MEANS
HEARING ON
"HEALTH CARE REFORM IN THE 21st CENTURY"

MAY 6, 2009

These are the answers for the record to be inserted into the hearing transcript:

Mr. BERKLEY: I am concerned about the lack of enough health care providers that currently exist in this country, including as we all know, we don't have enough primary care physicians. Coming from Las Vegas, I can tell you we don't have enough specialties either.

There are things we can do, and I am wondering what your opinion is on increasing the GMEs and better distribution of them so some of the States in the Western United States could take advantage of that program. Also, loan forgiveness; my own stepdaughter started practicing primary care medicine in September with a $190,000 debt.

And also SGR; I know the President's budget provided for a permanent fix, but we are hearing from the other side of the dome in the Senate that they are more willing to kick that can down the road. That would be a disaster. What do you think?

INSERT: Page 62, line 1443

Secretary SEBELIUS:

This Administration shares your concern about the shortages of primary care practitioners nationwide and that of health care professionals in underserved areas. I look forward to working with the Congress to find solutions to such shortages as we work together on broader delivery system reform. As you mentioned, some possible approaches to alleviate these shortages may involve targeted modifications to Medicare's graduate medical education (GME) program and expanded loan forgiveness for medical residents in certain specialties and geographic areas.

The Medicare program makes payments to hospitals with approved residency programs for GME costs based on the number of full-time equivalent (FTE) residents, subject to FTE caps imposed by statute. However, under current law, the statute allows new teaching hospitals to receive FTE cap increases for GME payment for training residents in programs that are accredited for the first time on or after January 1, 1995. In addition, rural hospitals, even those with existing teaching programs, may receive increases to their FTE caps for starting additional newly accredited residency programs.

Current loan repayment programs could also be expanded to increase the number of health care professionals in underserved areas. The American Recovery and Reinvestment Act (ARRA) of 2009 provides an additional $300 million for the National Health Service Corps (NHSC), which is administered by the Health Resources and Services Administration (HRSA), and recruits

primary care physicians, nurse practitioners, nurse midwives, and physician assistants, as well as mental and behavioral health professionals and dental hygienists. Participants in the NHSC Loan Repayment program can receive up to $35,000 per year to repay qualifying educational loans, in return for service in a designated Health Professional Shortage Area (HPSA). In addition, the ARRA provides $200 million for other Health Professions training programs.

With regard to the SGR, I am very concerned about the looming cuts that are projected for Medicare physician payments. While we need to address this funding shortfall, it is also critical that we reform Medicare's physician payment system for the long-term to ensure that it promotes more primary care, as well as more accountable care. As part of health care reform, the Administration supports comprehensive, fiscally responsible reforms to the physician payment formula. I look forward to working with you to improve Medicare's physician payment system.

Lead-In

Ms. BROWN-WAITE: I look forward to working with you on health care reform that I think all Americans do want. I think we may differ in how it is formulated, but we look forward to working with you. Representative Anna Eshoo and I introduced a bill on additional funding for pancreatic cancer research (H.R. 745). We have 130 cosponsors. And last year I found out, tragically, how quickly pancreatic cancer can take a life because my husband finally succumbed to it 6 months after he was diagnosed.

The bill also addresses other hard-to-find cancers that have a very—that, once diagnosed, people have a very short life span. So it is not just about pancreatic cancer. I would certainly welcome your views on it and your support. We are gathering more and more cosponsors every single day and I would appreciate your support on that bill.

I think we agree—and this is on another subject—I think that we agree that we should get individuals involved, everybody who is eligible for Medicare, Medicaid and CHIP. How do you propose that we enroll the 11 million Americans who are currently eligible for these programs, but are not yet enrolled in Medicaid and CHIP?

Ms. BROWN-WAITE: I know hospitals tell me all the time that parents bring their children in for care, and when they go over the fact that they don't have insurance, many of them are eligible for CHIP or Medicaid. So how do we encourage those individuals to sign up for the programs already in effect? I look forward to hearing your views on that.

INSERT: Page 77, line 1830

Secretary SEBELIUS:

The Department is committed to helping States find and enroll individuals who are eligible for Medicaid and CHIP. To that end, we are working with States to effectively implement the provisions in the recently-passed American Recovery and Reinvestment Act of 2009 (the

Recovery Act) and the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), both of which devote new funding to States for Medicaid and CHIP, and have key provisions that will aid States in finding individuals who are eligible but not enrolled in the programs.

In particular, the Recovery Act provides an estimated $87 billion through a temporary increase in Federal matching funds to States, to help them maintain their Medicaid programs despite budget shortfalls and decreasing State revenues. The FMAP increase will also help States cover health care for new people who could be driven onto Medicaid and CHIP rolls because of the loss of job-based health insurance.

CHIPRA extends the CHIP program through 2013, giving States a stable financial base so they can help families through these rough economic times. New CHIPRA funding will not only allow States to maintain health care coverage for 7 million children. It also gives them the resources to offer CHIP and Medicaid coverage to, on average, 4 million children who otherwise would have been uninsured. There are a number of new provisions in CHIPRA which target funding incentives to find and enroll uninsured children. For instance, CHIPRA creates a "CHIP Contingency Fund" designed to eliminate State shortfalls in funding, so States do not have to worry about running short of funding if they succeed in enrolling more children. It also provides bonus payments to States that increase enrollment in Medicaid for children who meet eligibility requirements.

And, most notably, CHIPRA supports greater outreach to children through several mechanisms, including additional funding for outreach and enrollment efforts designed to increase coverage of eligible children in Medicaid and CHIP.

Finally, several provisions in CHIPRA recognize that many uninsured children are enrolled in a number of other public programs. CHIPRA allows States to designate public agencies as "Express Lane" agencies for the purposes of determining eligibility for Medicaid or CHIP, and allow these agencies to use data that have already been collected by these agencies to assist in eligibility determinations. Express Lane agencies include public agencies that determine eligibility for TANF, Food Stamps, National School Lunch programs and others. We are currently working on providing guidance to States that wish to utilize this option.

I look forward to working with you and your colleagues in the Congress on quality and effective health care reform that includes initiatives and innovative ways of finding and enrolling individuals who are eligible for Medicaid and CHIP.

Additional Written Questions for the Record
For Secretary Sebelius
House Committee on Ways and Means
"Health Care Reform in the 21st Century"

May 6, 2009

Questions from Representative Tanner

1. As you know, the Bush Administration pushed forward and tried to implement a competitive bidding program for durable medical equipment. The bidding program was suspended by Congress in 2008 because the roll-out of the program was disastrous and flawed and many of us believed that the rule should have been totally rescinded. However, CMS has recently announced its intent to move forward with the competitive bidding program. Many Members, including me, were very disappointed in that announcement because we are convinced that competitive bidding for DME will actually reduce access and patient choice. Madam Secretary, what assurances can you give us that a competitive bidding program for DME will actually preserve competition and maintain quality and access for Medicare beneficiaries?

Answer:

This Administration is committed to protecting beneficiary access to care and improving the quality of care Medicare beneficiaries receive. The Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding program is founded on these same principles and includes a number of protections specifically designed to support beneficiaries.

For example, under the program, we will ensure that a sufficient number of contract suppliers are selected to more than meet beneficiary demand. Small suppliers, those with gross revenues of $3.5 million or less, made up about 64 percent of the suppliers offered contracts in the previous first round of the program. Further, under the program's grandfathering rules, beneficiaries can continue to receive rented items from their current supplier, even if that supplier is not a contract supplier, provided the supplier is willing to do so. In addition, contract suppliers must make available the same range of products to beneficiaries that they make available to non-Medicare customers. For transparency purposes, we will post on our web site a list of brands furnished by each contract supplier. Also, when a physician specifically prescribes a particular brand name product or mode of delivery to avoid an adverse medical outcome, contract suppliers are required either to furnish that item or mode of delivery, to assist the beneficiary in finding another contract supplier in the competitive bidding area that can provide that item or service, or to consult with the physician to find a suitable alternative product or mode of delivery for the beneficiary.

Just as important is the requirement that suppliers meet quality and financial standards. Contract suppliers will be subject to ongoing quality monitoring though the accreditation process and beneficiary satisfaction surveys.

Finally, competitive bidding will reduce beneficiary out-of-pocket expenses by bringing the payment amounts for these items more in line with those in a competitive market.

2. In recent years, CMS has undertaken numerous initiatives to combat fraud, waste, and abuse in the area of durable medical equipment (DME) under Medicare Part B. Programs include: competitive bidding, accreditation of DME suppliers and, more recently, a final rule requiring a surety bond in the amount of $50,000 per location. I commend the agency for taking steps to reduce the number of fraudulent suppliers in the Medicare program. However, I am also concerned that these initiatives could have the unintended consequence of driving legitimate providers from Medicare if complying with these requirements becomes too burdensome or costly. For example, many Medicare beneficiaries in my state rely on their local pharmacy for diabetes testing supplies and other durable medical equipment. These pharmacies are state-licensed and heavily regulated by their state boards of pharmacy. They also typically have long standing relationships with both the Medicare and Medicaid programs. Nevertheless, every pharmacy location will be required to spend thousands of additional dollars to comply with these new programs if they wish to continue to provide services to Medicare patients. I am concerned that some of these pharmacies will be unable to afford to continue to provide durable medical equipment to Medicare beneficiaries, and these patients will have trouble accessing the health care products and services they need.

How can we pursue efforts to combat fraud, waste, and abuse without overburdening legitimate providers, such as state-licensed pharmacies, and potentially create access issues for patients?

Answer:
Although I understand that some providers may feel that the accreditation and surety bond requirements impose a burden, the requirements are intended to create a level playing field for all DME suppliers, while protecting both Medicare beneficiaries and the program. All DMEPOS suppliers, unless they are exempt, are required to obtain accreditation and a surety bond in order to receive Medicare Part B payments and to retain their Medicare billing privileges. My understanding is that the statute does not allow for pharmacies to be exempted from these requirements.

