

National Coalition on Health Care

Containing Costs and Avoiding Tax Increases While Improving Quality: Affordable Coverage and High Value Care

October 22, 2009

Executive Summary

The National Coalition on Health Care's recommendations represent the consensus view of its 85 member organizations and are grounded in the understanding that America's health system is on an unsustainable course. The Coalition questions why -- when we have a health care system that is projected to waste an estimated \$10 trillion over the next ten years -- are we raising taxes to pay for reform rather than focusing on better utilization of the money already in the system? The sources of America's health care crisis are intrinsically linked; so too must be the steps we take to address them. Unless we improve the quality of care, we will not be able to manage costs or afford expanded coverage; unless we manage public and private sector costs effectively, we will not be able to achieve equitable financing or cover all Americans; and unless we assure coverage for everybody, we will not be able to make the system less complex, reduce overly high prices and cost-shifting, and create a truly competitive health care marketplace.

The goal of this paper is to augment the NCHC Principles and Specifications with a more detailed and selective set of policy recommendations on cost-containment and quality improvement which are:

- Politically viable, fiscally realistic and potentially scoreable by CBO
- Supported by a strong consensus of the Coalition
- Likely to earn the bipartisan support needed for enactment and effective implementation.

A condition of Coalition support for robust cost containment strategies is that they always be linked directly to improving access to care, affordable coverage and the improvement of health care quality and safety. The interconnected nature of these issues is evident in Institute of Medicine (IOM) data suggesting that excess U.S. health care expenditures in 2009 alone will cost \$810 billion and in other research, which estimates that 30 to 40 percent of all direct health care outlays are the result of poor quality care, consisting primarily of overuse, underuse, and waste. IOM has also estimated that 98,000 lives are lost annually due to preventable medical errors—the sixth leading cause of death in America.

The National Coalition on Health Care is a non-partisan organization of organizations — made up of roughly 85 of America's large and small businesses, unions, civil rights and advocacy groups, health care providers, associations of religious congregations, pension and health funds, and groups

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representing patients and consumers. The Coalition is the Nation's oldest and most diverse alliance working for the achievement of comprehensive health care reform. Collectively, our members represent — as employees, members, or congregants — at least 150 million Americans. The Coalition is united by our members' commitment to five goals for a reformed health care system:

- Health Care Coverage for All
- Better Cost Management
- Improvement of Health Care Quality and Safety
- Equitable Financing
- Simplified Administration.

The Coalition's members strongly believe in comprehensive health system reform that is patient-focused, value-based and fosters continuous quality and outcomes improvement while eliminating outdated programs, policies, processes and systems that result in high costs and below-average outcomes.

Meaningful reform must provide coverage for all and pay for itself in the coming decades. Real reform, the Coalition believes, must also result in a significant reduction in the tens of trillions of dollars in projected future private, federal, and state government health care expenditures. Moreover, it should better enable American businesses of all sizes to compete successfully in the global economy.

The Coalition set forth its basic policy perspective in its 2004 and 2009 reports, *Building a Better Health Care System, Specifications for Reform*.ⁱ The policies advanced herein are meant to amplify, not replace, those recommendations in a way that advances the current health reform debate. These proposals are intended to chart a path that will tame long-term costs in the nation's \$2.5 trillion health care system while expanding coverage to all Americans and improving quality. Importantly, this set of policy options, developed collaboratively by Coalition members, demonstrates that key stakeholders are able and willing to set aside parochial self-interests in order to forge a strong consensus in the national interest.ⁱⁱ

With an estimated \$800 billion being wasted annually within the U.S. health system on unnecessary services, inefficient delivery, excessive administrative costs, too high prices, missed prevention opportunities, fraud and abuse, the Coalition recommendations for cost-containment and quality improvement include:

ⁱ *Specifications for Reform, Building a Better System, 2004, revised 2009.*

ⁱⁱ Not every member organization can strongly support each individual recommendation but they do support the proposed systemic approach that addresses provider payment methods, delivery system reform, benefit design, and regulation as an interdependent and reinforcing set of initiatives to be implemented as a linked series of steps.

