House Policy Committee

Health Subcommittee

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Health Subcommittee Report For 2002

Chairman Ernie Fletcher (R-KY)

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ACKNOWLEDGEMENTS

Thank you to Full Committee Chairman Chris Cox, the Members of Congress who serve on the Health Subcommittee, and their staff. Your continued support and participation in Health Subcommittee briefings, discussions, and legislative initiatives are very much appreciated. Your hard work and contributions are recognized in this report to Republican Members of Congress.

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Some say an ounce of prevention is worth a pound of cure. In this case access to health insurance is the prevention that will cure many problems we face today in our health care system.

Noted businessman and presidential advisor Bernard M. Baruch once stated, "There are no such things as incurables; there are only things for which man has not found a cure." This statement is just as true for problems with America's health care system as it is with disease or affliction.

While we cannot solve all problems overnight, it's important for Congress and the President to work together to provide common sense and creative "cures" for providing affordable, quality, accessible health care for all Americans.

For more information, or if you have any questions, please feel free to contact me or my health care assistant, Holly Rocco, at x54706.

Introduction and Purpose

Along with House Policy Committee Chairman Chris Cox, Health Subcommittee Chairman Ernie Fletcher, M.D., recently held a series of briefings on the problem of the uninsured in America and the need for effective Medicaid reform. Intertwined in these briefings were discussions about the high costs of health care and the need for Medicare reform.

Improving health care for all Americans is a top priority Congress cannot ignore. That improvement in health care begins by ensuring all Americans have access to high-quality, affordable, and accessible care. With 41.2 million Americans lacking health insurance, there is an urgent need to address this problem.

The challenges facing health care in America are daunting but not insurmountable. While we cannot solve all ills overnight, it's important for Congress and the President to work together to provide common sense and creative cures for improving health care to benefit all Americans.

As Republican Members of the House of Representatives we need a vision for patient centered, consumer driven health care reform. At the conclusion of this report, which includes a review of issues and solutions explored by the Health Subcommittee and some facts and figures for your use, is the *"Health Care Pact With America"* developed for draft purposes, to be our collective vision for change.

Americans need a health care market that is more efficient and equitable. A reformed system that changes the way we think about health care, provides the care we need, and changes the way we get access to health insurance coverage will allow us to accomplish our goal of a more cost effective and more accessible, quality health care system.

Working together toward a patient-centered, consumer-driven health care system that will benefit all Americans should be our goal.

RUNAWAY HEALTH CARE COSTS

The problem of rapidly rising health care costs seems to have eclipsed other problems facing our health care system today. It is a problem that poses a struggle for most Americans.

The rise of health care costs

- The United States leads the world in the share of expenditures devoted to health care at 13.4% of our Gross Domestic Product (GDP). Expectations are that health care costs are going to continue to grow, outpacing the economic growth in the years ahead.

- Total health care expenditures will reach a total of $2.2 trillion by 2008.

- Health insurance premiums are rising at an average of 15% per year per participant within all employer-sponsored plans.

- Annual premium increases of 40% and even 50% and/or benefit reductions are typical of what small businesses and their employees throughout the nation are experiencing today.

- On average, workers in firms with less than 10 employees pay 17% more for a given health benefit than workers employed in a large company.

- The overall cost of a hospital stay nearly quadrupled between 1965 and the late 1980s (Medicare Watch).

- As reported in the National Journal's Congress Daily (9/26/01), a study by the Center of Studying Health System Change "found that increases in both inpatient and outpatient hospital spending accounted for 47% of 2000s overall 7.2% increase in health care costs.

The paradox of high health care costs in America

- We have a very strong health care system. In fact, much of the economic growth in recent years can be attributed to this section of our economy. Our high-tech industries are connected with health care developments that have been the foundation of American economic growth.

- The U.S. is leading the world in the development of new drugs, new devices, and new ways of delivering care. In fact, the U.S. has more Nobel prizes in medicine than all other countries combined.

- The U.S. leads the world in developing information systems to provide better access to information that patients and doctors need to make decisions about their health care.

- But these improvements come at a cost. These innovations in medical treatments and technologies are the largest catalyst of health care costs in the U.S. Other cost drivers are higher prices for drugs; doctors' care; medical liability; and, waste, fraud, and abuse.

- The value of our health care improvements exceeds its cost to the economy by as much as half. After a decade of cost control through managed care and attempts to control prices in the public sector, health insurance premiums are rising at double digit rates; federal and state expenditures on public programs are also rising.

Results of rising health care costs

- Due to the innovations in our health care system, life expectancy has increased in the last decade. For people born in 1990, life expectancy is seven years longer than it was in 1950. Mortality rates from all heart diseases have declined by 40% over the last 20 years. Disability among the elderly has decreased 20% in the last two decades.

- There remain real disparities in access, affordability, and quality of care. This presents us with a challenge and some significant opportunities to improve our health care system and to better our past record.

Solutions to rising health care costs

- While medical innovation is the backbone of our health care system, we can still address inefficiencies in the market for prescription drugs, the quality of care, the medical liability system, and reduce waste, fraud, and abuse.

- We must improve choice and competition. There is a role for the government in this vision, but it is not to tell people what health care they should or should not get, and it is not to decide how doctors can and can't treat patients. The role of government is to promote innovations that will help us accomplish the goal of improving access, choice, competition, affordability, and quality.

- By giving individuals the choice and personal responsibility they currently lack in our system, costs will decrease and care will improve. Patients will control the health care system and will truly get the most value for their health care dollars they spend. This health care system we should construct puts patients first. The end of this report details more solutions.

Medical Liability Reform can be one part of the solution

- H.R. 4600, The HEALTH Act, is a commitment and guarantee to provide quality, affordable, and accessible health care for all citizens. According to several sources, the high cost of health care is directly linked to the high cost of frivolous lawsuits.