Though pharmacies are licensed and surveyed, the licensure requirements and surveys relate to the pharmaceutical aspect of their business and not necessarily to the quality of the DME items being furnished. Participation in supplying some Medicare items and services, like DME, requires that the supplier meet criteria in addition to state licensure. The DME accreditation process includes a review of the quality of equipment, items, and services supplied to beneficiaries. The review also includes a measure of beneficiary satisfaction.

I agree that it is critically important that Medicare beneficiaries have continued access to needed medical equipment and supplies. CMS will be monitoring closely for any beneficiary access issues that may arise and will take necessary actions if needed.

Questions from Representative Thompson

1. As you know, recent CMS regulations require pharmacies to comply with accreditation requirements. Seventeen types of state-licensed medical professions were exempted from these requirements by CMS with the announced plan to later tailor accreditation requirements for each type of profession. It seems appropriate that retail pharmacies would be subject only to the same reasonable accreditation requirements as other state-licensed medical professions. Would you consider modifying the current accreditation requirements for retail pharmacies so they are more narrowly tailored to pharmacies and their practice?

Answer:
Section 154 of the Medicare Improvement for Patients and Providers Act (MIPPA) required that DMEPOS suppliers be accredited on October 1, 2009. MIPPA also exempted eligible professionals (as defined in section 1848(k)(3)(B) of the Social Security Act) and other persons such as orthotists and prosthetists as specified by the Secretary from meeting these standards unless the Secretary determines that the standards being applied are designed specifically for such professionals or persons.

It is my understanding that MIPPA allowed CMS to exempt "eligible professionals" that were specifically defined in statute and "other persons" as specified by the Secretary. Pharmacies are considered organizational entities. The MIPPA provision does not give me the discretion to define "eligible professionals" or "other persons" as organizational entities.

2. In addition, a significant number of pharmacists are already in the process of complying with accreditation requirements but might not meet the September 30th deadline. Unfortunately, small independent pharmacies have limited staff resources to take care of their accreditation process. A recent national survey of independent pharmacists conducted by National Community Pharmacists Association showed that of those that have completed an accreditation application but have not been surveyed, 73% will need an extension to meet the accreditation deadline.

Would you at least consider extending the September 30th deadline for pharmacies already involved in the accreditation process to ensure timely and accurate compliance with the CMS regulation?

Answer:
Section 154 of the Medicare Improvement for Patients and Providers Act (MIPPA)

required that DMEPOS suppliers be accredited on October 1, 2009. Despite that deadline, I understand that about 24,000 pharmacies have already received their DME accreditation and that 9,000 more pharmacies have applications for accreditation pending. It is very encouraging that so many pharmacies have already fulfilled the accreditation requirement. In light of this, an extension of the deadline may not be needed and might serve cross-purposes by creating confusion within the supplier community.

3. The requirement for Durable Medical Equipment (DME) suppliers to obtain a $50,000 surety bond was an important step to protect the integrity of the Medicare program and beneficiaries. However, CMS appropriately realized that the surety bond requirement isn't necessary for certain providers. CMS has exempted physicians and non-physicians, such as certain physical therapists and occupational therapists, from the requirement to obtain a surety bond. Although the statute does not specifically mention pharmacies, CMS would seem to have the authority to exempt those providers from the requirement. Do you believe that CMS has authority to exempt pharmacies from the surety bond requirement? If you believe that CMS has that authority, what is your rationale for not acting on that authority?

Answer:
Section 4312 (a) of the Balanced Budget Act of 1997 (BBA) directed the Secretary not to provide issuance (or renewal) of a provider number for a DMEPOS supplier unless the supplier obtains and maintains a surety bond on a continuous basis. CMS published a final rule on January 2, 2009 that required existing DMEPOS suppliers to obtain a $50,000 bond for each National Provider Identifier (NPI) location by October 2, 2009.

Certain DMEPOS suppliers such as government-owned suppliers and physicians and non-physician practitioners (if the DMEPOS items are furnished only to their patients as part of their professional services) are exempt from this surety bond requirement. However, pharmacies are not exempt as there was no specific provision in the BBA authorizing CMS to establish an exemption for pharmacies from the surety bond requirement.

Questions from Representative Van Hollen

Under the Bush Administration, CMS promulgated a regulation in 2008 that would phase out the budget neutrality adjustment factor (BNAF) in the hospice wage index over a three-year period. This regulation would reduce Medicare hospice reimbursement by more than $2 billion. The American Recovery and Reinvestment Act (P.L. 111-5) placed a one-year moratorium on the phase-out of the BNAF. Yet CMS issued a proposed FY 2010 hospice reimbursement regulation on April 21, 2009, that would phase-out the BNAF over a two-year period. An independent 2007 Duke University study showed that patients receiving hospice care cost the Medicare program about $2,300 less per patient than those that did not, amounting to an annual savings of more than $2 billion. Has the

Administration reviewed this study? Does it agree with conclusions of this study? If not, why not?

Answer:
I agree that the benefit of hospice care and overall savings associated with the benefit, when utilized as Congress intended, are apparent. With regard to the 2007 Duke University study you reference, I understand that CMS staff reviewed the study when examining the appropriateness of the budget neutrality adjustment factor (BNAF) and responded to comments related to this study in last year's final rule. While we agree with the study's conclusion that the hospice benefit, as envisioned by Congress, results in savings to the Medicare program, some trends are emerging in hospice utilization that reduce, and in some cases eliminate, those savings. The Medicare Payment Advisory Commission has noted that hospice's net reduction in Medicare spending decreases the longer the patient is enrolled and beneficiaries with very long hospice stays may incur higher Medicare spending than those who do not elect hospice—and data show that the hospice length of stay is steadily increasing.

The BNAF reduction policy was intended to phase-out a special adjustment that has been applied to the hospice wage index since 1998. The adjustment was to mitigate the effect of a 1998 wage index change. With the growth in the industry, and to achieve parity with Medicare's other home based benefits, we believe the adjustment is no longer needed.

Health care costs are spiraling out of control and, according to the CBO, are only projected to get worse. There are a number of initiatives that have been proposed and discussed as possible solutions to reign in health care spending and improve the delivery of care. One of those initiatives is to improve the management and coordination of care of Americans with chronic diseases. What is the Administration's view on improving the management and coordination of care of those with chronic diseases? What is the best approach to accomplish this goal? Which provider would be best to manage and coordinate the care of an individual with one or more chronic diseases? What incentives need be created so that providers do a better job in managing and coordinating care?

Answer:
Managing and coordinating care for people with chronic diseases is a key strategy for improving health care delivery and addressing rising health care costs. Past and ongoing disease management demonstrations for chronically ill beneficiaries in the fee-for-service Medicare program have provided insights into effective care management models. The goals of these initiatives are to improve quality of care and to achieve Medicare savings or, at a minimum, budget neutrality. While not all projects have been successful, to date, the features listed below are common among projects showing promise of attaining these goals. However, possessing these features does not guarantee success, as some unsuccessful projects have included the same elements.

- ***Reduction in hospitalization***. *High costs associated with chronic disease commonly arise from emergency room visits and hospital admissions for acute complications.*
- ***Coordination of transitions between care settings*** *(e.g., from home to hospital, or from hospital to nursing home). Such coordination can help reduce unnecessary hospital readmissions.*
- ***Integral involvement of physicians in care coordination.*** *Such involvement enables physicians to receive timely information about a patient's symptoms and to follow up with an urgent visit or a change in treatment plan.*
- ***Integration of care coordinators into the provider team*** *(e.g., dedicated care manager embedded within the physician's office). Such integration has been more successful than third-party care coordinators in off-site locations.*
- ***Contact with patients***. *Periodic contact with patients can improve self-management or recognition of symptoms early enough to prevent deterioration requiring hospitalization. Substantial face-to-face contact has proven more effective than telephonic interaction.*
- ***Commitment.*** *Strong commitment is needed from organization leaders to make patient-centered care management work.*

Behavior change on the part of providers and beneficiaries is critical to the success of chronic care management models. The President's Budget includes several proposals that would create financial incentives in the Medicare program for providers to reduce hospital readmissions and coordinate post-acute care after a Medicare beneficiary is discharged from the hospital. These proposals are estimated to save roughly $25 billion over the next ten years. The Administration will continue to work on identifying evidence-based interventions that are most effective in improving care management and reducing costs in the Medicare population.

Questions from Representative Davis (AL)

Alabama is involved in an ongoing dispute with the Centers for Medicare & Medicaid Services (CMS) regarding the State's conversion from intergovernmental transfers (IGTs) to certified public expenditures (CPEs) at the insistence of CMS in 2005. It has been more than 3 years since the State agreed to CMS' request that it switch to a CPE-based methodology after lengthy consultations with CMS and CMS consultants. However, it now seems that the mutual understanding reached between CMS and the State, specifically, that the conversion would be at the very least budget neutral, is not being honored. By not honoring this understanding, CMS is imposing hundreds of millions of dollars in retrospective liability. It has also prevented Alabama from financing its Medicaid program on a going-forward basis under its previously approved methodology.

Specifically, in reconciling the State's claiming of federal funds for fiscal years 2006-2008, CMS is utilizing a definition of "cost," which results in approximately $400 million less in federal funding than was expected. Among other things, with respect to

uninsured costs, CMS insists that "costs" do not include hospitals' uninsured costs if the hospital receives any amount of insurance reimbursement. The use of CMS' new definition would result in acute care services being paid approximately 50 percent of the actual cost of services which would lead to the closure of Alabama's safety-net hospitals.

CMS' actions and the departure from the mutual understanding with Alabama Medicaid have caused extreme instability and have jeopardized Alabama's ability to provide services. Will you and your Administrators be willing to work with the State to resolve this ongoing IGT/CPE issue without reducing the quality of care for Alabamians?

In recent years, CMS has proposed regulations which narrowly define uncompensated care within the Medicare and Medicaid payment rules. Hospitals and physicians are experiencing an increasing volume of people who cannot afford their co-pays and deductibles for services they have received. Given this trend, why wouldn't CMS consider those bad debts as uncompensated care components?

Answer:

The Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS) are committed to working collaboratively with States on issues pertaining to the financing and administration of their Medicaid programs. As a former Governor, I understand the importance of the Federal-State partnership and assure you that this Administration and CMS will continue to work with the State of Alabama in resolving the ongoing intergovernmental transfers (IGTs) and certified public expenditures (CPEs) methodology issue.