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- Workforce Reforms
- Acceleration of Cost Containment Reforms
- Codification of Voluntary Effort Commitments
- Innovations and Incentives
 - Health Innovation Zones
 - Health Information Technology and Administrative Simplification
- Aggressive Patient-Centered Delivery and Payment Reforms
 - Bundled Payments
 - Accountable Care Organizations
 - Virtual Integration
 - Medical Homes
- Stronger Comparative Effectiveness Programs
- Prevention and Wellness
- Drug and Device Cost Containment
 - Pharmaceutical Pricing
 - Generic Biologics
 - Durable Equipment Pricing
- Health Care Fraud Prevention and Enforcement
- Medical Liability Reforms and Cost Containment
- Scoreable Mechanisms and
- Governance Options.

While the Coalition salutes the President and Congressional leadership for having accomplished much, our members believe that much more remains to be done and that there is now an urgent need for bold leadership from independents and both major political parties, as well as for greater willingness to compromise across ideological, economic, and social divides. Absent these factors and political will, it will be impossible to address effectively the central question largely left unanswered by the current legislative vehicles for reform—

How to ensure that health care reform is fiscally sustainable for both the public and private sectors by reducing the rate of increase in future health care costs for American families, individuals, businesses and governments.

The Coalition's recommendations -- if implemented -- could reap well over \$1 trillion in cost savings in the next decade. There is a commitment to the necessary shared sacrifice and shared responsibility for achieving this goal among the Coalition's diverse membership. Now we need all the other major industry stakeholders who without cost containment changes stand to reap windfall profits -- many of whom like the Pharmaceutical Research and Manufacturers of America will be gaining tens of millions of new customers and patients -- to come back to the table again in order to contribute their fair share to enact secure and sustainable health system reform.

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Discussion of Recommendations for Containing Costs and Avoiding Tax Increases While Improving Quality: Affordable Coverage and High Value Care

❖ NCHC's Principles and Specifications

The Coalition's long held positions on containing costs while improving the quality and safety of care can be summarized as follows:

- Slowing health care spending growth requires a systemic approach that addresses provider payment methods, delivery system reform, benefit design, and regulation.
- The necessary reforms are interdependent and reinforcing. To be most effective, they should be implemented simultaneously as a linked series of steps.
- Systemic reforms depend on a foundation of better tools and information to guide stakeholders in taking the many small steps necessary to transition toward higher value lower cost care.

Systemic reform and deficit neutrality can only be achieved with genuinely shared risk, sacrifice and responsibility. Thus, expanded coverage and other insurance reforms will not be sustainable unless everyone is mandated to participate in the system and can afford to do so. The consequences of failure to meet fiscal targets for containing costs must be shared equitably by all stakeholders. Patients, physicians, nurses, the health industry and consumers, individuals, families, employers, unions, businesses large and small, the healthy and those with chronic conditions or disabilities, minorities, women, men and children—are all in this reform effort together.

With respect to the management of health care expenditures, we believe the health care system can and must be made far more efficient and affordable by providing more and better information for patients, providers, and purchasers; emphasizing—and investing in—prevention and wellness; improving the quality and outcomes of care; encouraging, with appropriate changes in payment incentives, better coordination of care; and building a national information technology infrastructure for health care. Long term cost savings inevitably will accrue from sound implementation of these initiatives.

However, as indicated in the NCHC *Specifications for Reform*, the urgent need for immediate cost relief also warrants consideration be given to deployment of short-term regulatory constraints, governance processes and limits, such as the options of including negotiations below budget caps, performance standards and some forms of rate-setting, all of which have been effective in constraining trajectories and levels of health care expenditures in other nations and in some American states, including Maryland. Granted that in the current political climate there is greater receptivity to using such mechanisms to bend the health care cost curve in

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public programs than in other settings, but the Coalition holds that with adoption of a common administrative platform and transparency across the market, true competition and greater cost savings could be generated.

❖ **Workforce Reforms: A Preliminary Note**

Among the strongest elements of America's health care system are the education and training of health care professionals, world class technology and state of the art medical research. However, imbalances in that system require a more aggressive approach to expanding, balancing and improving the Health Care Workforce.

Approaches could include:

- Incentives for states to amend scope of practice laws and adopt education standards and regulations as necessary to ensure optimal quality care
- Alignment of payments to better support the use of allied health professionals including physicians' assistants and advanced practice nurses as part of coordinated care teams
- Reform of graduate medical education payments—allowing use in outside clinics for expanding interest in primary care and lifting of caps on residency slots
- Workforce development incentives related to chronic disease management, primary care and pediatric subspecialists
- Integration of delivery reforms into graduate medical/allied education
- Incentives for providers in underserved areas and increase racial and ethnic (linguistic/cultural) diversity of medical and allied health professions
- Equitably realigning Medicaid provider rates with Medicare rates in order to ensure an adequate supply of providers for underserved populations as reform takes effect.