- This legislation, which passed the House by a bipartisan vote of 217 - 203 (Roll no. 421), seeks to return hospitals and health providers to the practice of sustaining life, preserving health, and preventing disease.

#1: LAWYERS PROFIT FROM FRIVOLOUS LAWSUITS

- 57% of medical liability premiums go toward attorneys' fees.

- Nearly 70% of all medical liability claims result in NO payment to plaintiffs. The median cost of defending such a case--one where the jury rules the defendant not guilty--was $66,767 in 2001.

- Plaintiff injury lawyers win only 20% of those cases that do go to verdict. As proven time and again, trial lawyers don't have to win often, because when they do they win big (i.e. medical liability, product liability, and tobacco suits).

- The median medical liability award in 1999 was $800,000 and the mean medical liability award in 2002 was $3,495,354, up 34% in only three years. Million dollar verdicts increased 45% for the years 1998-1999, up from 39% from the prior year.

- Plaintiff attorneys' contingency fees range from 33% to 50% routinely (1994 data).

#2: FRIVOLOUS LAWSUITS IMPACT PATIENTS AND QUALITY HEALTH CARE INCLUDING:

- The cost of defending medical liability claims has increased 268% for all claims, from a liability claim where no indemnity is paid has increased 297%, from $5,052 in 1985 to $20,045 in 1998. The estimate for claim expenses nationwide for claims closed without indemnity payment from 1985-1998 was more than $4.7 billion. This leads to an estimated national statistic of more than $3 billion paid to defend meritless claims in that 14 year period.

- According to a Physician Insurers Association of America (PIAA) data sharing project, 61% of medical liability claims filed in 1998 were either dropped, withdrawn, or dismissed. Of the claims that went to trial in 1998, it cost the defense $33,492,740. According to PIAA, the average cost of defending a claim in 1998, regardless of outcome, was $24,669. The average expense of a claim that had no indemnity was $20, 045. The cost of defending a claim has risen faster than the cost of inflation over the last 14 years and has risen at a greater rate than the indemnity to the patient.

- The previous data demonstrates the inefficiency of the current medical liability compensation system, where it requires $2.00 to deliver $1.00 in compensation to the injured party. The people benefiting most from the current system are the attorneys.

- Medical liability insurance rates increased in more than 12 states by as much as 81%.

- Medical liability premiums are the third largest expense incurred by physician practices, exceeded only by payroll and office space costs.

- According to Dr. Mark McClellan, nominee for FDA Administrator, current Member of the President's Council of Economic Advisors, and former Stanford economist, in his study "Do Doctors Practice Defensive Medicine," published in *Quarterly Journal of Economics*, defensive medicine costs $50 billion a year – and medical liability reform could lead to reductions of this cost – without serious, adverse consequences to patients.

- A recent study by the American Academy of Actuaries reports that a comprehensive medical liability insurance reform package containing a non-economic damage cap of $250,000, which H.R. 4600 provides, would achieve significant savings in medical liability costs. This

would set more definite parameters for awards based on objective evaluation of past and future economic losses of the plaintiff.

- The Institute of Medicine study suggests that the delivery of obstetrical care in all rural areas is seriously threatened by professional liability concerns.

- Some specialists such as Orthopaedic Surgeons have seen their premium rates raised by 200% – 300%—even without ever having a claim filed against them. Serious consequences result such as: the inability to recruit physicians to teaching hospitals, doctors retiring or moving to other states, physicians practicing defensive medicine rather than caring for their patients, and hospitals and trauma centers are closing their doors. All these consequences lead to a lack of accessible, affordable, quality health care.

- It is estimated that frivolous lawsuits drive up the cost of government health programs by over $25 billion every year. Medical liability reform is a national problem that requires a national solution.

- This problem particularly affects women and their health, as Ob-Gyn is one of the specialties most affected by the rise in premiums.

- The impact of rampant litigation is astounding. A recent study of long term care litigation costs conducted by AON Risk Consultants found: 1) Almost half of total claim costs paid for liability claims in long term care suits is going directly to litigation costs. 2) National liability costs are now TEN times higher than they were in the early 1990s. 3) Liability costs have absorbed 20% of the increase in the national average Medicaid reimbursement rate from 1995 to 2000.

#3: HOW MEDICAL LIABILITY LAWSUITS AFFECT STATES:

- Prior to enactment of $250,000 ceiling on non-economic awards in California, the state had the highest liability in the United States. Now its premiums are one-third to one-half of the cost compared to states without limits.

- There was a 125% increase in malpractice cost in California versus a 425% increase in the U.S. over same period of time.

#4: THE PUBLIC WANTS QUALITY HEALTH CARE – NOT FRIVOLOUS LAWSUITS.

- According to a recent public opinion study by Wirthlin Worldwide–conducted April 5-9th 2002:

- 78% AGREE that access to care is being impacted as Doctors and Health Care professionals leave their practices due to rising liability costs.

- 71% AGREE that one of the primary reasons health care costs are rising is because of medical malpractice lawsuits.

- 76% FAVOR a law limiting the percentage of a clients settlement or award a personal injury trial lawyer can receive in fees.

- 73% FAVOR a law that guarantees full payment for lost wages and medical expenses, but limits the amount that can be awarded for "Pain and Suffering" in medical malpractice cases.

#5: H.R. 4600, THE HEALTH ACT SUPPORTS PATIENTS, HOSPITALS, AND HEALTH CARE PROVIDERS AND NOT TRIAL LAWYERS:

- We need to keep in mind that everyone is entitled to full compensation for his or her actual losses, medical bills, and wages. Punitive damages under the HEALTH Act would be two times economic damages; which are not capped, or $250,000, whichever is greater.

- A cap on non-economic damages in no way takes away a patient's right to sue in the event of a medical injury.

- No other developed country compensates victims of health care injuries as generously for non-economic losses.

