Source: U.S. Senate Committee on Health, Education, Labor, and Pensions

Briefing Paper for Meeting of the Senate Committee on Health, Education, Labor and Pensions

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A New Vision for American Health Care: Strengthening What Works and Fixing What Doesn't

Overview and Background

For the greater part of the last 100 years, Americans have sought ways to provide affordable and quality health insurance coverage to all our citizens. In this journey, we have achieved notable successes, including the creation of Medicare and Medicaid in 1965, the inception of the Children's Health Insurance Program in 1997, the expansion of prescription drug coverage for seniors in 2003, and more. We have also witnessed setbacks and defeats, including the failure of reform efforts during the Administrations of Presidents Harry Truman, Jimmy Carter and Bill Clinton.

In recent years, the drive to cover all Americans has been joined with the imperative to reform a health care system which consumes far more of our nation's resources than merited by the results produced. While the men and women who work in U.S. medicine perform miracles and wonders every day, our health care system wastes precious dollars to produce uneven results.

For the past year, Democratic Members and staff of the Senate Committee on Health, Education, Labor and Pensions – along with our colleagues at the Senate Finance Committee, the House of Representatives and the Administration – have been laying groundwork and preparing legislation to reform the U. S. health care system. As we near the point of introducing legislation to achieve our vision, we issue this policy overview to lay out our priorities for the legislation.

We begin with our goals for the improvement of American health care:

- Assuring reliable, high quality and affordable health insurance for all Americans
- Improving value by creating a higher quality, more efficient delivery system
- Building a new framework to enhance prevention and wellness
- Creating a durable structure of long term supports and services for seriously disabled Americans
- Rooting out fraud and abuse in the public and private health systems
- Establishing shared responsibility and paying appropriately and fairly for reform

Source: U.S. Senate Committee on Health, Education, Labor, and Pensions

First, Assuring Reliable, High Quality and Affordable Health Insurance for All Americans

These are key coverage goals we seek to achieve through national health reform:

- Keeping in place what works today – Those who are satisfied with their coverage will be able to keep it, even as we work to expand access, improve quality and lower the rate of health spending growth for everyone.

- Making health insurance work for all Americans – Our health insurance system needs to work for everyone, not just the healthy and affluent; health insurance needs to be there for all Americans when we need it most.

- Addressing the health coverage needs of those left out, and those in danger of being left out – We will reform our system so everyone can get affordable and quality health insurance coverage, including nearly 50 million uninsured Americans and those whose health insurance policies leave them medically and financially vulnerable.

- Creating America's Health Benefit Exchange– We want to create a new state-based resource to make sure all Americans can easily obtain high quality and affordable coverage.

- Defining Personal Responsibility – To make this new structure work for everyone, everyone needs to participate and obtain health insurance.

Keeping in place what works today. About 200 million Americans obtain health insurance today through their employers and the private health insurance market. About 80 million Americans get their coverage through federal and state health programs, chiefly Medicare and Medicaid. Both public and private systems meet important needs, yet both systems need improvement. Most importantly, everyone wants the cost of their health coverage to be less and to grow at a less harmful pace. Despite these flaws, surveys show that most Americans like their coverage and want to keep it.

This is why health reform we intend to advance in the Senate HELP Committee starts with the commitment that if you like the coverage you have now, you can keep it. We want health insurance to be more affordable and more secure. We want health insurance coverage that ensures that you get the medically necessary services you need. We want health coverage which focuses on keeping everyone healthy and preventing injury and illness. We want health insurance coverage that protects every American from ever facing medical bankruptcy.

Source: U.S. Senate Committee on Health, Education, Labor, and Pensions

That is why we begin with the premise that the system has to work for everyone, including those who want to keep the coverage they have now.

Making health insurance work for all Americans: Reforming health care means fixing America's frayed health insurance system. Nearly 50 million Americans now lack health insurance, and tens of millions more hold policies – such as many sold in the individual market – that provide little real protection in the event of serious injury or illness. Even well insured Americans, facing a job loss, overnight can find themselves thrown into the ranks of the uninsured and "uninsurables." Even those satisfied with their coverage increasingly find the growing financial burden of paying for coverage unsustainable. Even if we and our immediate families are secure, we all know loved ones and friends skating near the edge of financial and medical disaster because of an insurance system that has lost its way.