While strengthening and balancing our workforce may require additional outlays, rather than yield immediate savings, improvements in workforce policy are prerequisites for many of the cost savings reforms discussed below.

❖ **Acceleration of Cost Containment Reforms**

One way to capture greater savings sooner would be to accelerate the inception and implementation of measures that are already included in some of the pending bills. Acceleration—while challenging—would mean that savings could be scored earlier in the budget window by the Congressional Budget Office—and that they could cumulate and compound in later years.

Acceleration would underscore the real urgency about reining in cost increases within public programs and across the health care system. It could

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be positioned as a set of adjustments undertaken in part to address the concerns about the importance of cost containment, efficiency and value.

Among the initiatives that could be ramped up earlier and more aggressively are changes in Medicare reimbursement policies and rates in the fee-for-service sector (including incentives to reduce preventable hospital readmissions); realignment of payment rates in the Medicare Advantage program; limits on medical-loss ratios for health plans; and steps to reduce paperwork burdens and costs and simplify administration. Centers for Medicare & Medicaid Services (CMS) and others have several pilots and demonstration projects underway regarding condition adjusted capitation and episode-based approaches to payment and performance measurement that can be implemented and tested on a wider scale in the near term, assuming meaningful patient protections and quality measures are identified and implemented to prevent under-service in the course of experimentation with alternative payment models.

Additionally, many of the other initiatives described in this document, particularly within the section on codification, could and should be implemented on an accelerated timeline. Tackling health care costs need not wait for full implementation of the rest of the legislation in 2013 or 2014.

❖ Codification of Voluntary Effort Commitments

On June 1, President Obama received a letter, with extensive attachments, from the chief executives of six major organizations in the health care industry. These organizations committed to initiatives—addressing the utilization of care, the costs of providing health care services, administrative simplification, and the management of chronic diseases—that, according to the materials provided, would produce savings in the coming decade of between \$1.0 trillion and \$1.7 trillion. Since that time, the White House has announced other similar agreements with pharmaceutical manufacturers and with hospitals that committed those sectors to reduced payments. Voluntary efforts such as these generally do not have a track record of success.

Therefore, at this juncture and to the extent possible, it would make good sense—substantively and politically—to incorporate provisions that codify the commitments that these segments of the health care industry have made but not to exempt them from other cost constraining provisions. The transmutation of voluntary initiatives and agreements with the White House into legislative provisions would provide transparency and could lock in those limited commitments. In addition such steps will enable it to credit scoreable savings. Moreover, codification could be an important signal to these sectors that they will be held accountable—and that Congressional leaders of the health care reform effort are intent on seizing this opportunity to bend the cost curve down across the health care system.

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More importantly, many health care experts caution, that the industry pledges to reduce health care spending by \$2 trillion over ten years is “largely speculative” and unreliable. At this writing, some analysts report that the pharmaceutical and hospital industries are struggling to identify more than \$235 million in concrete savings over the next decade. Hence, consideration should be given to including in the codification language a trigger mechanism—after perhaps five years—to assure that stronger regulatory means would be available to ensure that the promised savings accrue. The Coalition cautions that any codification of these pledges made by the industry be informed by CBO’s recent findings regarding the associated cost increases of some promises reportedly made by and to the industry. For example, the reported side agreements exempting the “big six” from all other cost containment requirements should be opposed.

❖ Innovations and Incentives

- Healthcare Innovation Zones, building on the concept as elaborated in H.R. 3134, Innovation Zones could be incorporated into the broader health care legislation—perhaps with an initial tier of zones to be identified in legislation and others yet to be developed. Innovations with incentives for delivery system reforms can improve quality, value and outcomes much more rapidly. As indicated above, the Coalition believes that current legislative proposals lack significant payment and delivery reform language, and that stronger language in this area—including incentives—is required to align payment to quality that could be addressed effectively in this manner.
- Health Information Technology and Administrative Simplification – An estimated 25% of America’s health care dollars are spent on administration. The Emdeon Index estimates the efficiency of US health care at 43%. There is strong support within the Coalition for implementing the utilization of electronic medical records *and* streamlining of administrative forms and processes. For many members it is ironic that American health care information technology is used more effectively by other nations than within the United States.