- At a time when the nation's Medicaid program is under increasing pressure to serve more and more Seniors with fewer dollars, it makes no sense to see an ever-increasing amount of scarce Medicaid dollars drained to cover growing lawsuit costs, rather than being used towards improved patient care.

- Taxpayers who expect their sizable federal income tax bill to go towards improving the public good – in this case, improved patient care for Seniors – need to be aware that the nation's trial lawyer community is increasingly siphoning into their own pockets these federal dollars meant for Seniors.

#6: IMPORTANT THEMES

- Access to care is seriously threatened in states such as Florida, Georgia, Mississippi, Nevada, New Jersey, New York, Ohio, Pennsylvania, Texas, Washington, and West Virginia where out of control liability has reached crisis levels. Many other states may soon follow.

- If opponents really looked at this bill they would see that the trial lawyers' clients are more fairly and more quickly compensated under this bill. It should become law.

- Our patchwork of state liability laws and runaway awards impacts everyone, especially:
  - Women and children and the unborn child,
  - Nursing homes and their residents,
  - Rural hospitals, all hospitals, and the people who receive care in them, and
  - Trauma victims.

- Our patchwork of state liability laws and runaway awards are causing health care costs to rise.

THE PROBLEM OF THE UNINSURED

The Health Policy Subcommittee held a series of meetings on the Uninsured in America (Dec. 5, 2001, Dec. 10, 2001, and Feb. 14, 2002). The first focused on identifying the uninsured and the effect that the large number has on health care policy and public health. The second provided an overview of legislative approaches to reducing the number of uninsured. The final meeting considered provisions in the President's FY2003 budget that would affect the uninsured population.

Snapshot:

- According to 2001 data issued by the U.S. Census Bureau in September 2002, there were 41.2 million uninsured Americans, or 14.6% of the population. This number reverses two years of improving rates. In 2000, there were 38.7 million uninsured Americans. The Census Bureau report says this increase was caused by a "combination of rapidly rising health care costs and a weak economy." In a post-September 11th world and with higher unemployment rates than in 2001, it is expected that the number of uninsured will rise even higher.

- Based on three-year averages, the proportion of people without health insurance ranged from around 7.2% in Rhode Island and Minnesota to around 23.2% in New Mexico and Texas. Based on two-year moving averages, the proportion of people without coverage fell in 14 states and rose in nine between 2000 and 2001.

- 11.7%, or 8.5 million children remained uninsured (there was no change) from 2000.

- 14.4 million low-income Americans (below $25,000 in income) had no health insurance (up from 14.0 million in 2000).

- 6.83 million African-Americans had no health insurance (up from 6.68 million in 2000).

- 12.4 million Hispanic-Americans lacked insurance (up from 11.8 million in 2000).

- Employment-based coverage is the primary vehicle for health insurance in the United States. However, the number and percentage of people covered by employment-based health insurance dropped in 2001, from 63.6% to 62.6%. Of the newly uninsured, companies who have 25 employees or fewer employ most of them. Small businesses employ more than 60% of the uninsured. Association Health Plans should be signed into law so that small businesses, as members of trade associations, can pool together to get more affordable, quality, accessible health insurance.

- A serious effort by Congress is needed to reform the individual insurance market place in order to reduce the number of uninsured. As we look at the possibility of offering tax credits for the purchase of health insurance on the individual market, it is important to ensure more viable health insurance options for consumers.

According to the September 2002 Current Population figures:

- 41.2 million Americans were without health insurance for all of 2001 (14.6%). This increase reverses a trend of two consecutive annual decreases in the uninsured rate. The previous year the uninsured rate was 38.7 million and the year before that there were 39.3 million uninsured Americans.

- The proportion of people who received health coverage through their jobs fell from 63.6% in 2000 to 62.6% in 2001, a difference almost entirely attributable to a decline in employer-sponsored health coverage at businesses with 25 employees or fewer.

- Considered by age, the percentage of uninsured people increased among those ages 25 to 64 but not among "very young" workers, who typically have lower rates of coverage.

- 62.6% of Americans in 2001 were covered by employment-based plans--a 1% decrease from 2000. 70.9% of Americans in 2001 were covered by the individual market, which represents a 1.1% decline—this number largely reflects the decline in employment-based coverage.

- Compared with 2000, the proportion of workers who had employment-based policies in their own name fell for workers employed by firms with fewer than 25 employees, but was unchanged for those employed by larger firms.

Medicaid and SCHIP—the figures demonstrate that SCHIP is working but that States have not taken advantage of the full flexibility SCHIP provides:

- The percentage of children uninsured dropped from 12.6% in 1999 to 11.7% in 2000 and remained at 11.7%, or 8.5 million children, in 2001.

- While most children (68.4%) were covered by an employment-based or privately purchased health insurance plan in 2001, nearly 1 in 4 (22.7%) were covered by Medicaid in 2001.

- 25.3% of Americans in 2001 had government insurance—an increase from 24.7% in 2000. In 2001, 11.2% of Americans were enrolled in Medicaid—up from 10.6% the previous year. Despite the Medicaid program, 10.1 million poor people, or 30.7% of the poor, had no health insurance in 2001. The uninsured poor comprised 24.5% of all uninsured people.

- Among the near-poor (those with a family income above poverty but less than 125% of the poverty level), 26.5% (3.3 million people) lacked health insurance in 2001. This percentage is unchanged from 2000 and is an increase from 24.7% in 1999.

- Private health insurance among the near-poor declined in 2001, from 40.3% to 37.8%—their rate of government insurance did not change from 2000, it was 47.1% in 2001.

- Children 12 to 17 years old were more likely to be uninsured (13.1%) than those ages 6-11 (11.2%) and under 6 years old (10.7%).

- 22.7% of all children were covered by Medicaid/SCHIP. Of those, 38.3% were black, 34.9% were Hispanic, 18% were Asian and Pacific Islander, 19.4% were white, and 15.3% were white non-Hispanic.