Health insurance in the United States is governed by an inconsistent patchwork of regulations which provide uncertain, uneven, and unreliable protections for consumers. Reform begins with a new set of national standards and changes:

- *Guaranteed issue and renewal* – All health insurers must take all comers. This will be a cornerstone rule for all health insurance markets, especially those for individuals and small employers seeking coverage for their workers.

- *No medical underwriting or pre-existing condition requirements* – All health insurers will be barred from issuing or renewing policies based on an applicant's health status or medical history or denying coverage due to a pre-existing condition.

- *Fair Premiums* – Premiums charged by health insurers should vary only by family composition, geography, and age, within clear and reasonable limits, unlike the current market where rates in most states may vary without limit.

- *Ensuring value in health insurance purchasing* – Insurance companies will be encouraged to offer better value to the public by maximizing the portion of every health insurance dollar which goes to pay for medical services.

Addressing the coverage needs of those left out: Fixing the rules governing health insurance will stabilize coverage for millions of Americans. Because health insurance and the underlying cost of medical care are so expensive, it won't be enough. The cost of health coverage today is out of reach for tens of millions of Americans. Many others who can't get access to employer sponsored coverage need help obtaining and paying for health insurance. Our plan will help in this way:

Source: U.S. Senate Committee on Health, Education, Labor, and Pensions

- *Premium assistance to make the purchase of private insurance affordable* – We will provide sliding scale premium assistance for individuals and families with income up to four times the federal poverty level to help them purchase quality health insurance policies.

Creating America's Health Benefits Exchange: Health insurance is so complicated, many Americans throw up their hands in confusion and frustration. Many find it impossible to sort through different companies' policies that don't compare. Some states have experimented with establishing health insurance "connectors" or "exchanges" to make this process easier and more consumer friendly. To fix health care, we have to make the process of finding the right health insurance one that meets the needs of consumers:

- *Establishing a new American Health Benefit Exchange*: This new national resource will provide consumers with clear and understandable health insurance choices guaranteed to provide high quality and more affordable options for consumers.

- *Setting up state-based offices to meet consumer needs:* At their option, states will be permitted to establish their own Exchanges in collaboration with the federal government, to ensure the best assistance on the ground, closest to consumers.

- *Creating a new national website to make purchasing coverage as easy as possible:* Today, websites make the process of booking an air flight, a hotel room, or a rental car easy. Through a new national website – linked with state and local options – we will make the purchase of health insurance easy and reliable.

- *Providing a public choice option:* To ensure that fiscal discipline and full accountability are built into this new structure, one health insurance option available to participants will be a publicly sponsored and guaranteed plan.

Defining Personal Responsibility: To establish this new set of protections and assistance, citizens also need to play an important role. Any health insurance system, public or private, can't workable and is more expensive if consumers wait until they get sick before signing up. That's why national health reform requires that everyone who can afford to must sign up for coverage.

Source: U.S. Senate Committee on Health, Education, Labor, and Pensions

Second, Improving Value by Creating a Higher Quality, More Efficient Delivery System

A national strategy to improve health care quality is needed to generate solutions to the biggest problems – medical errors, preventable hospital readmissions, and the failure to manage chronic diseases – that have a severe impact on people, their lives, their checkbooks and national health care costs. Reforming our sick care system into one that rewards health care value and not volume care begins with a new approach to quality care. It is crucial to saving lives and saving money through health care reform.

These are the key goals for quality and delivery system improvement we seek to achieve through comprehensive health care reform:

- Preventing medical errors by using innovative tools and methods
- Improving efficiencies in the delivery system by maximizing the use of health technology and simplifying administrative procedures
- Preventing hospital readmissions by mandating discharge planning
- Managing chronic conditions through better coordination and integration of care made possible by medical homes and community health teams
- Strengthening the health workforce by increasing the number of practitioners and providing training and quality initiatives for existing practitioners
- Reducing health disparities by ensuring they are taken into account in workforce programs and quality measures

Preventing medical errors by establishing a Patient Safety and Clinical Delivery Institute within the Agency for Healthcare Research and Quality that will strengthen best practice research and dissemination. Creating grants to identify and disseminate best practices to providers and patients will prevent medical errors. One such practice is the Pronovost Checklist, which uses 10 simple steps to properly insert a catheter and eliminate line infections.