In response to your second question, uncompensated care is defined in Medicare regulations as both charity care and the portion of bad debt that is not paid by Medicare. Charity allowances are defined in regulation as reductions in charges made by providers because of the indigence or medical indigence of the patient. While CMS does not preclude or discourage hospitals from offering charity care, charity allowances are not considered allowable debts.

As defined in regulation at 42 CFR 413.89, bad debts are amounts considered uncollectible, such as costs attributable to unpaid deductibles and coinsurance amounts of Medicare beneficiaries. Uncollectible debts that are related to covered services and derived from deductible and coinsurance amounts are charged off as bad debts where the provider can establish that a reasonable collection effort was made, that the debt was actually uncollectible, and that sound business judgment established that there was no likelihood of recovery. The amount of bad debt treated as an allowable cost for the cost reporting period is reduced by 30 percent, meaning that Medicare currently reimburses hospitals for 70 percent of their bad debt. Accordingly, that 70 percent is not uncompensated care.

Under the Medicaid statute at section 1902(a)(13)(A)(iv) of the Social Security Act (the Act) States are required to make Medicaid payment adjustments for hospitals that serve a disproportionate share of low-income patients with special needs. Section 1923 of the

Act contains the specific requirements related to these disproportionate share hospital (DSH) payments, including hospital-specific limits. Section 1923(g)(1) defines the hospital-specific uncompensated care limit as based only on costs arising from individuals who are Medicaid eligible or uninsured, not costs arising from individuals who have third party coverage. In implementing the law, CMS requirements are based only on costs arising from individuals who are Medicaid eligible or uninsured, regardless of a hospital's individual definition of charity care.

Questions from Representative Sanchez

I am very concerned about the uninsured. Under our current patchwork of programs—which do not really constitute a system—we know that at least 47 million of us go without: accessing healthcare, if at all, only in emergency rooms.

But even under a reformed system, one that included employer-sponsored insurance, an individual mandate to buy insurance, a health insurance exchange, and even a public plan, there would still be those who would fall through the cracks. For instance, homeless families, those only casually connected to the labor market, and new arrivals to the US are just a few of the identifiable populations who would experience periods of uninsurance because of their disconnect to health insurance access points. Moreover, the length of time that such disconnected families would go without health insurance is difficult to predict.

Unless we have a truly universal plan that reaches everyone present in the U.S. regardless of ability to pay, an outcome which seems unlikely given political realities and the need to compromise, we must have a plan to care for the uninsured that does not overburden full service hospitals, bleed community health centers dry, or unintentionally leave people out in the cold.

It is universally acknowledged that emergency room care is the most expensive kind of care there is. And, as the current swine flu outbreak demonstrates, infections do not ask about insurance status.

I would like to hear your thoughts on how we might build a **real** safety net that consists of **more** than just the local emergency room. I would also like to offer to work with you to construct a plan that can help the disconnected to access real healthcare—to manage their chronic conditions and get preventive treatments: a plan that would not bankrupt hospitals, drive away providers due to inadequate reimbursement rates, or leave struggling families without quality care.

Answer:

I share your concern about the uninsured and those lacking meaningful access to health care. I am deeply committed to finding better ways to deliver health services, beyond the emergency room, to everyone in the United States. Health centers are one avenue that we have already taken to build a safety net that extends beyond the emergency room to provide comprehensive primary care to those in need – and through the American

Recovery and Reinvestment Act, we will invest an additional $2 billion in them. But beyond that, we need comprehensive health reform to enable all Americans to access high-quality health care. I look forward to working with you and your colleagues in the Congress to help the uninsured gain access to a full range of services from primary and specialty care to improved models for managing chronic conditions, as well as promoting wellness and prevention to foster healthier communities.

Questions from Representative Higgins

1. One of the critical components to any health plan is a plan's quality of coverage. A plan's quality is a measure of both its breadth of benefits and the depth of its coverage, and the degree to which those benefits meet the reasonably foreseeable needs of the beneficiary. For cancer patients, their reasonably foreseeable needs are costly and sometimes unpredictable, and both the breadth and depth of coverage often does not keep up with what most beneficiaries would consider as "quality". An April 15th, 2009 New York Times article highlighted this problem in the context of reimbursement for intravenous, injectable, and oral treatments for beneficiaries. That article discussed how some insurance plans do not reimburse for oral treatments at the same rate as intravenous and injectable treatments, and how that affects the quality of care delivered for patients. Are you aware of this situation, and would you be willing to discuss the issue of cancer drug coverage parity as you work with President Obama and Congress on health reform?

Answer:

With respect to Medicare, in general, payments for oral cancer drugs are made under Part B, similar to Medicare payments for other intravenous and injectable therapies. In certain cases when these oral cancer therapies are used to treat diseases other than cancer, they may be covered under Medicare Part D. I look forward to working with you and your colleagues in the Congress on health reform and agree that health reform should ensure that benefit packages provide appropriate coverage for treatments needed by beneficiaries for different diseases.

2. One of the confounding notions with the difference in reimbursement between intravenous/injectable cancer treatments and oral pill treatments is the issue of which treatments are more effective and how authoritative the evidence is for one treatments being more effective than another. Research being done at our nation's most advanced cancer research institutions, all of whom receive significant funding from your Department, study and compare the effectiveness of these treatments, albeit usually on a targeted basis depending on each researcher's goals. As cancer treatment becomes more personalized to the patient, this type of research will become more important to improving patients' quality of life. The widespread dissemination of the results of such research will improve the quality of treatment received by all cancer patients, regardless of their circumstances. Do you see a role for this type of research in the context of the Department's comparative effectiveness research efforts authorized by the American Recovery and Reinvestment Act, particularly when assessing cancer treatments?

Answer:

With so many Americans affected by cancer, this area of research is critically important and impacts many lives. The American Recovery and Reinvestment Act (ARRA) provided substantial new funding for comparative effectiveness research including $300 million to be administered by the Agency for Healthcare Research and Quality (AHRQ), $400 million for the National Institutes of Health (including the National Cancer Institute), and $400 million to be allocated at the discretion of the Secretary. Additionally, the ARRA created a Federal Coordinating Council for Comparative Effectiveness Research to coordinate such efforts across the Federal government, recommend priorities for the Secretary's funds, and advise the President and Congress on the infrastructure needed to make comparative effectiveness research a success (including a focus on data registries, which are used by many cancer practitioners). The Council will also consider the needs of populations served by Federal programs and opportunities to build upon and expand current investments and priorities.

The Council is already hard at work and will be delivering an initial report by June 30, followed by annual reports thereafter. A complementary report is also underway by the Institute of Medicine (IOM). In conjunction with the Council, the IOM, and stakeholders from both public and private sectors, I will work diligently to ensure that the promise of comparative effectiveness research is realized. I share your belief that such research (including broad dissemination of its results) has great potential to improve treatment options and quality of life for persons affected by cancer.

The Council recently issued a draft definition of comparative effectiveness research for public comment, which is to be used consistently across the Federal government once finalized. This definition includes "Prioritization Criteria" to be used when allocating research funds – the first of which is to consider the potential impact of the research (based on prevalence of condition, burden of disease, variability in outcomes, and costs of care). (The draft definition and prioritization criteria are posted online at http://www.hhs.gov/recovery/programs/cer/draftdefinition.html). In addition, AHRQ's existing comparative effectiveness research program uses a list of "Priority Conditions" to guide its investments, and includes cancer as the second condition on this list of 14 priority conditions (available at http://effectivehealthcare.ahrq.gov/aboutUs.cfm?abouttype=program#Conditions). Although we won't know the exact total amount of ARRA CER funds allocated for cancer research at HHS until awards are finalized – since decisions about the funding of original research are typically made based on the scientific merit of proposals, taking into account prioritization criteria – we have funded comparative effectiveness research on cancer treatments in the past and can be expected to continue to do so in the future. Cancer strikes millions of Americans and we believe comparative effectiveness research should focus on this and other high impact diseases.

In addition, as you may know, in planning for the use of ARRA funds, the NIH has identified a range of Challenge Areas that focus on specific knowledge gaps, scientific opportunities, new technologies, data generation, or research methods that would benefit from an influx of funds to quickly advance the area in significant ways. One of the Challenge Areas is comparative effectiveness research. Within the cancer domain, comparative effectiveness research grant solicitations focus on cancer primary prevention, cancer screening, patient navigation, cancer treatment, and modeling in order to develop strategies in all of these areas. Comparative effectiveness research specifically regarding cancer treatment would use retrospective data and/or prospective interviews with patients, physicians and policy makers to assess the clinical benefits and risks of commonly used treatment approaches.

Also, the NIH Grand Opportunities funding announcement within ARRA includes two solicitations on comparative effectiveness research. These solicitations include comparative effectiveness research in cancer prevention, screening and treatment and comparative effectiveness research in genomics and personalized medicine. More information on these two solicitations can be found at http://www.cancer.gov/pdf/recovery/004_cer_prevention.pdf and http://www.cancer.gov/pdf/recovery/004_cer_personalized_medicine.pdf.

3. For cancer patients who are Medicare beneficiaries, the problem of reimbursement for cancer treatments can also be complicated. Anti-cancer drugs covered under Medicare Part B that can be administered in both intravenous/injectable form or orally with a pill are reimbursed equally. It is my understanding that some newer treatments, particularly oral chemotherapy "smart" drugs that do not have intravenous/injectable conduits are covered under Medicare Part D. Because these treatments fall under Part D, patients are subject to co-pays and the "doughnut hole" payment issue. Many of these drugs are classified into "specialty tiers" as part of the drug plan, making them more expensive for beneficiaries to receive than other treatments. My concern is that as more smart drugs come to market; this gap in coverage could grow as a determinative financial disincentive to Medicare beneficiaries to take them, as most Medicare beneficiaries are on fixed incomes, and thus lead to a marked decrease in quality of life. Has the Department made any recommendations on this issue? How could Congress be helpful in providing guidance to address this issue?