Employment-Based Coverage:

- Small businesses employ roughly 68% of the uninsured.
- Of the 142.6 million workers in the United States who were 18 to 64 years old, 56.3% had employment-based health insurance coverage *in their own name* in 2001.
- 37% of all Americans had employment-based health coverage.
- 17% of workers aged 18 to 64, who worked during the year, had no health insurance.
- 16% of workers aged 18 to 64, who worked full time, had no health insurance.
- 22% of workers aged 18 to 64, who worked part time, had no health insurance.
- Only 35% of small, low-wage firms (where 1/3 of the workers make less than $20,000 a year) offer their employees benefits; compared to 85% of small higher-wage firms (where less than 1/3 of the workers make less than $20,000 a year) in 2000.
- 31.3% of workers age 18 to 64 that worked in businesses with less than 25 employees had employment-based health insurance coverage in 2000.
- 56.8% of workers age 18 to 64 that worked in businesses with 25 to 99 employees had employment-based health insurance coverage in 2000.
- 65.3% of workers age 18 to 64 that worked in businesses with 100 to 499 employees had employment-based health insurance coverage in 2000.
- 67.8% of workers age 18 to 64 that worked in businesses with 500 to 999 employees had employment-based health insurance coverage in 2000.
- 69.6% of workers age 18 to 64 that worked in businesses with 1,000 or more employees had employment-based health insurance coverage in 2000.
- 68.4 % of children in 2001 were covered by employment-based coverage or privately purchased insurance, compared with 70.5% of children in 2000.

State high-risk pools: the purpose they serve, experiences with them, and their importance:

- State high-risk health insurance pools are programs that states initiate as safety nets to guarantee that everyone has an opportunity to purchase health insurance protection, regardless of their health conditions. Risk pools keep the individual insurance market viable for more companies to compete and will continue to evolve as they have for the past 24 years as a means to provide cost effective guaranteed access to insurance.
- State high-risk health insurance pools and similar state programs serve the so-called "uninsurable" population—those with pre-existing conditions that make it difficult to obtain affordable private health insurance coverage.

- Enrollment in all of the 28 state risk pools in operation through June 2002, totaled 153,351 up more than 20% from 127,406 reported last year (up almost 13% from a year before that).

- New Hampshire's new pool began operation in July 2002, and Maryland's will begin in July, 2003.

- Total medical claims paid by all the risk pools for 2001 was just over $840 million (up 26% from a year earlier). Program administration costs reported were just over $51 million. Total premiums earned were just under $491 million.

- Sharp increases in health care costs have led to rising claims and increased funding pressures for risk pools, particularly for those that rely on annual state appropriations (i.e. Louisiana and Illinois).

- There is more interest than ever in new, broader-based ways to fund pool subsidies. More states are spreading the funding of the pools over a more inclusive base, and are interested in creating low-income premium subsidy programs. Recently, Montana and Utah took these steps.

- Affordability and competitiveness are a major concern for all health insurance markets, but particularly for the individual insurance markets.

- Risk pools are a way to guarantee access and help provide more stability in the individual market.

- Different factors affect growth in enrollment in different states. Some of the factors include continued growth in federally eligible portability enrollees under HIPAA and the high costs of small employer coverage, which moves people into the individual market.

- States want to set up risk pools or expand them, but in many cases lack the funding. Arizona, North Carolina, and Florida are among those states. Congressman Fletcher worked to get language in the budget resolution that states, "It is the view of the Committee that grants to the States for the establishment of health insurance risk pools merit serious consideration." Congressman Fletcher also introduced H.R. 4170 that would do this and is endorsed by various groups.

The President's FY2003 $489 billion budget (outlays) for HHS included provisions to address the uninsured:

- $89 billion in tax credits that provide up to $3,000 in benefits to individuals for purchasing health insurance.

- The extension of SCHIP funding so that states do not lose unspent funds.

- Increased access to health insurance through health credits and expanded eligibility under the State Children's Health Insurance Program (SCHIP) and Medicaid programs, in addition to his long-term goal of doubling the number of community health centers nationwide.

On October 1, 2002, the House passed H.R. 3450, the Health Care Safety Net Improvement Act by a voice vote. The Senate passed S. 1533, the Health Care Safety Net Improvement Act of 2002, by unanimous consent on April 16, 2002. The House and Senate reached a compromise during an informal conference on S. 1533. The House passed an amended S. 1533 on October 16, 2002, by a 392-5 vote margin:

- This legislation reauthorizes and strengthens the country's key safety net programs, as well as provides the Secretary with the necessary flexibility to effectively and efficiently improve and expand access to health care services for the under-served. Specifically, the legislation provides for the five-year reauthorization of the Community Health Centers (CHC); National Health Service Corps (NHSC); and grants for rural health care programs.

The Trade Act of 2002; Public Law 107-210:

- Included language to strengthen the state high-risk pools and assist states that don't have a risk pool with starting one, similar to provisions in a bill (H.R. 4170) Chairman Fletcher introduced to address the needs of the uninsured and under-insured.

- The Trade Act includes seed grants of up to $1 million to each state that has not created a qualified high-risk pool for the state's costs of creation and initial operation of such a pool. In the case of a state that has established a qualified high-risk pool, the bill provides matching funds to states that agree to: keep the premiums at or below 150% of the premium for applicable standard-risk rates; offer a choice of two or more coverage options through the pool; and have a mechanism reasonably designed to ensure continued funding of losses incurred by the state after the end of fiscal year 2004 in connection with the operation of the pool.

- Some Members have introduced legislation that would extend the $40 million in annual matching funding provided for in The Trade Act through 2009. Rather than just extending funding, however, we must ensure that the Centers for Medicare and Medicaid Services (CMS) is properly implementing the risk pool provisions. Continued oversight of the regulatory process and state implementation of the provisions are necessary for Congress to ensure the intent of the law is being followed.

