

Finance Committee Report of the America's Healthy Future Act of 2009
Additional Views Submitted by Senator John D. Rockefeller IV
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Mr. Chairman, with the Committee's passage of America's Healthy Future Act, we are on a path toward fixing many of the problems plaguing our health care system today. While this bill is a start toward comprehensive health care reform, I have several remaining areas of significant concern, some of which I have highlighted here. Additionally, I have joined Senators Stabenow, Kerry, Menendez, and Schumer to express additional views regarding affordability and the high-cost insurance excise tax.

PUBLIC HEALTH INSURANCE OPTION

The Committee mark does not include a public health insurance option or any viable alternative to actively compete with private health insurance companies and lower health care costs for consumers. One of the major disappointments of the Committee mark is the lack of leverage over private health insurance industry prices. Families and employers have said repeatedly that their biggest complaint with their health insurance is the price of it. According to the Kaiser Family Foundation, in the last decade, premiums have increased four times faster than inflation (109 percent versus 26.5 percent). When wages rise 19 percent from 2000 to 2007, as they did in West Virginia, and premiums simultaneously rise at four times that rate, there is an undeniable strain on family budgets. The Committee mark spends nearly one-half trillion dollars in federal premium subsidies to supplement high private health insurance costs, rather than to bring those high costs down for consumers.

A public health insurance option can force insurers to do better by their customers and to once again compete for business by providing a reliable benchmark for cost and quality. The difference between a public plan and private insurance is that consumers choosing the public option would pay less in administrative overhead than under private plans, which could lower costs by as much as 20 percent, according to the Urban Institute. The availability of a public option with the authority to set reasonable provider rates will limit premium growth and create real cost savings for employers and families, while also curbing the growth of federal premium subsidies. (For instance, Medicare's costs rose an average of 4.4 percent between 1997-2007, while private insurance grew by 7.7 percent per capita in the same period.) In turn, employers would be able to turn those savings into increased wages for their workers, boosting federal and state tax revenues.

If an average family premium is \$13,375, a family wishing to enroll in the public health insurance option could save \$1,338 – \$2,676. This is a few mortgage payments, a few car payments – real money for families. Knowing that premiums will continue to rise faster than the federal premium subsidies provided under this bill, I remain extremely concerned that individuals and families would not have the option of purchasing a stable, quality product at an affordable price.

At its maximum within the budget window, the Congressional Budget Office (CBO) estimates only 27 million people will receive insurance through the exchanges (by 2019). In the four

Congressional reform bills that include a public option, CBO estimated only one-third of the people in the exchange would choose it. So, reasonably, only 8-9 million people would enroll in the public option, if one was included in the Finance Committee bill: approximately 3 percent of the insured population.

Arguments against a public option on the grounds of cost-shifting are unsubstantiated. Such cost-shifting arguments have been debunked by the national authority on Medicare payment – the Medicare Payment Advisory Commission (MedPAC). MedPAC argues that “high profits from non-Medicare sources permit hospitals to spend more.” Hospitals with the greatest resources are less aggressive about containing costs and therefore have the highest Medicare ‘losses’ (the difference between Medicare rates and a hospital’s average costs). MedPAC explained this cycle in its March 2009 report to Congress. MedPAC reported, “While insurers appear to be unable or unwilling to ‘push back’ and restrain payments to providers, they have been able to pass costs on to the purchasers of insurance and maintain their profit margins.” The real issue is not whether private plans pay doctors and hospitals more than government programs, but what is a fair rate based on the actual cost of providing quality care. MedPAC concluded, “Increasing Medicare payments is not a long-term solution to the problem of rising private insurance premiums and rising health care costs. In the end, affordable health care will require incentives for health care providers to reduce their rates of cost growth and volume growth.”

Additionally, CBO has indicated that many hospitals negotiate higher payments with private insurers as a form of price discrimination to maximize profits. They demand higher reimbursements from health insurers because they can, not because they are shifting costs. Hospitals have had a greater ability to do this as mergers have given them greater leverage over private insurance companies. A public option would not have these profit-maximizing incentives.