Specifically, consideration should be given to adopting language to better ensure that investments in Health IT provided by the American Recovery and Reinvestment Act and health reform legislation achieve maximum possible impact:

- “Meaningful use” health IT bonuses linked to achieving better results
- Making health IT startup funds available to health care practitioners beginning to implement Health IT -- without regard to case mix thresholds

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- Developing and adopting of interoperability and provider communication standards to help establish a common platform
- Providing technical support programs for providers and institutions struggling to adapt to Health IT
- Supporting infrastructure like Minnesota Institute for Clinical Systems Support which allow health care practitioners everywhere to practice independently yet provide coordinated care
- Accelerating administrative simplification by setting a requirement that all insurance forms and processes for billing, enrollment, and credentialing be standardized across all payers within four years or less.
- Burdensome citizenship verification and/or excessive documentation to determine eligibility for health insurance subsidies or to access the health insurance exchange should be opposedⁱⁱⁱ.

❖ **Aggressive, Patient-Centered Approach to Bundling and Other Delivery System Reforms**

Coalition members are deeply concerned about the paucity of delivery system reform language in many of the current legislative proposals and urges that alternatives to fee for service (FFS) be adopted to offer stronger incentives to align payment to quality, reward providers and hospitals that are doing what's right for patients, and making health care more efficient and less costly. Support for adoption of these alternatives assumes that patient protections and quality assurance mechanisms are in place to meaningfully protect patient care.

Certain forms of bundling and other delivery reforms—if appropriately formulated—seem likely to fit well into the evolving policy framework. Expedited adoption of such reforms many of which are now being tested in demonstration and pilot programs—provided they are designed in a way that reflects the interests of patients, consumers, and providers—could also be linked to a short-term savings trigger. However, a more cautious approach should be taken with bundling demonstrations and pilots of post acute care services for people with disabilities and chronic conditions to ensure that they receive medically necessary services at the appropriate level of intensity. It should be noted that a number of Coalition members strongly encourage permanent repeal of the Sustainable Growth Rate (SGR) provisions and new legislation to better address the quality and value delivery issues. SGR

ⁱⁱⁱ The General Accounting Office found that six states spent \$8 million to find ineligible 8 undocumented immigrants out of 3.7 million Medicaid enrollees for a savings of \$11,000. In addition, the impact of the Deficit Reduction Act citizenship documentation requirement has been to exclude eligible U.S. citizens, disproportionately those who live in rural areas, African Americans and youth.

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presents too many problems as formulated and presents too great a risk of misapplication and inequitable cuts while failing to recognize quality.

- **Bundled Payments** A passage in an analysis, entitled Health Care Reform and the Federal Budget, which CBO director Douglas W. Elmendorf transmitted on June 16 to Chairman Kent Conrad of the Senate Budget Committee was striking. In the context of a document that expresses skepticism (based on careful parsing of logic and literature) about the potential incentives to generate substantial savings, there is, on page 10, a discussion of an aggressive strategy, commended by the Commonwealth Fund, for “successively more inclusive”—and constraining—bundling of payments. (CBO notes that this is a much more aggressive pursuit of bundling than the scenario it had analyzed in its Budget Options volume, for which it had projected savings, within a ten year budget window, of \$19 billion). Then, without so much as a cavil, the report cites the Commonwealth Fund’s estimate that its proposal would reduce federal spending by more than \$200 billion over a ten-year period. In the sweep of CBO’s analysis of options to slow the rate of increase in health care spending, that is a significant number—which, in addition to other considerations of policy, may suggest that a more aggressive program of bundling is an option worth further exploration.

The Coalition believes that elements of the Commonwealth Fund model related to acute care episodes should be qualified and clarified before enactment. For example, it appears that acute care episodes are less amenable to acceleration than other areas. With that caveat and insistence that bundling must include substantial consumer protections for post-acute care rehabilitation and patients with chronic conditions, the Coalition encourages formulation and implementation of stronger, accelerated bundled payment provisions within Medicare than is currently provided for in HR-3200.