Additional Information:

The New England Journal of Medicine article, "Lack of Health Insurance and Decline In Overall Health in Late Middle Age," October 11, 2001:

Elderly Morbidity –

1. In the general population, persons without health insurance have a higher mortality rate than persons with private insurance.

2. There is an increased risk in adverse health outcomes among the uninsured participants in the study regardless of sex, race, and income—and this is consistent with the results of a previous study.

3. The increase in the risk of a major decline in health for the uninsured was greater among participants who were in better health.

4. Recent studies show that intermittently uninsured persons were less likely than others to have a primary care provider, more likely to delay seeking care, and more likely to go without needed care.

5. Conclusion of article: the lack of health insurance is associated with an increased risk of a decline in overall health among adults 51 to 61 years old.

"Empowering Health Care Consumers Through Tax Reform;" edited by Grace-Marie Arnett of the Galen Institute, contains a collection of essays by a group of leading health policy analysts who are primarily members of the Health Policy Consensus Group. In this peer-reviewed book, published by the University of Michigan Press, the authors explore the intersection of health and tax policy to offer a road map for reform and a vision of a revived free-market health care system. The volume also includes essays with perspectives of political, union, and medical leaders. In addition, the book contains the names of nearly 350 health economists and other health policy experts, including several Nobel Prize winners, who signed a petition circulated in 1995-96 expressing their support for reforming the tax treatment of employment-based health insurance.

"Market Driven Health Care: Who Wins, Who Loses in the Transformation of America's Largest Service Industry," by Regina Herzlinger, Harvard Business School, Perseus Books, Reading, Massachusetts, 1997. A review by Senator Bill Frist states that this book is "a provocative analysis, which will allow health policy makers in the public and private sector to regain their confidence in the ability of the market to deliver higher-quality, cost-effective care." Another review by the inventor of the kidney dialysis machine and professor of medicine and surgery at the University of Utah, William Kolff, M.D., Ph.D. states, "Regina Herzlinger fearlessly analyzes what is wrong in health care. She mercilessly exposes greed, lack of compassion, and resistance to change. She argues that the free market system will finally correct our system if it is consumer controlled. I hope she prevails."

Four Kaiser Family Foundation reports demonstrate how specific changes in the unemployment rate affect both the number of uninsured Americans and the demand for Medicaid coverage:

- "Medicaid Spending Growth: Results from a 2002 Survey"

http://www.kff.org/content/2002/4064/4064.pdf
The report presents the findings of a 50-state survey of Medicaid directors, identifying state Medicaid spending trends and how states are responding to them for FY2003 budgets.

- "Medicaid Matters For America's Families"

http://www.kff.org/content/2002/20020930/930brief.pdf
Twelve years ago, the U.S. Congress passed the law requiring that by the end of FY2002, states would complete a series of incremental steps to ensure all children in families with incomes at or below the federal poverty line would have Medicaid coverage. The day, September 30, has arrived, and the Commission put together a brief description of how Medicaid assists low-income American families with their health coverage.

- "Rising Unemployment and the Uninsured"

http://www.kff.org/content/2001/6011/6011.pdf
Examines the relationship between the unemployment rate and increases in uninsured and finds that **for every percentage point increase in the unemployment rate, 860,000 people will**

become uninsured. This suggests for example that 1.2 million more non-elderly Americans became uninsured due to the rise in unemployment (1.4 percentage points) between December 2000 and October 2001.

- "The Impact of Rising Unemployment on Medicaid"

http://www.kff.org/content/2001/4026/4026.pdf
Illustrates the relationship between rising unemployment and increased Medicaid enrollment and spending. According to this new analysis, **an increase in the unemployment rate from 4.5% to 5.5% would be likely to increase Medicaid enrollment by 1.6 million Americans and state Medicaid spending by $1.2 billion.** These projections reflect increases in Medicaid coverage as more people lose both jobs and income and move into the lower income groups that qualify for coverage.

NASCHIP, National Association of State Comprehensive Health Insurance Plans
http://www.naschip.org/
"Comprehensive Health Insurance for High Risk Individuals: A State by State Analysis," Sixteenth Edition, 2002/2003.

Communicating for Agriculture and the Self-Employed
http://www.selfemployedcountry.org/.
For 29 years, CA has been an advocate for rural consumers on health care issues, for health insurance affordability, and for ability of everyone to purchase health insurance protection. CA has supported the state high-risk pools and serves as an advocate and information source for the public.

"Abolishing the Medicaid Ghetto: Putting 'Patients First," report by the American Legislative Exchange Council (ALEC), 2002.
http://www.alec.org/
More than a quarter century ago, a small group of state legislators and conservative policy advocates started ALEC. The mission of the American Legislative Exchange Council is to advance the Jeffersonian principles of free markets, limited government, federalism and individual liberty among America's state legislators.

A BROKEN MEDICAID SYSTEM IN NEED OF REFORM

The Health Policy Subcommittee held a series of meetings on the need to reform Medicaid (June 6, 2002, June 12, 2002, and June 18, 2002) with officials from the Department of Health and Human Services, including Bobby Jindal, the Assistant Secretary for Planning & Evaluation, and Dennis Smith, the Director of State Operations at CMS.

The first briefing provided a broad overview of Medicaid's financial structure, the Medicaid benefit package, and trends in Medicaid. The second reviewed Administration waivers and the different ways states are approaching reform and addressing financial problems. The final meeting considered several innovative approaches to Medicaid reform which Congress, states, and the Administration can undertake.