I will continue to work with the Members of the Finance Committee and other Members to provide consumers with the choice of a strong public health insurance option.

TITLE I- HEALTH CARE COVERAGE

SUBTITLE A – INSURANCE MARKET REFORMS

The Committee mark makes significant changes to private health insurance coverage in the individual and small group markets that will improve the adequacy and dependability of coverage for millions of Americans. These reforms include new federal rating rules to limit variation in the cost of coverage, guaranteed issue, guaranteed renewability, no pre-existing condition exclusions, no lifetime or annual limits on coverage, and no rescissions. I remain concerned, however, that these new insurance market reforms do not apply to insurance products in every single market in order to guarantee that all consumers are offered comparable health insurance stability and protection. Additionally, federal oversight and enforcement of these new insurance market reforms is critical to making sure insurers actually comply with the new rules.

Self-Insured Market. Approximately half of the insured population in the United States (between 46 and 55 percent) obtains health insurance coverage through large, self-insured employers. These plans are not regulated by state insurance commissioners, and are instead regulated by the United States Department of Labor. The Employee Retirement Income Security Act (ERISA) of 1974 exempts self-insured health plans from state regulation and state external review processes, which has resulted in the self-insured market being less regulated and less accountable than fully-insured products in the private marketplace today. Yet, under America's Health Future Act, self-insured plans are not subject to the same level of consumer protections that would apply to health insurance products in the individual and small group markets. The Committee mark only includes two new reforms of self-insured plans – they must provide coverage that is at least equal to 65 percent of the actuarial value of the Blue Cross Blue Shield standard plan offered through the Federal Employees Health Benefits Plan (FEHBP), and they must provide first dollar coverage for preventive health benefits. While these are important steps, they are not enough to provide the vast majority of Americans with adequate consumer protections and insurance security. Throughout this important debate, I have asserted that the insurance market reforms that are applied to the individual and small group markets should also apply to self-insured plans.

Pre-Existing Conditions. The Committee mark eliminates pre-existing condition exclusions in the individual and small group markets. However, these provisions are not phased-in until July 1, 2013. In the years prior to 2013, the mark would allow individuals who are denied coverage based on a pre-existing condition to enroll in a high-risk pool. The prohibition on pre-existing condition exclusions is phased-in for large group plans over five years beginning in 2017, and the prohibition does not apply to the self-insured market. I remain concerned that the prohibition on pre-existing condition exclusions in the individual, small group, and large group markets does not start immediately on January 1, 2010. I also remain concerned that the prohibition on pre-existing condition exclusions does not apply to the self-insured market. I plan to continue working with Chairman Baucus on an expedited timeframe for the elimination of pre-existing condition exclusions, including the immediate elimination of pre-existing condition exclusions for children in all markets.

Annual and Lifetime Limits. Beginning in 2010, the Committee mark prohibits insurers from offering plans with annual or lifetime limits in the exchange. Beginning in 2013, these limits would apply to all new individual and small group policies (phased in over five years). The bill also prohibits large-employer plans (including self-insured plans) from implementing “unreasonable” annual or lifetime limits, although the term “unreasonable” is undefined.

I remain concerned that the mark does not implement a complete prohibition on annual and lifetime limits for large employer plans, including those in the self-insured market. I also remain concerned that the word “unreasonable” is not defined, as it relates to the limits on annual and lifetime caps. I intend to continue working with Chairman Baucus to improve the protections in the mark regarding annual and lifetime limits on coverage to make certain there is equal and sufficient protections for individuals and their families no matter what market they access health insurance coverage.

Minimum Medical Loss Ratio. The Committee mark includes premium subsidies for individuals above 133 percent of poverty to purchase health insurance coverage in the state exchanges.