Improve efficiencies in the delivery system: We will save money in the health care system by simplifying administrative costs and achieving efficiency in the health delivery system. We will do this by:

- Reducing administrative costs through computerization of routine transactions,
- Streamlining health plan enrollment and documentation,
- Promoting evidence-based medicine, and
- Promoting patient-centered health information by improving health literacy.

Source: U.S. Senate Committee on Health, Education, Labor, and Pensions

Reducing preventable hospital readmissions: Mandating hospital discharge plans that feature a discharge advocate working together with a pharmacist and others to coordinate hospital discharge, patient education, and medication reconciliation will reduce follow-up emergency visits and rehospitalizations. Medication consultation, counseling and education will assist patients in complying with their medication plans. Establishing a system that allows hospitals to confidentially report readmission rates and providing them with a technical assistance program will help hospitals reduce readmission rates.

Chronic disease management: Utilizing electronic health care records and the establishment of "medical homes" for patients will improve the management of chronic disease. Medical homes offer comprehensive health services promoting safe and quality care founded on evidence-based medicine, appropriate use of Health Information Technology and community health teams.

A patient's medical home is coordinated and integrated care that includes primary care providers, access to specialists and community teams of licensed providers to enhance wellness and lifestyle improvements. It is patient-centered and holistic in its orientation.

Every patient would have a case manager coordinating the care and a health coach carrying out a wellness and treatment plan. Medical homes will draw upon community resources and link patients to services, like fitness centers and social support groups, in their own communities.

Strengthening the health workforce: We will expand federal health care workforce development programs and create a Workforce Commission to strengthen the health workforce. The Commission will make recommendations on how to ensure a sufficient supply of primary care physicians, nurses, and other practitioners. The bill creates new grant programs to specially train health professional in geriatric care to address special needs of a booming aging population. Additionally, it strengthens primary care and nurse workforce development programs by, for example, adding new programs to increase the number of nurse faculty. We will build patient safety and best practices into curriculum for health practitioners to learn how to deliver new models of high quality care.

Addressing health disparities: We need to make sure health disparities, including differences in race, ethnicity, gender, and vulnerable populations are taken into account when developing quality measures. We will also expand scholarship and loan repayment programs to minorities to enter into health professions so they may return to serve the communities they come from. Additionally, we will provide technical assistance to implement quality improvement activities that can be adopted in different settings serving different populations. Finally, to improve patient engagement in shared treatment decision making, we require that tools and training are culturally component and health literate to engage patients.

Source: U.S. Senate Committee on Health, Education, Labor, and Pensions

Third, Building a New Framework to Enhance Prevention and Wellness

These are the key goals we seek to achieve in the Prevention and Public Health provisions of comprehensive health reform:

- Reimbursing for essential preventive services.
- Removing barriers to preventive services.
- Promoting community wellness and strengthening our public health system.
- Changing medical school and residency curricula.
- Promoting the benefits of wellness and prevention.
- Encouraging workplace wellness programs.
- Creating a Federal-level Prevention and Public Health Council.

Reimbursing for essential preventive services: We will reform our health insurance system to incentivize providers to promote basic preventive services such as screenings for diabetes, depression, and colorectal and other forms of cancer, tobacco cessation, and nutrition counseling. These types of basic preventive services save money and improve the quality of life for all Americans.

Removing barriers to preventive services: We will remove barriers to preventive services that discourage individuals from participating in screenings and preventive initiatives. Studies show that even small copayments and deductibles cause individuals to forego essential screenings and annual physicals which detect health problems before they become full blown conditions. These and other barriers to preventive services will be eliminated.