The purpose of these meetings was to:

- Help develop majority policy on Medicaid reform, and
- Pave the way for legislation to improve service for Medicaid beneficiaries

Highlights:

- In 1967, Medicaid was a $1 billion program. In 2001, Medicaid cost approximately $226 billion ($130 billion federal share) and covered 40 million Americans. Medicaid will cost roughly $280 billion ($159 billion federal share) in 2003.
- 10% of Medicaid beneficiaries are elderly, 17% are disabled, 50% are children, and 23% are non-disabled adults.
- Medicaid covers one-fourth of the nation's children and is the largest single purchaser of maternity care and nursing home/long-term care services. The elderly and disabled comprise one-third of Medicaid beneficiaries but account for two-thirds of Medicaid spending.
- The State Children's Health Insurance Program (SCHIP) was established in 1997. It makes available approximately $40 billion over 10 years for states to provide health care coverage to low-income, uninsured children. Approximately 4.6 million children were enrolled in SCHIP programs in 2001. SCHIP gives states broad flexibility in program design while protecting beneficiaries through federal standards. *Unfortunately, this broad flexibility remains largely untapped*. Some of the innovative ways states have implemented SCHIP could be used as a model for broader change.
- Medicaid spending varies from state to state. Three states (NY, CA, and TX) account for approximately 30% of the total Medicaid and SCHIP spending. Nine states (NY, CA, TX, PA, FL, OH, MI, IL, and NC) account for approximately 53% of Medicaid and SCHIP spending.
- States can provide optional services under Medicaid beyond those that are federally mandated. These optional state services account for a larger share of Medicaid spending than the mandatory services, and thereby account for some of the expenditure disparities between states. Other factors contributing to state by state disparities in Medicaid spending include:

- The ability of states to contribute more to their programs,
- Different state eligibility requirements and admission criteria,
- Different numbers of prescription drugs allowed per person in each state, and
- Different state shares of payments to disproportionate share hospitals

Facts and Figures:

- Medicaid is the second largest item in most states' budgets (next to education), often representing up to a quarter of all expenditures.
- Medicaid spending increased 3% to 4% in 1996 to 1997 and 1997 to 1998 due to welfare reform's impact on eligibles, but greater spending will occur. Congressional Budget Office (CBO) estimates 7.8% increase to 2009.
- It has been estimated that Medicaid's long-term care costs will at least quadruple by 2020, leaving no money for other state programs.
- State-run Medicaid programs are in big trouble. Last year, 37 states spent more on Medicaid than they had budgeted--$410 million in Indiana alone--and 20 states anticipate shortfalls in this year's spending.
- The National Cancer Institute reports that women on Medicaid are three times more likely to die from cancer, than women who aren't on Medicaid. The Institute also found that women on Medicaid were 41% more likely to be diagnosed with breast cancer "at a late stage" and 44% less likely to receive radiation treatment.
- The federal share of Medicaid ranges from 50% to 77%, with an average match rate of 57%. SCHIP matching rates vary from 65% to 85%. About $3.2 billion is available to states for SCHIP programs in addition to almost $11 billion in unspent funds from previous years. According to HHS, more than 1 million additional people have gained Medicaid or SCHIP coverage since January 1, 2001.
- 25.3% of Americans have government insurance (Medicare, Medicaid, and Military). Of those 11.2% of Americans are enrolled in Medicaid. Although Medicaid insured 13.3 million poor people, 10.1 million others still were uninsured.
- Among the near-poor, 26.5% (3.3 million people) lacked health insurance in 2001. This percentage is unchanged from 2000 (up from 24.7% in 1999).
- Among low-income Americans (below 200% of poverty), Medicaid covers 40% of children and 17% of nonelderly adults.
- Medicaid covered one in four children in 2001. In addition, over 2 million children are enrolled in SCHIP. Nearly all low-income children are eligible for Medicaid or SCHIP, but 21.6% remain uninsured.

- Children 12 to 17 years old were more likely to be uninsured than those under 12—13.1% compared with 11.0%.

- Of the 22.7% of all children were covered by Medicaid/SCHIP, 35.3% were black, 34.9% were Hispanic, 18.0% were Asian and Pacific Islander, 19.4% were white, and 34.9% were white non-Hispanic.

The Future of Medicaid

- As baby boomers age, long-term care costs could sink some Medicaid programs by 2010 and almost all by 2030. It has been estimated that Medicaid's long-term care costs will at least quadruple by 2020.

- State Medicaid spending will crowd out spending for every other state program in twenty years and is unsustainable in its current form, says a new report by the American Legislative Exchange Council (ALEC), "Abolishing the Medicaid Ghetto: Putting 'Patients First.'"

- To avert a fiscal disaster, Congress should give states greater responsibility for implementation and administration of Medicaid and mandate a change from Medicaid's welfare-entitlement-style structure to a consumer-driven structure with flexible markets and choices with a greater emphasis on patient education.

- Medicaid reform is the Welfare reform of this decade. Congress needs one Governor to become to Medicaid reform what former Gov. Tommy Thompson, now Secretary of Health and Human Services, was to Welfare reform. The opportunity is there. The need is real. The process is known. Reform alternatives exist.

The Administration's Waivers

- The Administration provides several waivers including, Pharmacy Plus, Independence Plus, and Health Insurance Flexibility and Accountability (HIFA). Some of their goals are to:

  - Expand access to health care coverage for low-income individuals,

  - Increase access to assistive and universally designed technologies,

  - Integrate Americans with disabilities into the workforce,

  - Provide guidance for states to create programs that allow people with disabilities to plan, obtain, and sustain community based services, and

  - Provide guidance to states on how to develop programs within existing federal requirements.

- 16 states have taken advantage of the Administration's waivers and implemented comprehensive health care reform demonstrations as of 12/31/2001.

- CMS pointed to Tennessee's NEW TennCare plan as a model under the 1115 waiver program. It is a statewide 5-year program that includes mandatory Medicaid services, Medicaid assistance, and a pharmacy benefit for the elderly. TennCare provides health care benefits to Medicaid beneficiaries, uninsured residents, and those with medical conditions

that make them uninsurable. The plan emphasizes preventative care by providing it to adults and children without co-payments or deductibles. Nine managed care organizations (MCO) contract with providers on a fee-for-service or capitation basis. Participants with incomes over the federal poverty level pay graduated premiums so that payments increase with income.