According to CBO, these federal subsidies will cost \$461 billion over the ten-year budget window. Additionally, estimates suggest that it will cost approximately \$20 billion more than current law to give Medicaid-eligible populations between 100-133 percent of poverty premium subsidies to enroll in private insurance coverage in state exchanges. The Committee mark also directs the Secretary of Health and Human Services (HHS) to require private health insurers to report their medical loss ratios.

While reporting of medical loss ratios is an important first step, I remain concerned that the Committee mark does not require private health insurance companies, particularly those offering federally subsidized coverage through the state exchanges, to spend the majority of the nearly one-half trillion dollars in federal premium subsidies on actual medical care. Without a minimum medical loss ratio to hold insurance companies accountable there is no limit on the amount of taxpayer resources that private health insurance companies can spend on executive compensation, shareholder profits, marketing, and other activities that do not add value for the consumer. As I asserted during the Committee debate, I believe that private health insurers should spend no less than 85 percent of premium dollars on actual medical care, and I look forward to ongoing discussions with Chairman Baucus on how to include a minimum medical loss ratio requirement in this legislation.

SUBTITLE B – EXCHANGE AND CONSUMER ASSISTANCE

State Exchanges. Under the Committee mark, states would be required to establish an exchange for the individual market and a Small Business Health Options Program (SHOP) exchange for the small group market, with technical assistance from the Secretary, in 2010. After states adopt Federal rating rules and the exchange is functional for at least three years, states could permit other entities to operate an exchange (i.e. multiple competing exchanges) — but only if it met specified requirements, and subject to approval by the Secretary. States could, through interstate compacts, form regional exchanges, subject to approval by the Secretary. I remain concerned about multiple state exchanges and believe that one national exchange, implemented and regulated by the HHS Secretary, would minimize insurance enrollment churning, lower administrative costs, and improve the value of benefits and coverage while lowering premiums by creating a larger risk pool.

SUBTITLE C – MAKING COVERAGE AFFORDABLE

Minimum Credible Coverage for Children. I commend Chairman Baucus and the Members of this Committee for supporting the continuation of the Children Health Insurance Program (CHIP) for vulnerable children. Medicaid and CHIP are proven programs that work well for children, and we should continue to build upon what works. In addition to protections for children enrolled in Medicaid and CHIP, there should also be adequate protections for children enrolled in private health insurance coverage through state exchanges. I remain concerned that cost-sharing is not limited for children in the exchanges, and I believe it should follow the cost-sharing protections provided for children enrolled in CHIP. I also worry that this mark does not do enough to cover preventive health services, with minimal cost-sharing, for pregnant women, infants, children, and adolescents. Additionally, I remain concerned that federal subsidies for private coverage in the exchanges will incentivize inefficient provider payments instead of

payments to health care providers that incentivize case management, care coordination, use of medical home, child health measures, and culturally and linguistically appropriate care. At a minimum, I believe the standard for minimum creditable coverage for children should include the Health Resources and Services Administration consensus guidelines for children as well as maternity and newborn care, mental health services, rehabilitative and habilitative services and devices, and pediatric services including oral, dental and vision care.

SUBTITLE D – SHARED RESPONSIBILITY

Employer Mandate. The Committee mark includes a free-rider provision as an alternative to a true employer mandate. It would penalize employers with more than 50 employees that do not offer coverage, but employ individuals eligible for premium subsidies. This policy results in a net increase in employer-based coverage of about one million individuals, according to CBO.