The Coalition believes that patient-centered bundling of services can improve efficiency, quality of care, and reduce admissions. The Coalition understands fully that there exist a wide range of distinctly different proposals labeled “bundling” and urges that care be taken in policy formulation to ensure savings are linked to improved quality of care and outcomes. Bundling of payments may be based upon condition, episode or outcome but each has differing incentives and risks. Nonetheless, consideration must be given to adoption of a phased-in process beginning with well established areas of practice that could move rapidly from existing demonstrations through pilots to scoreable wide scale implementation across Medicare. Regarding post-acute care (PAC) bundling, which can raise significant concerns regarding potential negative impact on persons with chronic conditions or disabilities, the Coalition

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recommends adoption of the proposed consumer protection language to address this risk developed by the Consortium for Citizens with Disabilities (CCD)^{iv}.

- **Accountable Care Organizations** The Coalition supports policies to more strongly incentivize both:
 - Actual Accountable Care Organizations (ACO) and
 - Virtual integration systems (ACC model of virtual bundling/virtual ACO).

Strong consideration should be given to supporting more actual and virtual ACO pilots and incorporating other bonuses which encourage the transition to accountable payment systems that emphasize measurable impacts on quality and costs.

- **Medical Homes** In addition to encouraging better care coordination through information sharing and integration whether actual or virtual, the Coalition generally endorses incentivizing patient-centered medical homes as a viable cost containment and quality improvement option. Incentives need to ensure that medical homes include facilitating access to specialists as part of the care-giving process—especially for people with serious and chronic conditions. Further work is required regarding the issue of the ratio of primary care physicians to specialists (see workforce development) as it relates to medical homes.

❖ Stronger Comparative Effectiveness Programs:

Comparative Effectiveness Research (CER) is a critical factor in improving quality and controlling costs. CER funding should be targeted better and allocated in a coordinated manner.

The Coalition has two overarching caveats regarding CER:

- CER should serve to inform, not prescribe treatments and

^{iv} Specifically, these protections include rigorous pilot testing of post-acute care bundling, including studies that determine whether bundling should be limited to certain acute care diagnoses that are common and highly predictable and exempt from bundling other diagnoses that are of low predictability and highly complicated. The final health reform bill should grant the Secretary discretion to explore alternative approaches to payment of post acute care, as long as these approaches achieve the stated goals described above. Protections should ensure that PAC bundling provisions do not create disincentives for the provision of medically necessary and appropriate services, including rehabilitation services and devices for individuals with disabilities and chronic conditions, and that undermine physician and clinical judgment and patient choice.

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- Cost effectiveness should be a factor for decision making but not the focus of CER.

External coordination should be required for CER and include the involvement of experts as well as patients and consumers on an independent board or commission. It is important that CER include diverse populations – age, ethnic, race, gender and people with disabilities. With appropriate bipartisan appointments and balanced representation of industry, independent experts and consumer representatives, the CER board should not merely serve in an advisory capacity. CER board discussions should focus on clinical effectiveness rather than cost effectiveness solely. For example, CER research programs should include:

- Focusing on areas of medical uncertainty and provider practices as well as evaluating different system approaches to health care
- Protecting providers and insurers from liability when they use available evidence based guidelines (see Liability Reform below)
- Using CER to identify risks, benefits and costs of different health care practices—including community interventions; evaluate and revise policies based on CER to influence practices; and develop ways of targeting practices to specific groups of patients.

Additionally, comparative effectiveness research should be used not only to compare treatments, costs and outcomes to maximize efficiency but also to improve standards across the board with evidence-based national practice standards. With this approach, CER will enhance quality, reduce health care costs and dramatically reduce future risks of malpractice litigation.

❖ Prevention and Wellness

The Coalition strongly supports the inclusion of cost effective, evidence informed prevention, health and wellness initiatives. Comprehensive health care reform must include a major focus on preventive care. The best investment we can make in the health and well-being of Americans is to take necessary steps to prevent illness and injury from occurring in the first place. Payment reforms should include first dollar coverage for services that are highly rated under the U.S. Preventive Services guidelines and adequate health promotion funding managed by the CDC for America's network of state and local health departments and community based organizations to improve utilization of cost effective evidence based services. CBO has acknowledged that effective prevention campaigns save lives and dollars but take time. While public health campaigns and prevention services may not have a significant public health impact within the 10 year window that CBO uses in its scoring, this should not be an impediment to beginning to bring down long term costs through accelerated implementation.