- CMS mentioned Utah's program as another model program. It is a combination of private coverage and Federally Qualified Health Center (FQHC)-based, but is moving more toward FQHC. The program provides differential benefit packages and covers primary care and preventative services. The waiver is unique in that it requires Medicaid clients living in urban counties to select an MCO that provides--through an ongoing patient/physician relationship--primary care services and referral for all necessary specialty services. In the rural areas of Utah, Medicaid clients are offered the selection of a Primary Care Provider or MCO, when available; traditional fee-for-service remains an option, as well. Services not covered under the waiver are provided under fee-for-service. The State arranges for an annual independent review of the quality of services delivered under each MCO contract. HealthInsight, the federally designated Peer Review Organization for Utah, performs the review.

Chairman Fletcher has outlined the following principles which should remain the focus as we work with the Administration and the states:

- Put patients first,
- Promote patient satisfaction and responsibility,
- Allow provider participation,
- Encourage patient and provider education,
- Allow patient choice in plans,
- Encourage flexible benefit packages tailored to patient need,
- Focus resources on the truly needy,
- Promote Medicaid best practices,
- Reduce bureaucracy and the number of bureaucrats,
- Reduce waste, fraud, and abuse, and
- Ensure Medicaid remains solvent in the future

Conclusion:

- Congress and the Administration must examine ways to move Medicaid away from institutionalized care and toward home and community-based care.
- Congress must look at ways to stabilize and reform long-term care because without substantial changes, it will collapse Medicaid.

- Improper utilization, lack of preventative services, and lack of general education about Medicaid are problems we need to overcome.

- As the Administration continues with the waiver approach, Congress should be supportive, but must also exercise its essential oversight duties to ensure accountability, program integrity, and that the programs meet principles and objectives consistent with those previously discussed.

- Personal responsibility needs to be encouraged in plan design and implementation. For example, many dentists do not participate in Medicaid because of the high level of missed appointments. Missouri's "three strikes, you're out" plan--incorporating personal responsibility--could serve as a model for curbing this problem.

- The Medicaid Commission and the provision to buy out the dual eligibles' drug costs in the recent House-passed prescription drug bill, H.R. 4954, are good steps forward--but they are just a small part of the reform process.

- Chairman Fletcher has laid out a set of principles and discussed them at the subcommittee briefings and with the Energy and Commerce Committee. These principles should be adopted to guide Congress through Medicaid reform.

Next Steps:

- Chairman Cox and Subcommittee Chairman Fletcher will continue to work with Energy and Commerce Committee on Medicaid reform and Medicaid reform legislation.

- Continuation of Briefings in Health Policy Subcommittee: Governor Engler has discussed the need for reform, and other Governors have been invited to discuss ideas and actions.

- Chairmen Cox and Fletcher are working on the development of a Medicaid GOP Communications Plan which will guide Congress and work to inform the public of the need to support the GOP Medicaid reform principles and an eventual plan.

MEDICARE MODERNIZATION TO MEET SENIORS' HEALTH CARE NEEDS IN THE 21ST CENTURY

Medicare has provided an invaluable service to Seniors since it was founded in 1965. The program has provided a safety net for Seniors--an assurance that the health care needs of older Americans and individuals with disabilities would be addressed. But more work remains to be done. Chairman Fletcher and many GOP Members have supported improving the Medicare program, reducing fraud and abuse, and making the program more responsive to the needs of Seniors.

Facts and Figures:

- Of the 40 Million beneficiaries, 34 million are 65 and older, 6 million are younger disabled persons.

- 87% of Medicare Beneficiaries have some form of prescription drug coverage (whether through employer-sponsored (33%), Medicare HMO (17%), Medigap (24%), Medicaid (11%), other public (2%) based on 1999 figures, which are most recent).

- Only 13% of Medicare beneficiaries lacked drug coverage in 1999.

- 44% of Medicare beneficiaries have incomes below 175% of the federal poverty level

- The GOP prescription drug plan provides catastrophic coverage to about 10% of Medicare beneficiaries, and these beneficiaries make up about 20% of the expenditures.

- 2002 Poverty Levels:

Single Beneficiary
100% of poverty: $8,860
150% of poverty: $13,290
175% of poverty: $15,505

Married Beneficiaries:
100% of poverty: $11,940
150% of poverty: $17,910
175% of poverty: $20,895

- Medicare expenditures as a percentage of GDP are projected to increase rapidly, from 2.4% in 2001 to 5% by 2035, and then to 8.6% by 2076.

- Medicare covers 10 preventive services: 3 types of immunizations including: Pneumococcal, Hepatitis B, and Influenza, and 7 types of screening including: Cervical cancer, Breast cancer, Vaginal cancer, Colorectal cancer (fecal-occolt blood test, sigmoidoscopy, and colonoscopy), Osteoporosis, Prostate cancer, and Glaucoma.

- According to a recent General Accounting Office (GAO) report (GAO-02-422, April 2002), "While the use of preventive services offered under Medicare has increased over time, use of

these services varies widely by service and state. It also varies by ethnic group, income, and education."

- CMS is implementing interventions in all states through its Quality Improvement Organizations, formerly Patient Review Organizations (PROs) as GAO refers to them, to improve access mainly to three preventive services—immunizations against flu and pneumonia and screening for breast cancer.

- CMS is also sponsoring PRO interventions and educational projects in each state to increase use of Medicare preventive services by minorities and low income beneficiaries.

- In comments to GAO, CMS suggested that GAO only looked at activities by the PROs and did not review other CMS activities. CMS goes on to list several activities they are currently undertaking to encourage the use of Medicare preventive services.

Conclusion:

- On June 28, 2002, the House passed H.R. 4954, a bill that will improve Medicare and add a prescription drug benefit under Medicare.