I remain concerned that this provision provides a disincentive for employers to hire or maintain employment for low-wage workers. It would be particularly burdensome for states, like West Virginia, with a higher percentage of low-wage workers. Additionally, I have concerns about the fact that the trend in the last few years of the budget window indicates growing reductions in employer-based coverage of two to three million every year between 2016 and 2019. In contrast to the policy included in the Finance mark, the Health, Education, Labor, and Pensions (HELP) Committee health reform bill, the Affordable Health Choices Act, has a true employer mandate, and increases employer-based coverage by 14 million people over the ten-year budget window. I look forward to continuing to work with Chairman Baucus and other Members of the Committee to implement a true employer mandate that creates a fairer system of employer shared responsibility

SUBTITLE E – CREATION OF HEALTH CARE COOPERATIVES

Consumer Operated and Oriented Plan (CO-OP). The Committee mark authorizes \$6 billion in funding for the Consumer Operated and Oriented Plan (CO-OP) program. In its preliminary score of the Committee mark, CBO states that “the proposed co-ops had very little effect on the estimates of total enrollment in the exchanges or federal costs because, as they are described in the specifications, they seem unlikely to establish a significant market presence in many areas of the country or to noticeably affect federal subsidy payments.” As a result, CBO estimates that of the \$6 billion in federal funds that would be made available in co-op start-up funding, only about \$3 billion would be spent over the ten-year budget window. As I have asserted throughout this debate, health insurance cooperatives are not a substitute for a strong public health insurance option. Additionally, I remain seriously concerned about the viability of consumer health cooperatives in the health insurance marketplace at all.

There has been no significant research into consumer co-ops as a model for the broad expansion of health insurance. What we do know, however, is that this model was tried in the early part of the 20th century and largely failed. There is a lack of consistent data about the total number of consumer health insurance cooperatives in existence today, although most estimates indicate that

only between four and seven exist, and there have been no analyses of the impact of existing health insurance cooperatives on consumers. All of the consumer health insurance cooperatives identified by the U.S. Department of Agriculture and the National Cooperative Business Association operate and function just like private health insurance companies. There have been no analyses of the regulatory structure for existing health insurance cooperatives. Consumer health insurance cooperatives are currently regulated by the states, and there have been no studies conducted to evaluate the consumer experience with them. Health insurance cooperatives simply have not been proven to meet the policy goals of cost-containment, transparency, and innovation that a strong public health insurance option guarantees.

SUBTITLE F – TRANSPARENCY AND ACCOUNTABILITY

Federal Regulation of Insurance. The Committee mark creates an entirely new construct for the sale and purchase of private health insurance that is more affordable and comprehensive than most coverage options for consumers available in the individual and small group markets today. Additionally, the mark applies new consumer protections in these reformed markets that prohibit insurers from using common practices that delay or deny necessary care. I commend the Chairman for these critical provisions. However, the Committee mark does not include any new federal resources or infrastructure to regulate private health insurance companies and make certain they are actually abiding by the new insurance market rules. Without a new, robust federal regulatory role, I remain extremely concerned that private health insurance companies will continue their long-standing practice of exploiting loopholes in the law and skimming on coverage for beneficiaries to increase profits. I look forward to working with Chairman Baucus to address these concerns.

SUBTITLE G – ROLE OF PUBLIC PROGRAMS

Part I – Medicaid Coverage for the Lowest Income Populations

Medicaid Expansion. The Chairman should be commended for expanding Medicaid to 133 percent of the federal poverty level. Medicaid is a program that works. This expansion is long overdue and will go a long way to help vulnerable populations historically ineligible for Medicaid. However, as I have stated several times during the debate in Committee, I am extremely concerned about the structure of this expansion.

First, as part of the Medicaid expansion, all newly-eligible, non-pregnant adults would receive a benchmark benefit package consistent with section 1937 of the Social Security Act, which was passed as part of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171). The Deficit Reduction Act was enacted with the stated purpose of reducing Medicaid spending. Many of the policy changes in the DRA shift costs to Medicaid beneficiaries and have the effect of limiting health care coverage and access to services. Specifically, the DRA allows states to offer more limited benefits for some groups and to offer different benefits to different groups of enrollees. It also allows states to impose cost-sharing in the form of premiums and co-pays on individuals and families who are economically impoverished. For families who are struggling financially, even seemingly small amounts of cost-sharing raise significant barriers to pursuing needed health care services. While the DRA gave states the option of implementing so-called “flexible” benefit

packages, the language included in the Committee mark makes DRA benefit reductions mandatory for newly-eligible populations, which effectively undermines the Medicaid entitlement.