Promoting community wellness and strengthening our public health system: Health reform must occur in communities as well as in medical settings. Most chronic diseases can be prevented through lifestyle and environmental changes. Community prevention programs encourage physical activity, good nutrition, and the reduction of tobacco use, helping individuals to make healthy choices easier. Strengthening our public health system is critical to protecting people from health threats beyond their control, such as bioterrorism, natural disasters, infectious outbreaks, and environmental hazards.

Changing medical school and residency curricula: Currently, health care professionals receive little or no formal training in prevention and public health. The Hippocratic Oath says: "First, do no harm." A reformed curriculum will teach the next generation of health care professionals: First, prevent unnecessary disease.

Promoting the benefits of wellness and prevention: People need information to take charge of their health. This includes educating the general public and health care providers about the benefits of lifestyle changes that keep people healthy and out of the hospital. Also, we must support health literacy programs to relay information in the most understandable manner.

Encouraging workplace wellness programs: We must give employers technical assistance and evaluations of effective workplace wellness programs.

Creating a federal-level Prevention and Public Health Council: The goal of the Council will be to improve coordination among federal agencies to incorporate wellness into national policy and to develop a national strategy with public health goals and objectives for the nation to achieve.

Fourth, Financing Long-Term Services and Supports

Health care reform must ensure that vulnerable populations have access to coverage that meets their needs. For persons with disabilities and seniors with chronic illness, long-term services and supports are their primary unmet health care needs. These are critical to promoting health, preventing illness, and helping people to function independently instead of in institutions. Ten million Americans need long-term services – personal care, assistive technology and other supportive services – a number that will increase to 26 million by 2050. Over 200 million adult Americans lack protection for the costs of long-term services and supports. The nation lacks a coordinated, national public-private system to deliver quality long-term services and supports. Nearly half of all funding for these services is now provided through Medicaid, a burden on states requiring individuals to become and remain poor to receive help.

These are key goals we hope to achieve through long term services and supports:

- Supporting America's workers with a new financing alternative for long term services and supports
- Promoting individual choice and independence through self-determination
- Ensuring fiscally responsible and affordable premiums

- <u>Strengthening Medicaid for those who need it by reducing dependence on Medicaid for long term services and supports</u>

- <u>Retaining the role of private insurance in providing long term services and supports</u>

Supporting America's workers with a new financing alternative for long term services and supports: Through participation in a new voluntary nationwide insurance program, people with disabilities and chronic illnesses will have a cash benefit to pay for and choose the services and supports they need to function and independently.

Financed through voluntary payroll deductions (with Medicare Part B-style enrollment opt-out), this program will remove barriers to independence and choice (e.g., housing modifications, assistive technologies, personal assistance services, transportation) by providing a cash benefit to individuals who become disabled. We will help employers by providing support to persons with disabilities to enable them to work and to working caregivers to help reduce absenteeism and maintain productivity

To qualify for benefits, individuals must have contributed monthly premiums through a voluntary payroll deduction for at least five years. Tiered benefits ($50 - $100.00 per day) will be payable to individuals unable to perform two or more Activities of Daily Living (ADL's) or have the equivalent cognitive impairment.

Promoting individual choice and independence through self-determination: Benefits will be accessed using a "Life Independence" debit card to purchase non-medical services and supports the individual needs to maintain independence at home or in a community residential setting of their choice, including home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, and home care aides. These cash payments avoid bureaucracy and empower consumers to control what services they get, how, where and from whom.

Ensuring fiscally responsible and affordable premiums: The program will be self-funded through participant premiums and will be a primary payer to Medicaid. Premiums will be limited to $65 per month; those with incomes below poverty will pay no more than $5 per month. Younger participants will pay less than older participants, and no one will pay over $65 per month. The Secretary of Health and Human Services, with assistance from the Treasury Board of Trustees and the CLASS Independence Advisory Council, will monitor fund solvency and make recommendations 20 years ahead of time if solvency is in question.

Strengthening Medicaid for those who need it by reducing dependence on Medicaid for long term services and supports: One essential element of reform is ensuring health security. Individuals and families should not go bankrupt in paying for needed care. Reform must help Americans who are forced to pay the highest, catastrophic, out-of-

pocket costs. Under our current system, families impoverish themselves by spending down their life savings before receiving the care they need through Medicaid. This program will offer an alternative and be payer of first resort to Medicaid.