- In 1995, the Medicare program was expected to be bankrupt by the year 2002, perhaps sooner, depending on economic conditions. Today, Medicare is projected to be solvent until the year 2030. This is an improvement, but more work remains to improve the program for Seniors and to protect the program's long-term solvency.

- To help modernize the Medicare program, Chairman Fletcher and many GOP Members strongly support adding a prescription drug benefit to Medicare that will not hurt the long-term solvency of the program or put our children and grandchildren deep into debt. Under this voluntary plan, Seniors can either stay in the plan they have now or choose between at least two plans offered by Medicare. Under the Democrat plan, Seniors are herded into a one-size-fits-all government plan that will lead to the rationing of medicine and stifle innovation. The GOP plan, will reduce drug costs by up to 44% and contains catastrophic coverage and full coverage for low-income Seniors to protect those with high out-of-pocket drug costs.

- An ounce of prevention is worth a pound of cure. For this reason, Chairman Fletcher and many GOP Members have sponsored, cosponsored, and voted for legislation to expand the preventive benefits that are covered under the Medicare program, including: screenings for breast and prostate cancer, diabetes self-management, expanded immunization outreach programs, and bone mass measurement coverage to help alleviate osteoporosis.

- We must preserve our rural health care safety net. Chairman Fletcher and many GOP Members have sponsored, cosponsored, and voted for legislation to ensure that our Seniors continue to have access to needed hospital, home health, and nursing home care.

- The health care needs of no two people are alike, and the Medicare program should recognize this. That is why many of us support efforts to give Seniors new health care choices under the Medicare program.

A BOLD APPROACH TOWARD HEALTH CARE REFORM

Senator Robert F. Bennett (R-UT) delivered a speech on June 27, 1994, to his colleagues in the Senate, which stated: "...the issue is tortuously complex and huge in its implications. The chances that we might produce enormously difficult and costly problems if we do it wrong are overwhelming. But complex as it is, it can be solved as other complex social challenges have been solved throughout history. Trust Americans to make their own individual decisions. That is the key. If we do, we will wend our way through the thicket as we always have when we have made liberty our full star. This has been the sum and essence of our success as a people. It will not fail us here."

DRAFT HEALTH CARE PACT WITH AMERICA

As Republican Members of the House of Representatives, we have a vision for patient-centered, consumer-driven health care reform.

We accept the challenge to bring to America a market that is more efficient and equitable and a reformed system that will change the way we think about health care, the way we get the care we need, and the way we get access to health insurance coverage—with the goals of increasing access to quality, affordable, and accessible health care and lowering health care costs.

The challenges facing health care in America are daunting but not insurmountable. We are reminded of a statement by noted businessman and presidential advisor Bernard M. Baruch: "There are no such things as incurables; there are only things for which man has not found a cure." While we cannot solve all ills overnight, it's important for Congress and the President to work together to provide common sense and creative cures for improving health care to benefit all Americans.

A common resolve to work together toward meeting our absolute goal—a compassionate, patient-centered, consumer-driven health care system that is affordable and available to all Americans.

Republicans will immediately work to pass major reforms guided by our shared principles:

- ***FIRST, Quality of Care.***
- ***SECOND, Consumer Choice.***
- ***THIRD, Competition.***
- ***FOURTH, Focused applied medical research.***
- ***FIFTH, Best Practices.***

- ***SIXTH, Parity in Tax Incentives.***
- ***SEVENTH, Health Care Consumer Education.***
- ***EIGHTH, Personal Responsibility.***
- ***NINTH, Group Purchasing.***
- ***TENTH, Innovative Community-Based Solutions.***
- ***ELEVENTH, Utilization of the Power of Health Care Technology to Promote Quality Patient Care.***

Thereafter, we shall work to enact the following bills:

☐ H.R._____ **Medicare prescription drug benefit for Seniors**

Provides a voluntary prescription drug benefit under Medicare for all Seniors that allows a choice of plans.

☐ H.R._____ **Risk Pools for the Uninsured**

Builds on provisions in the Trade Act, Public Law 107-210, which provides assistance to states to promote the establishment and operation of qualified high-risk pools.

☐ H.R._____ **Health Education**

Provides better education to patients and providers so that the best decisions can be made about medical care. Ensures that Americans are living healthy lifestyles so that disease and adverse events can be avoided.

☐ H.R._____ **Medicaid Innovation and Improvements**

Stabilizes long-term care and reforms Medicaid to allow consumers to chose a quality plan that is right for them while ensuring the strength and long term solvency of the system. Educates providers and patients about the system to ensure proper utilization and participation.

☐ H.R._____ **Medicare Enhancement and Modernization**

Modernizes Medicare to reflect today's health care needs to increase preventative services, to ensure comprehensive coverage, to streamline the bloated bureaucracy, and to shore up the system without bankrupting future generations.

☐ H.R._____ **Medical Liability Reform**

Makes changes to the health care liability system, including compensation for injured patients and other issues arising out of health care lawsuits in order to ensure efficient, accessible, and affordable health care.

☐ H.R._____ **Association Health Plans**

Improves access to, choices, and affordability of health insurance for entrepreneurs with small businesses, their employees, and the self-employed.

☐ H.R._____ **Expanded Medical Savings Accounts**

Removes restrictions and limitations on MSAs to fully expand them and encourage their use.

☐ H.R._____ **State Cooperative Health Care Access Plan**

Provides for cooperative governing of health insurance policies by states and financial incentives to encourage health coverage for employees and individuals.

☐ H.R._____ **Nursing Home Quality and Standards Improvement**

Promotes improvement and quality of care for beneficiaries. Patients need smarter regulation, not less, more, or duplicative regulation. Ensures that steps taken to improve quality are not used against nursing homes in a court of law. Removes disincentives to improving care. Allows other options to protect residents, and gives them and their families more of a voice in decisions about the future of a facility. Prevents transfer trauma.

Respecting the judgment of our fellow citizens as we seek their mandate for reform, we hereby pledge our names to this Health Care Pact With America.