Second, effective July 1, 2013, the Committee mark would require states to offer premium assistance and wrap-around benefits to Medicaid beneficiaries who are offered employer-sponsored insurance (ESI) if it is cost-effective to do so, consistent with current law requirements. Creating mandatory state Medicaid premium assistance puts beneficiaries, including children, at risk of losing benefits and creates an unnecessary burden on states that already have the option to provide premium assistance under Section 1906 of the Social Security Act. Historically, premium assistance programs have not been very successful; they often increase state and federal expenditures instead of decreasing them. The 2009 CHIP reauthorization law recognized the limitations of premium assistance and made changes that have not yet had a chance to be implemented. I believe Congress should wait for the results of the GAO study on premium assistance expected in January 2010 before making any changes to current law with regard to premium assistance.

Third, beginning in 2014, non-elderly, non-pregnant adults between 100 percent (\$22,050 for a family of four) and 133 percent of poverty (\$29,327 for a family of four) would be able to “choose” between Medicaid and coverage through their state exchange. This provision is estimated to cost \$20 billion over the budget window, largely because private insurance is much more costly – approximately 25 percent more costly – than Medicaid, which is more efficient and provides better coverage. This \$20 billion is in addition to the \$461 billion that we are giving private insurers in federal tax subsidies.

I remain concerned that the Medicaid overpayments to private insurers that would be allowable under this bill are similar to the Medicare Advantage overpayments. States can already contract with private insurers, in a cost-effective manner, to enroll Medicaid-eligible populations in private managed care plans. These existing Medicaid managed care plans have to meet beneficiary protections required under the Balanced Budget Act of 1997, which would not be required of private plans operating in the exchange. Additionally, I am very concerned that private-fee-for-service plans – the most inefficient and expensive private plans in the market – would be able to enroll vulnerable Medicaid populations. Private insurers have a long history of inadequately serving vulnerable, low-income populations. I am very concerned that the Committee mark overlooks the substantial deficiencies in the private health insurance system – and puts vulnerable populations at risk of losing critical Medicaid benefits and cost-sharing protections in the state exchanges. There are no provisions in this mark that would prohibit states from creating barriers to Medicaid enrollment so that Medicaid beneficiaries are forced to “choose” inadequate and more expensive private coverage in the exchange.

I look forward to working with Chairman Baucus to address each of these concerns.

Part IV – Medicaid Services

Curative and Palliative Care for Children in Medicaid. The Committee mark includes an important provision that makes concurrent care – both curative and palliative – available to

children under Medicaid with terminal, hospice-eligible prognoses. This provides the palliative care these children need without forcing their parents to make the impossible choice of foregoing curative measures in order to qualify for hospice. I look forward to working with the Chairman to also provide concurrent care to children enrolled in CHIP.

Community First Choice Option. The Chairman should be commended for including the Community First Option in the Committee mark. This critical provision will create a state plan option to provide community-based attendant supports and services to individuals with disabilities who are Medicaid-eligible and require an institutional level of care. This is a significant step in the right direction, but more needs to be done to improve long-term care supports and services. I look forward to working with Chairman Baucus and other Members of the Committee to provide the infrastructure necessary for a comprehensive long-term care system.

Part VII – Dual Eligibles

Federal Coordinated Health Care Office. The Chairman should be commended for establishing the Federal Coordinated Health Care Office (CHCO) within the Centers for Medicare and Medicaid Services (CMS). The CHCO would substantially improve care coordination for individuals dually eligible for both Medicare and Medicaid and is a long overdue improvement to our health care system.

ADDITIONAL COVERAGE VIEWS

Number of People Covered. The Chairman should be commended for providing health insurance coverage to 29 million previously uninsured Americans. I remain concerned, however, that 16 million men, women, and children will remain uninsured under the Committee mark. Universal coverage has always been the goal of health reform. We should spend the resources necessary to insure every person.