Answer:
I appreciate your concerns about coverage for beneficiaries who take Part D anti-cancer drugs and I am committed to further analyzing the experience of all beneficiaries with high drug utilization in the Part D program. With our recent access to prescription drug event data we will be able to further assess how the benefit design features such as the coverage gap and specialty tiers have specifically affected beneficiaries in this subpopulation. This additional analysis is a necessary first step before considering any changes to Part D, given the complexities and costs associated with making structural changes to the benefit.

While non-low-income subsidy beneficiaries on anti-cancer drugs may be exposed to the coverage gap, the Part D benefit does provide these non-LIS beneficiaries with an important safety net. Most of these beneficiaries will reach the catastrophic phase of the benefit and will be generally assessed 5 percent coinsurance on their drug costs for the remainder of the plan year. As a result of catastrophic coverage available to Part D beneficiaries, the yearly average coinsurance that these beneficiaries pay for Part D anti-cancer drugs may potentially be less than the 20 percent coinsurance that is assessed for Part B drugs.

Questions from Ranking Member Camp

Secretary Sebelius, during the hearing, Congressman Herger asked you if the creation of a government-run health plan that could result in 120 million Americans losing their current health coverage ran counter to the President's stated principle that "if you like your current health care, you can keep it." You responded that there are examples "in place across the country: thirty of the states have state employee health plans, where there is a public option for state employees side-by-side with a variety of private options. …A number of states have constructed their CHIP programs—the health insurance plans for children—in exactly the same way: there is a side-by-side option of a private provider and a public provider."

Can you please tell me how many of these 30 states you referenced have opened up their state employee health plans to any resident of the state? We were able to identify only one state that allowed such outside enrollment – Kentucky. Does Kentucky still permit outside enrollment? If not, why was this enrollment option terminated and for what period was outside enrollment permitted?

Answer:

Some states do allow public employees outside of state employees – such as school employees or local employees – to participate in their benefits plans. Kentucky allows all State employees and also school teachers, retirees, and employees of certain local entities to enroll in their State employee health plan. The program currently has 260,000 enrollees. A main reason why they have not opened the plan up to every State resident is because the Commonwealth of Kentucky subsidizes 85 percent of the premium.

How many of the 30 states you referenced are actually running and operating the day to day activities of their state employee health plan (from paying claims, to forming provider networks, to providing consumer and provider support) versus contracting with a third-party administrator for those functions?

Answer:

States differ in the degree to which they run and operate the day to day activities of their state employee health plan. Louisiana, for example, has been cited as an example of a State that does its own claims administration, and Washington State does its own provider rate and network negotiations, and sets its own premium rates. CalPERS in California has its own actuaries that work with third parties to come up with premiums, and it sets thresholds for cost and quality in provider network negotiations.

Questions from Representative Ryan

Secretary Sebelius, thank you for your testimony today. After reviewing the President's budget submission and the proposals advocated by organizations that have testified before this committee, I have strong reservations about a so-called "public health care plan." We have heard testimony that under this scenario, providers would be reimbursed using Medicare's current reimbursement methodology. Reputable actuarial firms such as The Lewin Group have estimated this would result in 120 million people loosing their private coverage and instead enrolling in a public plan. I would like to know how you plan to resolve this issue and whether it is the Administrations intent to use Medicare's payment policies as the framework for determining reimbursement rates for benefits provided under a public using Medicare's current payment systems.

Answer:
The President and I strongly believe in the principle of choice; we want to give Americans a choice of which health insurance option works best for them, yet still ensure that all have appropriate access to health insurance. Americans should have the choice of a public health insurance option operating alongside private plans. This will give them a better range of choices, make the health care market more competitive, and keep insurance companies honest. Coverage in the Exchange would be accessible, reliable, meaningful, and designed to promote competition on cost and quality, not cream-skimming and risk selection. The President also recognizes the importance of a level playing field between plans to encourage this competition. As you know, there are a number of ways a public plan option could be designed that would create a level playing field and preserve fair competition in the health care market. The President and I are open to ideas from all stakeholders and legislators on both sides of the aisle; I look forward to working with you and your colleagues in Congress on this particular issue and other elements of any reform plan.

My next question relates the amount of new spending the Administration plans to pursue in order to enact health reform legislation. Health care currently consumes 16 percent of our overall economy and is one of the largest expenditures in the Federal budget. It is widely accepted that the unfunded liabilities of Medicare and Medicaid are currently driving our Federal budget into ruin. Indeed, the Medicare Trustees recently reported that the Medicare trust funds will become insolvent by the year 2017 absent any changes in health care spending. The President's budget carves out $646 billion in new spending

for health care reform. About half comes from provider cuts, from Medicare and MedPAC recommendations, while the other half comes from revenues, such as limiting the deduction on charitable contributions. Will you please elaborate on the rationale behind spending additional money on health care yet requiring no changes in the Medicare program?

Finally, it has been widely reported that $646 billion falls well short of what a health care reform proposal will cost. I would like to know if additional funds will be spent health care reform outside of what was proposed in the President's budget and where those funds will come from?

Answer:

The United States has an outdated system of health delivery and a growing population of more than 45 million uninsured individuals, which results in cost shifting and a lack of investment in prevention and chronic care management. Medicare and Medicaid have performed as well if not better than many private insurers on cost and quality. Their growth rates are often comparable to and their payment rates lower than those of the private sector. However, they need improvements to emphasize quality and primary care.

Given the influence of Medicare and Medicaid in the health care market, and the large number of Americans who depend on these programs for their health care needs, any comprehensive reform of the health care system should also consider changes to Medicare and Medicaid that modernize these programs and make them leaders in value-based purchasing and quality. Because health care expenditures consume a significant portion of federal, state, local, and family resources today, we can't afford to wait any longer to get health care costs in this country under control.

A number of proposals to do so are in the Administration's FY 2010 budget request. These proposals are a starting point for the conversation about health reform and a down-payment on the costs of reform. The President and I are committed to working with you and your colleagues in the Congress to identify additional resources and innovative ways that we can achieve our overarching goal of making health care both high-quality and affordable for all Americans.

Questions from Representative Davis (KY)

1. As you know, recent CMS regulations require independent pharmacies to comply with costly and burdensome accreditation requirements. Seventeen types of state-licensed medical professions were exempted from these requirements by CMS with the announced plan to later tailor accreditation requirements for each type of profession. Retails pharmacies were not exempted by CMS. In order to avoid duplication with pharmacies' existing licensing requirements and thereby eliminate unnecessary costs, would you

consider modifying the current accreditation requirements for retail pharmacies so they are more narrowly tailored to pharmacies and their practice?

ANSWER:

Section 154 of the Medicare Improvement for Patients and Providers Act (MIPPA) required that DMEPOS suppliers be accredited on October 1, 2009. MIPPA also exempted eligible professionals (as defined in section 1848(k)(3)(B) of the Social Security Act) and other persons such as orthotists and prosthetists as specified by the Secretary from meeting these standards unless the Secretary determines that the standards being applied are designed specifically for such professionals or persons.

It is my understanding that MIPPA allowed CMS to exempt "eligible professionals" that were specifically defined in statute and "other persons" as specified by the Secretary. Pharmacies are considered organizational entities. The MIPPA provision does not give me the discretion to define "eligible professionals" or "other persons" as organizational entities.

2. A significant amount of independent pharmacists are already in the process of complying with accreditation requirements, but still might not meet the September 30th deadline. A recent national survey of independent pharmacists conducted by the National Community Pharmacists Association showed that, of those that have completed an accreditation application but have not been surveyed onsite by the accreditation organization, 73% will need an extension to meet the deadline. Most small independent pharmacies do not have adequate administrative personnel to handle the accreditation process. Would you consider extending the September 30th deadline for pharmacies that have already started the accreditation process, but haven't been able to complete it yet due to time and capacity constraints?

ANSWER:

Section 154 of the Medicare Improvement for Patients and Providers Act (MIPPA) required that DMEPOS suppliers be accredited on October 1, 2009. Despite that deadline, I understand that about 24,000 pharmacies have already received their DME accreditation and that 9,000 more pharmacies have applications for accreditation pending. It is very encouraging that so many pharmacies have already fulfilled the accreditation requirement. In light of this, an extension of the deadline may not be needed and might serve cross-purposes by creating confusion within the supplier community.

Question from Representative Roskam

Recently, speaking to a group of single-payer advocates, Rep. Jan Schakowsky articulated the notion that a "public option" health insurance plan is merely a stepping stone toward a single-payer system:

"And those of us who are pushing for a public health insurance option don't disagree with the goal [of single-payer healthcare]. This is not a principled fight. This is a fight about strategy for getting there, and I believe we will."

We're told that a "public option" will foster enhanced competition in the health insurance marketplace. However, the Lewin Group predicts that 120 million Americans would lose their current health insurance under a government-run plan, and we know from experience that a government subsidy distorts the marketplace and provides an unfair advantage to the recipient. Given the expressed wishes of some Congressional Democrats, how will President Obama work with Congress on healthcare reform in a way that guards against a single payer system and doesn't discourage a vibrant marketplace through government distortions?

Answer:
I cannot speak to intent of Representative Schakowsky's comments, but I can tell you that the President and I strongly believe in the principle of choice; we want to give Americans a choice of which health insurance option works best for them, yet still ensure that all have appropriate access to health insurance coverage. Americans should have the choice of a public health insurance option operating alongside private plans. This will give them a better range of choices, make the health care market more competitive, and keep insurance companies honest. Coverage in the Exchange would be accessible, reliable, meaningful, and designed to promote competition on cost and quality, not cream-skimming and risk selection. This Administration recognizes the importance of a level playing field between plans and ensuring that private insurance plans are not disadvantaged.

I disagree with your assertion that a public plan would automatically undermine the private plans that are currently serving the needs of Americans. As you know, there are a number of ways one could design a public plan option that would create a level playing field and fair competition in the health care market. The President and I are open to ideas from all stakeholders and legislators on both sides of the aisle; I look forward to working with you and your colleagues in Congress on this particular issue and other elements of any reform plan.

[Submissions for the Record follow:]

Statement of Amy Kaplan

My congratulations to AHIP and the other stakeholders for coming to the table. Their cooperation is essential … if only for self-preservation. Please, however, do not allow them to sabotage the 'public/exchange' option.