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As stated in the *Specifications for Reform*, preventive services including vaccinations and dental care should be available to all—especially to all children—in order to avoid risks to public health and the far greater costs of crisis intervention. Prevention initiatives must also target the elimination of racial and ethnic health disparities. According to a recent report by the Joint Center for Political and Economic Studies, eliminating health disparities for minorities would have reduced direct medical care expenditures by \$229 billion for the years 2003-2006. More than 59% of these excess expenditures were attributable to African Americans, who fare worse than any other racial/ethnic group with respect to health. Similarly, access to preventive care for legal immigrants ultimately saves money. Furthermore, an inclusive system where everyone can contribute and gain access to health services is fiscally sound. The five-year waiting period prevents new citizens and legal residents from accessing the care that they need while serious medical conditions such as cancer, diabetes and asthma worsen is not fiscally responsible.

❖ Drug and Device Cost Containment

- Pharmaceutical Pricing
The House Energy and Commerce Committee adopted an amendment to use a drug formulary in the public plan option to control prices and to set transparency requirements for Pharmacy Benefit Managers. Coalition members support creating far greater transparency in the drug industry and strongly supports a provision for establishing an evidence based drug formulary with public input and openness.
- Generic Biologics
Furthermore, the importance of achieving an exclusivity period of less than 12 years for biologics should be addressed. Members believe there is an achievable balance between protecting the incentives for biotech innovation and ensuring room for generic biologics to enter the market for competitive pricing of specialized drugs.
- Durable Medical Equipment Pricing
A recent demonstration project has demonstrated that competitive bidding for suppliers of durable medical equipment would generate substantial savings without affecting beneficiaries' access. In 2003 Congress authorized a competitive bidding program for durable medical equipment but the program's implementation was postponed, amidst objections from suppliers and disability organizations that were concerned with competitive bidding's impact on quality, access and choice. Congress and CMS refined the competitive bidding program and are poised to implement it in a phased-in approach. Coalition members believe competitive

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bidding for durable equipment can be a valuable component of overall reform as long as sufficient patient protections are implemented to ensure that Medicare beneficiaries have reduced copayments while not compromising the quality of care or access/choice of a wide range of DME items and suppliers.

➤ Health Care Fraud Prevention and Enforcement

It is projected that billions of dollars are lost to health care fraud and abuse on an annual basis. These losses lead to increased health care expenditures and potential increased costs for coverage. Therefore, given the strong ratios of dollars recaptured from these efforts, increased spending on programs to reduce fraud, waste, and abuse as well as to enhance enforcement should be considered. Greater administrative costs aimed at uncovering medical fraud would be money very well spent. CBO in 2008 estimated increased enforcement in the area of fraud prevention would save Medicare and Medicaid \$2 billion over ten years. The Department of Health and Human Services' Office of the Inspector General in 2008 estimated that for every \$1 spent on health care oversight, the government sees a return of \$17.

❖ **Medical Liability Reforms and Cost Containment**

Reforms of the medical malpractice system should not punish the victims whose lives have been irreparably damaged by wrongdoing. Efforts should be focused on the true causes of increased medical malpractice premiums for health professionals and solutions crafted around them, including increased discipline of the small number of physicians responsible for most malpractice claims and examination of insurance industry pricing practices.

The importance of some liability reforms to attracting bipartisan support as well as to addressing liability related costs faced by many providers should not be underestimated. The critical factor to the Coalition in this regard is to the creation of clear linkages between tort reform and care quality/patient safety strategies.

Tort reform—even absent caps—can play a modest but important role in restraining health care costs. A report co-authored by Michelle Mello, a professor of law and public health at Harvard University School of Public Health which appeared in the July 2 *New England Journal of Medicine* identified potential savings from specialized health courts, early-disclosure and early-offer programs, and evidence-based safe harbors as promising liability alternatives. The study notes that defensive medicine costs are difficult to estimate, "But even if we conservatively estimate it at 1%" of all health care spending, or \$22 billion per year, "that's still a lot of money." And

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that is exactly the cost of medical malpractice (malpractice premiums and legal defense) estimated by CBO.

However, the bigger savings is attributed to the cost of defensive medicine. While the amount is controversial, it has been estimated by a some sources to approximate \$200 billion annually. Therefore, the medical provider members of the Coalition have argued that a little bit of malpractice relief could save a lot of money in reducing defensive medicine. If, for example, tort reform was able to save \$50 billion per year in defensive medicine, it would add up to \$500 billion over 10 years—over half the projected costs of health care reform spending.