Advance Care Planning. The Committee mark is silent on advance care planning. As I have asserted throughout this debate, a critical component of a modernized health system is the ability to address the health care needs of patients across the life-span – especially at the end of life. Death is a serious, personal, and complicated part of the life cycle, and care at the end of life is eventually relevant to everyone. Americans deserve end-of-life care that is effective in providing information about diagnosis and prognosis, integrating appropriate support services, fulfilling individual wishes, and avoiding unnecessary disputes.

Most people want to discuss advanced directives when they are healthy and they want their families involved in the process. However, the vast majority of Americans have not completed an advance directive expressing their final wishes. In 2007, RAND conducted a comprehensive review of academic literature relating to end-of-life decision-making. This review found that only 18 to 30 percent of Americans have completed some type of advance directive expressing their end-of-life care wishes. Perhaps most alarmingly, between 65 and 76 percent of physicians whose patients had an advance directive were unaware of its existence. In its present form, end-of-life planning and care for most Americans is perplexing, disjointed, and lacking an active

dialogue. In its 1997 report entitled *Approaching Death: Improving Care at the End of Life*, the Institute of Medicine found several barriers to effective advance planning and end-of-life care that still persist today. I am extremely concerned that the Committee mark does nothing to inform consumers of their treatment options at the end of life or help them document their individual wishes for care.

Need for a Comprehensive Approach to Long-Term Care Policy. There is no question that we need a long-term care system in this country – one that provides adequate and affordable long-term care coverage for all Americans. The Pepper Commission called for this in 1990, but little if any progress has been made since that time. Medicaid has become the long-term care payer of last resort, with recipients having to spend down their income and assets to the point of impoverishment in order to qualify. As the baby boomers continue to age, it is imperative that we have the same sense urgency and commitment regarding long-term care as we have regarding acute and primary care reform.

TITLE II – PROMOTING DISEASE PREVENTION AND WELLNESS

SUBTITLE C – WORKPLACE WELLNESS

Incentives for Participation in Voluntary Wellness Programs. The Committee mark would codify the existing HIPPA non-discrimination regulation relating to workplace wellness programs. This rule allows employers or issuing plans to provide “rewards” for employees’ participation in a wellness program or for meeting certain health status targets associated with that program. Employers, under the regulation, can provide a reward (or penalty for those who do not participate or do not meet certain health status targets) to participants of up to 20 percent of the total cost of the plan. Additionally, the Secretaries of HHS, Labor and Treasury may raise the threshold to 30 percent of the total cost of the plan. I am very concerned that these provisions are discriminatory and have not been shown to be effective. In addition to posing problems for people with less-than-perfect health, the premium “incentives” would unfairly penalize people who have other barriers to participation in such programs, like working mothers or people who work two or more jobs. This provision means that some employees will now have to pay more than their fellow employees for the same benefits. It also means that people who do not participate in such wellness programs will be subsidizing the premiums of those who do participate. There is evidence that some employees who do not get the discounts will opt-out of coverage altogether; some of the savings attributed to the wellness program in fact come from people with health problems dropping employer-sponsored health insurance. I do not believe these provisions should remain in the final bill.

TITLE III- IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

SUBTITLE A – TRANSFORMING THE HEALTH CARE DELIVERY SYSTEM

Part IV – Strengthening Primary Care and Other Workforce Improvements

Primary Care/General Surgery Bonus. The Chairman should be commended for including geriatricians among providers eligible for primary care bonuses. Geriatricians are vital to quality care for the elderly, including those receiving institutional or home and community-based services. Such measures also provide incentives for more medical students to pursue careers in geriatrics.