After perusing Sen. Baucus' and the guidelines proposed by some of the citizens-for-reform groups, all seem excellent preparation for the inevitable haggling over details. One point they all stress is **making insurance more readily available and affordable**. But two critically relevant points seem to have been overlooked. The first, that:

IMPROVING ACCESS TO HEALTH INSURANCE IS NOT THE SAME AS PROVIDING HEALTH INSURANCE COVERAGE AND AUTHORIZING ESSENTIAL TREATMENT

And, second, is the existence of a sidelined third category, beyond the oft-considered uninsured and underinsured:

THE FALSELY INSURED

The falsely-insured are those people who have purchased individual policies from private insurers, but are routinely denied benefits when a major (expensive) health catastrophe occurs. This happens all too often because the language of individual policies is intentionally arbitrary, ambiguous, contradictory and evasive.

Surely it is ironic that as Karen Ignagni and AHIP now seek national regulations to expand access, they have yet to concede any responsibility, accountability, let alone culpability, for rectifying the circumstances of their falsely-insured clients.

Case-in-point: What qualifies as "Durable Medical Equipment that we determine to be covered?" This exact phrase, never clarified in my 2 years of dialogue with Assurant Health (whose CEO sits on the board of AHIP) was used to deny a medically-necessary pediatric power wheelchair for my grandson, born with Type II Spinal Muscular Atrophy (SMA), a genetic degenerative disease. (When my daughter first challenged their denial she was told, "You should have read your policy more carefully before giving birth to this child.")

While AHIP now says they will abandon "pre-existing conditions" as an exclusionary category, what about their recission and denial practices based on their subjective interpretations of language and their various definitions of "fraud?"

"Fraud" is claimed to deny coverage:

> … when a policyholder doesn't know that he/she had at condition at the time they were approved and purchased their individual policy (specifically for HIV/AIDS)
>
> … when a policyholder failed to correctly comprehend the catch-all categories on the medical history forms. How should one answer the question "Have your ever had …" when epilepsy and headaches are in the same question? (Specifically, failure to acknowledge a headache is "fraud" for later coverage of a brain tumor.)
>
> … when a policyholder has minor lapses of memory. (Specifically, failure to mention a hospitalization at age 6 for a tonsillectomy is later designated as fraud for the treatment of cancer.)

No doubt all the above, and more, can be construed as claimant-fraud, but is it not also fraudulent for insurers:

> … to imply that a consumer's timely payment of premiums buys them health care insurance?
>
> … to pay bounties to low-level claims agents for identifying the legal loophole by which benefits can be denied?
>
> … after denying benefits, to offer the claimant a convoluted grievance procedure stacked in the insurer's favor? (This process only further victimizes the claimant, particularly when the insurer includes use of an outside arbitrator but then, in writing, says the insurer is not bound by the findings of such an arbitrator.)
>
> … to have such influence that a State Insurance Commissioner can tell his employee, "Drop the case. You're making too many waves." (The case manager handling the dispute of Assurant's denial of the power wheelchair.)

And should a disgruntled claimant take his/her case to court and win, it is merely a victory in one case, in one State, against one company; and the industries' access to denials via fraud are not compromised.

At this moment in time, private insurance companies rightfully fear competition from a government sponsored public/exchange plan.

But until that industry, with guidance and oversight from Congress and the other stakeholders, agrees on binding legislation that ends their legal and egregious denial of benefits, no private health care consumer, despite purchasing a "competitive plan," can be assured of buying anything more than improved access—without necessarily improved coverage.

Private policies must be regulated as if they were a tangible product; one that, should it prove either ineffective or dangerous, could be pulled from the market and its manufacturers held accountable. To be equitable, private policies must include the guarantees of coverage that stand behind all Federal plans: Government worker plans, Medicare and Medicaid, the VA, and even private employer-sponsored group plans.

While it is not the job of the government to act as big-brother to individual Americans, at this moment of increased vigilance and pending change, the government must protect consumers from existing practices which put it's individual citizens at risk.

Thank you and please share these thoughts with anyone more influential than I.

Sincerely and persistently,

Amy Kaplan

Statement of Claire H. Altman

To: Hon. Charles Rangel, Chair, House Ways and Means Committee
From: Claire H. Altman, Director of Capital Projects, HealthCare Chaplaincy
Re: Proposal to Develop a National Strategy for End-of-Life Care That Reduces Cost and Increases Quality of Care
Date: April 16, 2009

Summary

The United States health care system is poorly organized to address end-of-life care. This brief will make the case for a new national strategy to reduce cost and increase quality of care. End-of-life care is one of several major areas in health care where the status quo both *raises* costs to the system and *decreases* consumer service and satisfaction. Patients, families, and staff often agree the patient is best served by *less* aggressive medical intervention, but inertia, lack of education, and reimbursement structures in the system push powerfully for continued treatment. An urgent need exists for a coordinated, systemwide approach to providing end-of-life care that focuses on quality of care for individuals and their families while avoiding extraordinary costs—often for unwanted and unnecessary interventions. The United Kingdom issued a "Strategy for End-of-Life Care" in July 2007 that could serve as a guide for a U.S. plan.

Background

Dying has been viewed as a *medical event* in American hospitals, a mind-set that limits the capacity of the health care system to provide optimum quality of care and to contain costs. End-of-life with dignity, however, is a profound *spiritual event* for patients, families, and oftentimes staff. If handled well, the spiritual dimension of "une belle mort," a good death, can reduce costs and emotional suffering.

In addition to the need to provide end of life care that is more responsive to patients' needs and desires, there is an opportunity for significant cost savings. Twenty-five percent of the annual Medicare budget of $627 billion is spent on care for persons in the last year of life, with 40% of that number spent in the last 30 days. Medical care at the end of life consumes 10–12% of the Nation's total health care budget.[1] These numbers have not changed significantly over the last 10 years despite the fact that in-patient, residential and home hospice care services are less costly *and* underutilized—and provide higher quality service. Existing data (mainly from the 1980's) suggest that hospice and advance directives can save between 25 and 40% of health care costs during the last month of life, with savings decreasing to 10–17% over the last 6 months of life.[2] The Congressional Budget Of-

[1] Emanuel, EJ, "Cost Savings at End of Life. What do the data show?" JAMA, Vol. 275, No. 24, 6/26/96.

[2] Hogan, Christopher, et. al., "Medicare Beneficiaries' Cost of Care in the Last Years of Life," Healthaffairs.org/cgi/content/abstract/20/4/188, 2001.

fice forecasts that the cost of long term care will reach $207 billion in 2020 and $346 billion in 2040.[3]

Exploding health care costs and unnecessary patient suffering will only accelerate with the exponential growth in the population over 65 that will live longer, have more chronic diseases, and require more care in their last years.[4] People 85 years of age and older—those most likely to need expensive long term care—were 1.7% of the U.S. population in 2005 but are expected to grow to 2.2% in 2020—an increase of 38% only 11 years from now.[5]

Poor quality and high end-of-life care costs have many causes, which include:

- The challenges of dealing with death for health care professionals, who often do not know about their patients' preferences for end-of-life care.[6]
- Patients and their families not understanding their choices at end-of-life.[7]
- Focus of medicine on curing disease and viewing death as the enemy or as a failure.[8]
- Most insurance plans do not cover services that are necessary for good quality end-of-life care. Traditional health insurance favors high-tech/high-cost services and inpatient hospital care.[9]
- Health coverage is often linked to site of care provided, rather than the person, and by time limits not by the amount of service needed.[10]
- Many dying patients may be better served with comfort care and interventions that help families deal with forgiveness, reconciliation, and other topics that arise at the end-of-life.
- Issues around access: Medicare beneficiaries who die in low income areas have higher end-of-life costs, are less likely to use hospices, and are more likely to die in a hospital than the general population.[11]

Development of a National Strategy for End-of-Life Care

It is critical to identify the barriers and incentives to moving larger numbers of dying patients, earlier in their disease paths, from acute treatment to comfort care into environments that are characterized by sensitivity and respect. Conceptual and ethical challenges are inherent in this topic, but research can identify innovative, cost-effective solutions in the best interests of patients, State and Federal Governments, and hospitals.[12] **New thinking is needed about the management of death and dying. New frameworks are needed that utilize the most effective intervention points by which to move the health care culture toward an approach to end-of-life care in which the whole person is served with medical and spiritual tasks better balanced than they are today.**

The national health reform effort needs to include a national strategy for end-of-life care. This could be accomplished within 6–12 months with the immediate appointment of a National Panel of the leaders in end-of-life care to: inventory the challenges and innovative programs nationwide; propose new policy frameworks at the Federal and State level; and propose critical demonstration projects.

Some of the issues to be addressed include:

- Identifying communication and cultural competency problems that impede the ability of health care professionals to communicate effectively with patients and their families about death and dying, thereby limiting patients' abilities to make informed choices;
- Identifying innovative approaches to educating health care professionals about death and dying;

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[3] "Redefining and Reforming Health Care for the Last Years of Life," RAND Health Research Highlight, 2008.

[4] Ibid.

[5] "The New York Long-Term Care Compact Proposal: Update, Analysis, and Recommendations," Stephen A. Moses, President, Center for Long-Term Care Reform, 2008, p. 2.

[6] "End of Life Issues and Care," Issues of Access and Variability in Health Care at the End of Life," http://www.apa.org/pi/eol/access.html.

[7] Valente, Sharone, and Bill Haley, "Culturally Diverse Communities and End of Life Care, American Psychological Association.

[8] Ibid.

[9] Raphael, Carol, PPA, Joann Ahrens, MPA and Nicole Fowler, MHSA, "Financing end of life care in the USA," Journal of the Royal Society of Medicine, v. 95(9), Sept. 2001.

[10] Ibid.

[11] Hogan, et. al.

[12] End of Life Care Strategy, United Kingdom, July 2008.