Retaining the role of private insurance in providing long term services and supports: Benefits will cover about half of the current average cost of long term care, retaining a role for private insurance. This balanced public/private structure, with a broad-based public option to "provide a minimum floor of protection", supports the purchase of private insurance wrap-around products – thus creating a flexible way to help families and disabled individuals meet their unique circumstances. Long term supplemental coverage can be made available through the American Health Benefit Exchange.

Fifth, Rooting Out Fraud and Abuse

The National Health Care Anti-Fraud Association estimates that at least three percent of all health care spending – or $72 billion in 2008 – is lost to health care fraud. Other estimates are as high as 10 percent. Fraud committed by providers, medical equipment suppliers, drug companies, and by corrupt plan operators and brokers increases costs for everyone, puts families' security and health at risk, and undermines public trust. The HELP Committee has responsibility for oversight of private health insurance, and our goals seek to advance the rooting out of fraud and abuse in the private sector and to link better private and public sector efforts.

Establishing a Health Care Program Integrity Coordinating Council: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a national Health Care Fraud and Abuse Control Program to facilitate collaboration among federal, state, and local law enforcement. As healthcare reform expands coverage for all Americans, we need broader and more inclusive coordination. We will establish Health Care Program Integrity Coordinating Council (PICC) to provide more effective coordination and strategic planning to address.

Create senior level positions at the Departments of Health and Human Services and Justice to coordinate health care anti-fraud activities: The persons serving in these two positions would serve as the "point persons" for purposes of inter-agency coordination, coordination of program integrity efforts with respect to private plans, and coordination with State-level entities such as insurance regulators and State Medicaid Fraud Control Units.

Address unauthorized and sham health insurance plans: The private health insurance market has serious problems with operators of phony health plans who prey upon small businesses and self-employed individuals by collecting premiums for health insurance

that is non-existent or has insufficient funds to pay claims. Individuals, families, and small businesses, despite having paid thousands of dollars in premiums, are left with unpaid medical bills and uninsured; authorized, licensed insurers are deprived of premium dollars that should have flowed to the legitimate market; state governments are left with uninsured residents who are not eligible to have their claims paid through the state guaranty fund. Under reform, we will deter and punish fraudulent health plans.

Sixth, Establishing Shared Responsibility and Paying Appropriately and Fairly for Reform

Fixing America's health care system will provide real benefits for everyone and every part of our society – patients and consumers, businesses, hospitals, physicians and nurses, community health centers and other providers, health plans, business and labor, and government at all levels. Fixing this will carry a cost – and the only way to make this work is to embrace the principle of shared responsibility. Everyone must take some responsibility to fix the system. That means:

- *Individuals must take personal responsibility to obtain quality health insurance that is affordable to them*: These reforms will only work if everyone takes personal responsibility to obtain health insurance once affordable, meaningful coverage is available. Otherwise, too many will wait until they get sick to obtain coverage, driving up premiums for everyone else. This requirement will include a mechanism to make sure everyone has coverage meeting essential needs.

- *Employers take responsibility to support the health coverage needs of their workers*: Most businesses provide coverage to their workers and already pay more than their fair share. Many U.S. workers must rely on the public sector to provide for their family's health security. Employers, just like individuals, must assume a fair measure of responsibility, especially when their workers can only rely on public coverage for themselves and their families.

- *Health Insurers must assume a different business model focused on meeting the health coverage needs of all Americans*: The health insurance industry must eliminate practices that have been core elements of its business model for decades. Insurers must offer policies that emphasize value to ensure that our health care dollars are spent on providing meaningful and effective care.

- *Medical providers must meet the challenge to reinvent medical care to improve care and to better use our health care dollars:* Hospitals, physicians, nurses, community health centers, home health agencies and all providers must share

responsibility by moving our health care system toward better value and by embracing practices and tools which promote better quality and improve performance.

- *Government at all levels must be part of the solution:* Federal, state, county and local governments all have an important part in a reformed system. Government must focus on those parts of the system in need of improvement, and partner with all system participants to protect and improve what works, and to change what doesn't.