Redistribution of Unused GME slots to Increase Access to Primary Care and Generalist Physicians. The Chairman should be commended for including geriatricians in the definition of primary care for the purpose of determining graduate medical education (GME) slots. Such efforts are important because our nation is behind in developing the workforce necessary for current and projected demographic shifts. According to the American Geriatrics Society, in 2008 there were 7,590 certified geriatricians in the nation. The Alliance for Aging Research projects a need for 36,000 geriatricians by 2030. This provision will help to close the growing workforce gap.

SUBTITLE B- IMPROVING MEDICARE FOR PATIENTS AND PROVIDERS

Benefits for Seniors. The Committee mark includes important improvements to Medicare that will have a positive impact on seniors. Wellness benefits are enhanced, with an annual wellness visit where a beneficiary's health behaviors are assessed and discussed with his or her physician. Out-of-pocket costs are eliminated from preventative health screenings, so that any barriers to getting these screening on a regular and timely basis are removed. Half of the Medicare prescription "doughnut hole" is closed for beneficiaries, reducing out-of-pocket drug costs for many. In addition to the improvements in Medicare benefits for seniors, the mark also includes delivery system reforms that will ultimately benefit seniors and individuals with disabilities.

The mark makes progress, but more is needed to improve Medicare for seniors and those with disabilities. I will continue to work with Chairman Baucus and other members of this Committee to make such improvements.

SUBTITLE D—IMPROVING PAYMENT ACCURACY

Hospice Payment Reforms. The Chairman should be commended for including reform of the Medicare hospice payment methodology consistent with MedPAC recommendations. This methodology will pay hospices in a way that better accounts for the trajectory of care expenditures, and thus pay more accurately across different diagnoses. The Chairman should also be commended for including hospice data reporting, which will be extremely useful in quality assurance and oversight. I remain concerned, however, that the Medicare Commission as drafted in the Committee mark would exempt hospices from the payment reforms recommended by the Medicare Commission. I will continue to work with Chairman Baucus to correct this provision.

SUBTITLE E – ENSURING MEDICARE SUSTAINABILITY

Medicare Commission. The Committee mark would establish a Medicare Commission, charged with providing annual recommendations for Congress regarding changes to Medicare payment

policies. Congress would have six months to act upon these policies, and potentially change them, before they would automatically go into effect. In the event that Medicare spending exceeds certain growth targets, the Commission would be required to offer policies that reduce Medicare spending by set amounts. In years where there is no estimated excess cost growth in Medicare spending, the Commission has no power to implement changes to the Medicare program. In the mark, the Commission is prohibited from reducing reimbursement for hospitals, hospices, and potentially other providers. CBO also assumes that the Commission will not reduce reimbursement for physicians or suppliers of durable medical equipment offered through competitive bidding.

I remain concerned that the Medicare Commission policy, as drafted, is flawed and will not achieve success in improving Medicare over the long-term. First, based on CBO's assumptions, the providers protected from the Commission's recommendations constitute half, if not more, of total Medicare spending. By including a carve-out of any kind to protect a subset of providers, I am concerned that Commission is fundamentally unsound because it is barred from looking at Medicare from a comprehensive perspective. The original intent of the *MedPAC Reform Act* (S. 1380), the policy upon which the Medicare Commission is based, was to protect Medicare's solvency by taking the special interests out of the process of determining Medicare coverage and provider reimbursement policy. The Commission is meant to be a responsible, independent entity charged with implementing reasonable, evidence-based Medicare policies that serve to protect access to necessary medical care for our nation's seniors and disabled. However, the language to protect certain providers weaves special interests into the very fabric of the Commission. Furthermore, I am particularly concerned about CBO's assumption that limiting the Commission's options for exploring greater efficiencies in Medicare means that the Commission is likely to decrease premium subsidies for Medicare beneficiaries enrolled in the prescription drug program. I look forward to working with Chairman Baucus to restore the integrity of this Commission by eliminating carve-outs for all providers and preserving beneficiary cost-sharing protections.