- Documenting issues related to culture, communication, and dying that lead to unwanted and unnecessary treatments;
- Recommending financial incentives to hospitals for discussing advanced directives with *every* patient and her family (if applicable) and for obtaining signed advanced directives; and
- Authorizing Medicare demonstration programs to provide reimbursement for assisted living programs for persons with serious progressive illness and/or terminal diagnoses to test the hypothesis that this care option might be preferred by individuals and be more cost effective than the current pattern of frequent hospitalizations and high-tech interventions in the last year of a patient's life. Individuals might choose compassionate care over acute care or skilled nursing care; if reimbursement were available (reimbursement might be limited to those with annual incomes of less than $100,000).[13]

HealthCare Chaplaincy is committed to working with other organizations that share these goals to assist the Health Reform movement to achieve a coordinated, integrated strategy for quality end-of-life care.

Statement of Clark Newhall, M.D., J.D.

We don't have a health care problem. We don't have a health care crisis. What we have is a health care famine. I realized this when a friend told me that she was not in favor of universal health insurance. She was opposed to paying for health care for all. She has a little boy with cancer. She was afraid that universal health care would mean her little boy would not be able to get an appointment with the oncologist. "But all those other children with cancer deserve treatment too don't they?" I asked. "I guess so" she grudgingly admitted, "but I have to worry about my little boy."

Too many other people's children would be trying to get appointments and treatment. Too many other people would be competing for a scarce resource—the time of a doctor.

It Is a Health Care Famine

Perhaps you know the story of Jacob, who predicted 7 years of plenty and 7 years of famine. When famine came, he was prepared with full granaries. His brothers, who had sold him into slavery, begged him for grain for their starving families and he gave them grain. We are like Jacob's brothers in the famine, begging for health care. But for us, there is no Jacob. There is only the for-profit medical-industrial complex, "gate-keeping" us out of the health care system.

When too many people are fighting to get the scarce stuff to stay alive, whether the scarce stuff is food or health care—that is a famine.

When those of us who have barely enough are willing to sacrifice those others of us who have too little or none at all—that is a famine.

When our own situation is so desperate that we turn a blind eye to the more desperate situation of others—that is a famine.

When 'dog-eat-dog' surpasses 'do unto others' as the Golden Rule—that is a famine.

A famine never strikes everyone equally. In a famine, the 'have-nots' become the 'have-nothings' while the 'haves' become the 'have-barely-enough.' And as always, the wealthy survive, even thrive, even profit, from the shortages that are killing others.

This famine is not new—it has been slowly building for years.

The price of our privately-run, profit-driven medical-industrial complex has caused this famine. About one-third of every dollar going to health care pays for administrative costs—for utilization reviewers, for computer programmers, for advertising, for sales managers, for executives of all kind, for billing clerks, for coding clerks, for CEO bonuses in the millions and hundreds of million—and for profits.

[13] Assisted living offers an option that is half the cost of skilled nursing care and a fraction of the cost of acute hospital care. Current regulations in New York State, for example, permit assisted living residences that apply for an enhanced assisted living license to care for residents through the end of life, bringing in necessary skilled nursing and hospice care. Persons facing serious progressive illness and end-of-life want an environment that offers autonomy, independence, and privacy. Assisted living communities are organized so family members can spend time with the individual in a non-medicalized but supportive setting, in which basic care (assistance with activities of daily living) are provided. This ensures the "peace of mind" that family members need and want without the institutional model of a hospital or nursing home.

We are not talking about government waste. We are not talking about the cost of actually treating the sick and nurturing the healthy. We are talking only about the cost of running our profit-making health insurance industry.

One-third of the health care dollar—that amount is far more than enough to give excellent medical care to everyone in the Nation. It is far more than enough to fund the (privately-owned) surgical centers and imaging centers and Lasik centers that sprout up on every corner. It is even more than the amount we have given to Wall Street to bail out financiers and bankers from their hubristic near-demise.

The famine has grown while insurance companies charge higher premiums and reduce coverage, while employers cut their contribution and increase deductibles, while legislators reduce Medicaid and CHIP budgets, and on and on.

We are in a health care famine. Millions of us are suffering and millions more will suffer soon. More than 20,000 people die each year in this famine because they cannot afford the price of for-profit health insurance.

The famine will not end until, like Jacob, we open the granaries and give aid to the starving. The health care famine will not end until we end the money hoarding that health insurance companies call 'reserves' and 'administrative cost' and 'profits.' It will not end until we open our blind eye and see the plight of our neighbor. It will not end until we learn that tolerating a profit-making middleman in the health care system builds a wall between patient and doctor. It will not end until we learn that good things for everyone can only be accomplished by the will of everyone. It will not end until we pay for health care in the same way that we pay for everything else that we value highly—our security, our freedom, our laws. It will not end until we have a national health care system that covers everyone equally and is paid for by everyone equitably. It is time for national single payer health insurance. It is time to remove the profit-making middleman from medical care. It is time to see health care for the public good that it is and not for the profitable business it has become. Support Medicare For All.

Statement of Congressman Patrick J. Kennedy

The World Health Organization defines health as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity." As we reform and re-incentivize our health care system, this must be acknowledged. Health care reform must be a whole body initiative, recognizing that mental health is integral to overall health, and that optimal overall health cannot be achieved without this.[1] Integration, as a strategy, is meant to be as broad and over-arching as a whole body approach to health care, and as specific as ensuring that new policies, such as health information technology, integrate mental health. The integration of primary care and mental health is a national priority that was not only identified in the recommendations of the New Freedom Commission on Mental Health, but is recognized in programs and activities of 11 Federal agencies that have initiatives to integrate services to improve access, services, and outcomes.[2]

According to the Institute of Medicine, together, mental and substance-use illnesses are the leading cause of combined death and disability for women of all ages and for men aged 15–44, and the second highest for all men. When appropriately treated, individuals with these conditions can recover and lead satisfying and productive lives. Conversely, when treatment is not provided or is of poor quality, these conditions can have serious consequences for individuals, their loved ones, their workplaces, and the Nation as a whole.[3] Tragically, individuals with serious mental illness have a life expectancy of 25 years less than general population.[4] In order to effectively combat this and create a sustainable health care system which embodies the concept of whole body care, the following principles must be incorporated into health care reform.

Primary and coordinated care. Health care reform must make changes to the delivery system to provide incentives for models of care which treat the whole person. Health care reform policy should support and encourage practices that fully in-

[1] "Mental health" as defined in this paper, includes substance abuse disorders and related conditions.

[2] Compendium of Primary Care and Mental Health Integration Across Various Participating Federal Agencies, January 2008. *www.samhsa.gov/Matrix/MHST/Compendium__Mental%20Health.pdf*.

[3] Institute of Medicine, Improving the Quality of Health Care for Mental and Substance-Use Conditions, Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, Washington, D.C.: The National Academies Press (2006).

[4] NASMHPD, 2006.

tegrate mental health into primary care. All providers, and in particular primary care doctors, must be trained and adequately reimbursed, for providing comprehensive and coordinated care—care which approaches health as a whole body initiative. Primary care physicians must be given the resources needed to adequately address the mental health needs of their patients. Innovations, like medical homes, are working to improve quality and contain cost, but the primary care workforce is not sufficient to meet the country's needs. Over the last two decades, fewer medical students are choosing primary care for a number of reasons, including reimbursement issues. Payment policies do not adequately compensate doctors for the time it takes to coordinate care, provide case management, or address mental health and substance abuse issues in the primary care visit. Specialty providers and other physicians must likewise have training on mental health and substance abuse problems and be trained to provide collaborative care and case management, and be reimbursed accordingly.

Coverage. For the 45.7 million Americans without health insurance (a number which has grown due to the recent economic downturn), we must create an affordable, quality health care system in which all Americans are covered. Providing coverage alone, as it exists now, is not a solution unto itself however. The coverage we provide for all Americans must include the full spectrum of evidence-based mental health care, including both treatment and prevention services. Mental health coverage should not be subject to restrictive or prohibitive limits when formulating coverage determinations on the frequency or duration of treatment, cost-sharing requirements, access to providers and specialists, range of covered services, life-time caps, and reimbursement practices.

Access. The expansion of insurance coverage is not the same as ensuring access. Lack of insurance is only one of the many barriers to care for those seeking mental health services. Those with coverage also face financial barriers to care due to prohibitive cost sharing requirements, limited access to providers, and denials of coverage for mental health conditions. Once all Americans have health insurance, coverage must provide for access to affordable, high-quality care. Current barriers to care within the health insurance system must be eliminated, and mental health coverage must include access to the full spectrum of evidence-based care for both prevention and treatment of mental health conditions. This includes, but is not limited to, access to and choice of doctors who approach health as a whole body initiative.

Standardized rules for payment. Instituting rules for standardized payments, as done in Medicare, would save significant time and cost. Many large hospitals carry numerous plans, all of which have different rules for payment submission. Time spent determining how to process a claim, as well as how much a claim is worth, is time that raises the cost of health care, and time that could be spent on patient care.

Clinical necessity. Clinical necessity should be the determinant of patient care. All patients have the right to have their medical decisions made by a doctor, rather than what an insurer chooses to reimburse. Coverage must include treatment deemed clinically necessary to treat symptoms, as well as treatment to prevent more serious mental illness, or to prevent relapse.

Community rating. Replacing underwriting with a "community rating" system would set premiums based on age and location instead of the health status of the individual. This would bring down the cost of insurance for higher risk populations and guard against radical changes in premiums from year to year. Thus, people with pre-existing conditions would not be subject to discriminatory premiums, nor would females be charged higher premiums than males.

Transparency. Any denials of coverage must be transparent and subject to a meaningful and independent review process. A review process should enable individuals to effectively understand the grounds for denial and include clear direction on how to appeal the decision.

Prevention and wellness. Our current "sick-care" system must be transformed into one which is patient-centered, collaborative, and focused on prevention. Coverage and access policies must reflect this. Half of all people with a mental health diagnosis first experience it by age 14, but will not receive treatment until age 24.[5] Early detection and treatment is essential for ensuring positive health care outcomes. Prevention, especially in behavioral health, is given a mere fraction of the attention as treatment. Prevention and wellness programs must also promote and incentivize mental health prevention programs as part of an improved approach to treating health care as a whole body initiative. This includes promoting and reim-

[5] Kessler R.C., Berglund P., Demler O., et al., Lifetime Prevalence and Age-of-Onset Distributions of DSM–IV Disorders in the National Comorbidity Survey Replication, Arch Gen Psychiatry, 2005; 62:593–602.

bursing for brief interventions and screening and mental health check-ups, along with the full integration of mental health into primary care settings. This also includes investments in research aimed at determining effective prevention strategies.