These theories remain largely untested and for that reason, the most robust liability reforms have not won widespread support. However, it seems prudent to the coalition to explore improvements to today's medical liability system. Toward that end, the Coalition encourages adoption of the concepts of the Gordon Amendment, as adopted by the House Energy and Commerce Committee which would encourage states to explore two specific liability reform alternatives—certificate of merit requirements and early—offer programs. This legislation's limited approach to reform has won acceptance from both the American Medical Association and the trial lawyers' organization, the American Association for Justice. It would offer financial incentives to states that enact certain liability alternatives that meet yet to be defined federal standards—as long as they do not limit attorneys' fees or impose damage caps. While the Gordon Amendment as adopted lacked clear definitions of key terms, such as “certificate-of-merit requirements” and “early-offer programs,” the concepts could be defined in rulemaking.

Struck from the Gordon amendment as it was initially offered was language which incentivized states to explore other liability reform alternatives:

- allowing physicians to apologize to patients for bad treatment outcomes without those statements being used against them in court;
- supporting medical review panels;
- providing for voluntary alternative dispute resolution mechanisms not as a condition but as an option; and
- authorizing state pilot programs with liability safe harbors for doctors who adhere to evidence-based guidelines.

Of these deleted provisions, liability safe harbors for adherence to evidence based guidelines of the appropriate academy of medicine, earned a strong consensus of support from Coalition members. Other options for medical malpractice/litigation reform with some support across the Coalition are Good Samaritan provisions with adequate consumer protections, rewards for open reporting and focusing on root cause analysis. These reforms could help move medical services more towards a patient-centered environment

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and limit overutilization due to defensive medical practices. Coalition members believe there are many ways that we can increase access to care, protect consumers and victims of malpractice while also beginning to reform the malpractice system and help to reduce costs associated with defensive medicine.

❖ Scoreable Mechanisms

With regard to proposals identified by the Coalition, it is recognized that CBO would not be able to score many of these proposals until they are put into practice in the earliest period after enactment. However, we believe a number of options are scoreable now.

Acceleration easily could be achieved by enabling HHS to administratively approve early adoption of successful pilots and demonstrations without the delay of related Congressional approval. This provision is already included in the House American Affordable Health Choices Act and the Senate Finance American Healthy Futures Act.

Another way to score these proposals would be to pair a set of proposals such as those above with triggered cost-savings:

This approach would begin by setting a ten year savings target in the legislation. This target would be reflective of the best estimates of potential savings for each reform. Four years following enactment, after initial pilots and demonstrations have been evaluated, Centers for Medicare & Medicaid Services would be required to provide a new, more informed estimate of how much implementation of these proposals would save. If savings estimated by CMS fall short of the original target, then the shortfall would have to be made up by a combination of mechanisms e.g.,

- Targeted regulatory reduction of Medicare reimbursements under current law,
- Lower the phase out of premium subsidies from 400% of FPL to 375% (only works if starting point is well above 300% FPL)
- Reduce the small business tax credit
- Other steps which would spread the pain of failing to meet targets somewhat equitably across all stakeholders.

Congressional creation of specific “trigger” options designed to measure targeted expenditures and to automatically implement specified policies to achieve greater savings, if needed, should also be considered. The Coalition supports such trigger legislation with the qualification that the impact of triggered policies must be equitable across the system. Ideally, such trigger point readjustments will help Congress act responsibly and provide a path for evolutionary adjustments every few years.

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❖ Governance Options

A related option supported by many Coalition members is that of an Independent Governance Council to insulate decision making related to cost containment and performance improvement from political pressures. An autonomous Health Care Commission entity modeled after the Federal Reserve Board or BRAC could be charged by Congress to develop and submit specific proposals to Congress and the President to reduce any short falls. Proposals would have to be acted upon by Congress under special expedited procedures allowing for limited opportunity if any for amendment. In order for new and complex payment reforms to succeed it is essential that some new process be developed to ensure that reimbursement rates are no longer a political football but are the fact driven results of an equitable process. Too often influential vested interests have driven decisions against the commonweal. (NB: The Coalition recognizes these IMAC type proposals remain controversial but believes that there is an emerging consensus about the unlikelihood of sound policies being sustainable absent such an insulating mechanism.)