I also remain concerned that the trigger for the Commission to issue recommendations is tied to excess cost growth in the Medicare program as it relates to growth in the gross domestic product, instead of being tied to the solvency of the Medicare program. The original intent of the *MedPAC Reform Act* was to create an independent commission to drive Medicare quality improvement and increase the efficiency of the program, so that it continues to exist for seniors and individuals with disabilities ten, twenty, and fifty years down the line. It was never meant to cut costs just for the sake of cutting costs. I look forward to working with Chairman Baucus to restructure this policy going forward to make certain the delicate balance of sustaining the program is not found on the back of our most vulnerable seniors and disabled.

Finally, I remain concerned that six months for Congressional review and amendment of the recommendations included in the mark is too great an opportunity for these same special interests to water-down, or eliminate altogether, the policies put forth by the Commission. I will continue to work with Chairman Baucus to create a more effective timeframe within which Congress can consider the Commission's recommendations.

ADDITIONAL DELIVERY SYSTEM VIEWS

Palliative Care. I remain concerned that more was not done in the Committee mark to improve the delivery of palliative care. More palliative care specialists are needed, including palliative medicine physicians. Additionally, general and continuing medical school education must be strengthened so that providers are more knowledgeable about palliative and end-of-life care, and better prepared to counsel patients regarding advance care planning. I look forward to working with Chairman Baucus to address the workforce needs in this area.

Health Information Technology. The American Recovery and Reinvestment Act (ARRA) rightly made substantial new investments in health information technology (HIT). ARRA included about \$17.5 billion in Medicare and Medicaid incentives over multiple years to providers that achieve meaningful use of electronic health records (EHRs), and \$2 billion in grants and loans to states for activities necessary for sharing data across providers, including the building of a Health Information Exchange infrastructure.

The Committee mark appropriately recognizes the importance of using HIT in optimal care delivery models. Furthermore, the mark wisely includes HIT training as a part of health care workforce development. The mark also recognizes the importance of including free clinics – crucial to the health care safety net – in EHR funding.

While progress has been made in this mark, I remain concerned about the persisting barriers to affordable HIT and EHRs for all providers, including small rural providers with very limited financial resources. The availability of open source solutions, in addition to the current market for more expensive proprietary solutions, is an area where I will continue to work with Chairman Baucus to improve. This includes the expansion of open source governmental software programs, already developed at taxpayers' expense, such as the Veterans Health Administration's VistA software and the Indian Health Service's Resource and Patient Management System. Such additional options would help health care catch up to other industries in realizing the potential of information technology.

TITLE VI- REVENUE ITEMS

Budget Failsafe Provision. The President outlined from the beginning of this process that this health reform bill must be deficit-neutral. This Committee has had to make difficult decisions in order to make sure this standard was met, and I commend the Chairman for having produced the most fiscally responsible bill of any of the committees, one that even decreases the deficit. However, I remain very concerned about one particular provision in the Committee mark aimed at reducing the deficit. The Committee mark includes a provision that requires the Director of the Office of Management and Budget to annually certify that none of the provisions of the legislation will increase the budget deficit in the coming year. In the event that the legislation is projected to increase the federal deficit in the coming year, then premium subsidies for families and individuals who cannot otherwise afford coverage would have to be reduced to make up for the anticipated increase in the deficit. CBO assumes that the amended Finance mark would increase the deficit in fiscal years 2015 through 2018. Consequently, under CBO and the Joint

Committee on Taxation's estimates, this provision would require a reduction in premium subsidies averaging about 15 percent for fiscal years 2015 through 2018.

This so-called "failsafe" provision has the potential to undermine critical affordability of health insurance. The failsafe provision would automatically decrease premium subsidies for low- and middle-income families who would be relying on them to purchase insurance. I am also concerned that the annual nature of the review realistically means that it will make subsidized coverage unstable for consumers because the subsidies will fluctuate based on the budget. I look forward to working with Chairman Baucus to guarantee that this bill offers reliable and consistent subsidies, while finding other ways to reduce the deficit.