Health information technology. Health information technology is an essential aspect to improving the coordination and quality of health care. As we continue to build and advance this aspect of our health care system, it is essential that these efforts integrate mental health consumers and providers, and continue to place high value on consumer privacy and protection.

Outcome measures. High-quality health care relies on the implementation of evidence-based practices. In order to achieve this, existing behavioral outcome measures must be improved so that the effectiveness of prevention and treatment programs can produce functional standards. Health care reform should require the regular use of standardized, objective, and uniformly applied clinical outcome measures. Outcome measures should also be benchmarked, in an effort to establish best practices.

Workforce development. To effectively achieve full integration of mental health into health care, workforce training in mental health is necessary. All health care providers must have more inclusive health care training which includes behavioral health, including cross-training for co-occurring health conditions. Behavioral health must be given fuller weight in medical training, continuing education, and required examinations for all medical specialties. Further, in some areas of the country there are shortages of mental health providers and some mental health specialties. Federal grant or loan repayment programs that include students of behavioral health should continue to be expanded. Graduate Medical Education can also be expanded to further support mental health professionals.

Improved coordination among sectors. In order to achieve optimal health, mental health services must be more fully integrated into non-traditional settings such as schools, juvenile justice settings, early childhood programs, community-based programs, housing and welfare programs.

New post for behavioral health. To achieve full integration of mental health into health care reform, a new position may need to be created, either at the White House or at a Federal agency, which has as its responsibility the oversight of the coordination between behavioral health and overall health care. This position would bring with it the expertise and authority necessary to achieve integration and would represent the commitment by Congress and the President that optimal mental health is essential to achieving optimal overall health.

Single-payer. In order to truly achieve the above stated principles, we need health care reform that addresses the underlying, systemic issues in our current system. We are the only industrialized country that treats health care like a market commodity instead of a social service. Thus care is not distributed according to medical need but rather according to ability to pay.[6] Cost savings cannot be discussed without acknowledging that 31 percent of all health care expenditures in the U.S. are administrative costs. The average overhead for private insurance in this country is 26 percent, compared to 3 percent for Medicare.[7] The majority of doctors and Americans support a single-payer health care system, yet this option has been dismissed by many policymakers as unrealistic.[8] As elected representatives of this democratic system, we are responsible for representing the views of the public. Therefore, it is imperative that we keep this option in the discussion of health care reform.

Statement of Larry Frazer

Committee Members, it's time to take action on behalf of America and its citizens.

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[6] Marcia Angell, MD. CMAJ • October 21, 2008; 179(9). First published October 6, 2008; doi:10.1503/cmaj.081177.

[7] Journal of American Medicine, 2007.

[8] A CBS News/New York Times poll published in February 2009 reported that 59% say the government should provide national health insurance (up from 40% 30 years earlier). A study published in the Annals of Internal Medicine concluded that 59% of physicians "supported legislation to establish national health insurance" while 9% were neutral on the topic, and 32% opposed it. CBS NEWS (Sunday, February 1, 2009). CBS NEWS/NEW YORK TIMES POLL. Press release. http://www.cbsnews.com/htdocs/pdf/SunMo__poll__0209.pdf. "Americans are more likely today to embrace the idea of the government providing health insurance than they were 30 years ago."

Carroll AE, Ackerman RT (April 2008). "Support for National Health Insurance among U.S. Physicians: 5 years later." Ann. Intern. Med. 148(7): 566–7. PMID 18378959.

The Congress has to step up to the plate and provide some leadership for America. The Obama administration is demonstrating its lack of experience and naivete in their role in the White House. The ***stimulus spending is not working***, the economy is trying to recover but the Federal Government keeps knocking the slates out from under it.

We don't need more taxes, to support ***Obama's health care proposal***, in a time of economic recession. You don't take money out of people's pockets with more taxes to satisfy a misguided President's desire to destroy the health care system for 95% of the population for the benefit of only 5% of the population. *Yes, that's right, only 5% would benefit from Obama's proposed health care plan while 95% will get higher taxes and poorer quality health care.*

Furthermore, Obama's numbers are fraught with errors and falsehoods. He projected GDP at growth rates higher than has ever been achieved, reduction of his massive deficit spending in his current term (based on inflated GDP numbers), which the White House Budget Office has already increased projected deficit amounts before the ink dries. No other Federal agency outside of White House influence uses such inflated projections for GDP.

Under his proposals the **American taxpayer** (that's you and me by the way) will accumulate debts greater than the sum of all Administrations before this one. *We don't have the money!*

Obama through his naivete is sending this country down the proverbial river without a paddle!

The **CONGRESS must stand up**, do the right thing and provide much needed national leadership. Stop this runaway spending and don't raise taxes. Allow the economy to recover, and facilitate it don't hobble it!

Health care changes may be required but *NOBODY* has performed an objective analysis and assessment of the "Health Care Process" in America to determine what the cost drivers are or where the real problems are. I haven't seen any numbers from creditable sources, just hallucinatory shouting from the Administration and other noncreditable sources. The Congress must obtain creditable factual information from nonpartisan sources before developing a policy direction. The current and apparent Obama policy direction spells disaster for Americans.

Obama, I guess from his "community organizer" experience, thinks he can look at the situation from 30,000 feet and see the problems. I'm sorry, but he does not have the knowledge or visibility to determine the problems and solutions. But I am sure that he is getting *advice from special interest groups/persons* who will stand to make "big bucks" from Federal intervention.

The **FIRST TENET** of a lobbyist, consultant or service "for hire" provider is to create (or proclaim) situations (or conditions) to ensure employment opportunities regardless of the need or justification.

The CONGRESS must take the reins and perform an OBJECTIVE analysis to determine the right course of action before taking any action. *America's health care system, even with its problems, is the best in the world; DO NOT destroy our health care system to appease poor leadership from the White House.* There is no manmade system on earth that cannot stand improvements from constructive justifiable changes.

Be vigilant and frugal with MY money; stop allowing it to be thrown away.

We have some **far bigger problems looming**, look at **Social Security** (which begins paying out more than it takes in by 2016 and will be bankrupt by 2037) and **Medicare** (will pay out more than it takes in this year, 2009, and begin drawing down trust fund assets). (Ref: http://www.ssa.gov/OACT/TRSUM/index.html). If **Congress** doesn't take some action here we won't have just *5%* of the population with problems you'll have **20%** of the population with problems.

Los Angeles County Department of Mental Health
May 6, 2009

Hon. Charles Rangel, Chairman
Committee on Ways and Means

Dear Chairman Rangel and Committee Members:

As the Director of Los Angeles County Department of Mental Health, I wanted to express concern and interest as progress toward health care reform continues. Los Angeles County Department of Mental Health is the largest public mental health service provider in the Nation and we serve a multi-ethnic population with a myriad of needs. In California, as in 70% of the jurisdictions nationwide, health

care services are provided by county government. We believe and our experience has shown that individuals present with a complex set of interrelated needs; we are very certain that there can be no real health care reform without the inclusion of mental health in this discussion and planning effort.

We in California believe that it is important to adopt certain basic core principles for any health care reform plan. The principles are:

(1) Good health care is holistic and integrated in that it is inclusive of all facets of the individual's well-being. **There is no health without mental health. Physical and mental health care issues are integrally linked and must be treated in an integrated fashion.**

(2) The lack of a cohesive Federal health care policy has led to an inefficient and costly method of health care delivery in the U.S. that is crisis driven. **Prevention and early intervention are key components to a cost effective health care delivery system.**

(3) Equal access for all U.S. citizens and residents remains an unresolved issue. Individuals who do not have private insurance or who have insurance with limited coverage continue to present in emergency rooms throughout the country for treatment. These people do not get early, non-emergency treatment but rather present in the emergency rooms for treatment that is much more costly. **Standard coverage for U.S. citizens and residents alike will result in long term savings as the emphasis of the health care system moves from crisis or emergency intervention to the less costly prevention and early intervention model.**

(4) Our fragmented, "de facto" health care delivery system results, at best, in duplication of multiple services and wasted resources as individuals are pushed from one provider to another to have health care needs met. In the worst case, it results in confusion and in a lack of compliance for many people with disabilities as the system is too complex and difficult for them to navigate without assistance. **Individuals with mental illness die on average 25 years earlier than individuals that do not have mental illness. Simplify the system with (a) full service provider sites that can deliver multiple appointments on the same day and (b) give each individual a "medical home" or case manager to assist with followup for improved results.**

(5) There is an increasing body of evidence as to what treatments and services produce the best outcomes for treatment of mental illness. **Health care payment and finance programs should be revamped to support evidence-based treatments. Documentation, recordkeeping, billing submission and payment of claims processes should be simplified. Audit processes should be combined and simplified.**

(6) The mechanism for record sharing and information sharing should be less cumbersome between health and mental health agencies. Treatment would be improved with collaboration and there would be cost efficiencies. **Implement the electronic health record with inclusion of health and mental health information so it can be shared by all county agencies involved in providing health care services.**

In Los Angeles County, we have identified our 250 highest cost users of health and mental health services and have found that we can, in fact, coordinate services and control costs with good case management services. We have implemented numerous programs here locally with integrated physical health care and mental health care services with great success. Our Skid Row Project 50 has saved more public funding that the actual project cost in 1 year. We would love to share our experience with the Committee.

Respectfully,

Marvin J. Southard, D.S.W.
Director of Mental Health

Statement of Patricia Ryan, MPA
Executive Director, California Mental Health Directors Association

Health Reform in the 21st Century

Thank you for the opportunity to offer to this Committee the perspective of California's county mental health/behavioral health directors on health care reform.

My name is Patricia Ryan, and I am the Executive Director of the California Mental Health Directors Association (CMHDA), which represents all 58 county (and two city) mental health and/or behavioral health directors. CMHDA's mission is "to ensure the accessibility of quality, cost-effective, culturally competent mental health care for the people of the State of California, and to provide the leadership, advocacy and support to county and city mental health programs for quality care necessary to meet our vision and values for the public mental health system." The core principle underlying all of the work we do is to advocate for social justice and the needs of persons with mental illness in California, especially those who are served or in need of services by the public mental health system.

I am also a member of the Board of Directors of the National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD). As such, this testimony also reflects many of the principles adopted by NACBHDD related to national health care reform.

Counties in California are responsible for managing the public community-based system, including the Medi-Cal (Medicaid) Specialty Mental Health Managed Care program. Collectively, counties manage a system that totals over $4 billion Statewide (including State, county and Federal revenues).

County governments are an integral part of America's current health system, and in many ways are leaders in determining what is most effective in addressing the diverse health and mental health care needs of our communities.

Below is CMHDA's perspective on the importance of ensuring recovery-oriented, person centered, culturally competent services for individuals with mental illness and substance use disorders in any health care reform proposal. How we handle these issues in the context of health care reform is critical to our ultimate success, and to the optimum health of our communities.

Behavioral Health Care is Essential to Health Care Reform

CMHDA endorses the Campaign for Mental Health Reform's "recognition that there can be no health without mental health, that prevention of and recovery from many health care conditions rests on mental wellness in each individual." (William Emmet, Director, Campaign for Mental Health Reform, September 10, 2008).

As health care reform evolves in Washington, DC, across the Nation and in individual States, it is critical to focus on enhancing and preserving systems of care that serve people with mental illnesses and substance use disorders. Any discussion of health care reform must include the importance of access to and coverage of recovery-oriented, person centered, culturally competent services for individuals with mental illness and substance use disorders. We must ensure the integration of behavioral health services as a fundamental component of any comprehensive reform plan that is developed, enacted, and implemented.

Behavioral health issues must be addressed because it makes no policy or fiscal sense NOT to. Consider that:

- One in four adult Americans has a mental disorder, substance use disorder, or both.
- Mental illness is the leading cause of disability in North America for people between the ages of 15 and 44. The burden of disease from mental health disorders exceeds those from any other health condition.
- Adults with serious mental illness die, on average, 25 years sooner than those who do not have mental illness due to a lack of primary care for physical conditions such as heart disease, pulmonary diseases, high blood pressure, diabetes and other conditions.
- In 2005 alone over 32,000 individuals in this country took their own lives. Suicide was the third leading cause of death for young people aged 10–24 in 2004. According to the World Health Organization, mental illnesses, including alcohol and drug abuse, have the greatest negative impact on society in terms of lost days of healthy productive life, of any disease, accounting for 21% of the total.
- Almost one in four stays in U.S. community hospitals involves depression, bipolar disorder, schizophrenia or other mental health and substance use disorders.
- ***Treatment for mental health and substance use disorders is effective. Recovery rates for mental illness are comparable to and even surpass the treatment success rates for many physical health conditions. Relapse rates for drug/alcohol treatment are less, and compliance is higher, than those for hypertension and asthma; they are equal to diabetes relapse and compliance rates.***

Coverage Does Not Guarantee Access

Adults with serious mental illness are a medically vulnerable population. Many will not access needed physical health services or comply with medical treatment

without significant support. Any health care reform plan must recognize the need for specialized mental health and social services—including case management—to enable this population to benefit from health care coverage and eliminate the disparities in health outcomes for those with serious mental illness.

Further, while we applaud the recent enactment of mental health parity laws at the Federal level, we must also ensure that private health plans include coverage for the types of person-centered recovery and resiliency-oriented behavioral health services that work, and that they provide access to those services. In California, which adopted a mental health parity law approximately 9 years ago, health plans have found many ways to make it difficult for their beneficiaries to access needed care. Individuals with severe mental illnesses must have access to the range of rehabilitation services that enable them to function. As with other chronic ailments such as asthma or diabetes, they may require lifelong management; but those who have these disorders can live full, healthy, and productive lives in the community with the proper support. Coordination between private health plans and public mental health sector services should also be encouraged for this group.

System Accountability and Outcomes

A reformed health care system should be informed by those who are being served, and be accountable based on measurable outcomes. Establishing a consensus of specific and measurable criteria as to what constitutes positive outcomes is an essential element of a reformed U.S. health system.

Prevention and Wellness Strategies Are Essential

Health care reform must include a public health effort to identify health risks and prevention strategies that address the emotional, psychological, and neurological development and wellness of all, and to inform and educate the public about these strategies.

In California we are finally beginning to make prevention in the area of behavioral health care a reality with funding from our voter-approved Mental Health Services Act (Proposition 63, enacted November, 2004). The theory behind the Act is that we must move from a "fail first" system for those with serious behavioral health disorders, to one that recognizes and addresses the early signs of potentially severe and disabling mental illnesses. The Mental Health Services Act (MHSA) combines prevention services with a full range of integrated services to treat the whole person, with the goal of self-sufficiency for those who may have otherwise faced homelessness or dependence on the State for years to come. We are already beginning to see phenomenal results. For example, in Los Angeles County, nearly 40,000 individuals living with mental illness have been served through the MHSA. In one program alone, individuals on Skid Row served by MHSA-funds showed an 83% decrease in homelessness, a 40% decrease in jail time, and a significant decrease in hospitalizations.

Integration of Behavioral Health and Physical Health Services is Critical

To be successful, health care reform must ensure that individuals have access to both physical health and behavioral health care services. Strategies for integration should be based on principles that recognize and embrace a person-centered approach; family involvement; cultural competency; evidence-based/practice-based approach; and multi-systemic frameworks.

Specifically, CMHDA believes health care reform should:

- Address and enhance access to care that embraces a holistic approach to care, centered on the person's strengths and integrates care which is person directed.
- Incorporate behavioral health care screenings, assessment, and treatment in physical health care settings through collaboration with behavioral health providers, for children, adults and older adults.
- Incorporate access to physical health care services in behavioral health settings to help address the 25 year lifespan deficit for individuals with serious and chronic mental illness and/or substance use disorders who would be at risk for increased morbidity and mortality due to an inability to access physical care.
- Prioritize and recognize the provision of physical health services; oral health services; and behavioral health services in school settings for children and adolescents.
- Assure parity in benefits and coverage provisions for diagnostic categories of behavioral health services in order to eliminate disparities in care.
- Support adequate reimbursements for delivery of behavioral health services that take into account the locus of delivery, recognition of evidence-based practice, intensity of care, and level of provider.

- Recognize publicly funded behavioral health organizations as eligible "safety net" providers and "medical homes" with pathways to primary and specialty care.
- Provide the social services and supports that encourage recovery and resiliency, especially for persons with severe or chronic psychiatric disabilities and substance use disorders/addictions.
- Address the workforce shortages of psychiatric specialty providers and specially trained behavioral health staff.

Recovery Principles Are Essential

Recovery principles must guide any behavioral health services reform. The fundamental principles of a recovery-based service system—including self-direction, individualization, strengths-based approach, peer support and hope—have proven necessary to achieving mental health recovery. The Federal Substance Abuse and Mental Health Services Administration's (SAMHSA) 2006 consensus statement on mental health recovery is as essential a guide today as it was then: "Recovery must be the common, recognized outcome of the services we support." (SAMHSA Administrator Charles G. Currie, 2006).

Cultural Competency

A culturally and linguistically competent service system is essential in order to eliminate disparities in access, and in the quality of services for all members of the community. The design, implementation and evaluation of programs that are responsive to the cultural and social contexts of all individuals are critical to the achievement of system reform, and to promote recovery of individuals with behavioral health disorders.

Mental Health Workforce Development

Vitally important to the success of any comprehensive health care reform is assuring that an adequately trained workforce is available to deliver the necessary range of services. A shortage of qualified mental health clinicians is prevalent across the Nation, and constitutes a serious barrier to the expansion, enhancement and/or improvement of the existing mental health service delivery infrastructure. It will also impede implementation of reform proposals no matter how well designed. Attention must be given to finding ways to develop a workforce reflective of the cultural and linguistic diversity of our communities, and to equip these mental health clinicians with skills that incorporate the principles of recovery and cultural and linguistic competency into their everyday practice. Schools of higher education need to update their curricula to emphasize recovery and cultural and linguistic competence principles and models, and experienced clinicians should be offered continuing education credits for receiving training in these recovery principles and treatment approaches that may not have been part of their education.

Health Information Technology (HIT) Must Include Behavioral Health

The accurate capturing of health information is critical. Our reformed health system must build on the increasing availability of health information technology (HIT) to provide a system of electronic health records (EHRs) that is universally available, affordable, accessible to large and small providers nationwide, and provides for capturing *both* physical and behavioral health information. EHRs allow the sharing of information across providers and facilitate care coordination, while also enabling national and regional data collection to monitor and measure access to and cost effectiveness of care. To maximize the value of these tools, we need to adopt a uniform language and format, and ensure that consumers retain control and ownership of their health data.

Summary and Future Hopes

In summary, CMHDA believes that any universal health care system must be an integrated system of prevention, assessment, early intervention, treatment, wraparound services, care management and long-term supports. Beginning with prenatal care and ending with improved end-of-life care, the new system must be person-centered, providing the mix of physical and behavioral health care services each consumer requires. Silos between physical health care and behavioral health care must be eliminated; both types of care must be available to consumers whether their "medical home" is a physical care setting or a behavioral health care setting. Electronic health records and other health information technology (HIT) innovations must be included, in order to facilitate care coordination, reduce errors and lower costs.

Financing for the new system should be shared among Federal, State and local governments along with significantly improved third-party private sector reimburse-

ments and services. Public behavioral health systems must be designed at the local level, tailored to the geographic, demographic, ethnic and cultural needs of the service population. Multiple Federal funding streams should be available to support local systems of care, but be braided in a manner that allows reimbursements for clinical care, social services, supportive housing, supported employment, job training, transportation subsidies and other essential services.

If we can accomplish all of this, we see a future where individuals with mental illness and substance use disorders are able to live and work in their communities with proper supports; and where jails, prisons, skilled nursing facilities and hospitals are no longer inappropriately housing persons with serious mental illness and addictive disorders because they will be able to access and afford the care they need to move to recovery and live productive, rewarding lives.