



**Summary of the Deliberations
and Recommendations of
The Rolling Hills Group**

A Plan for Healthcare Reform for Tennessee and the Nation

November 2008

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INTRODUCTION

THE ROLLING HILLS GROUP

At the 2007 Tennessee Hospital Association (THA) board of directors' retreat, the board reviewed the McKinsey Global Institute report that compares U.S. health care spending with expenditures in other developed countries. The report concluded the U.S. spends more on health care than any other developed country. Following that retreat, the THA board authorized the association to form a group of prominent Tennessee "thought leaders" to devise a healthcare reform plan for Tennessee. This group, chaired by Clayton McWhorter and named the Rolling Hills Group, was established and met as a group throughout 2008.

The charge to the group was to develop a healthcare reform plan for Tennessee that can serve as a model for other state and federal reform efforts. In addition to five hospital and health system CEOs and CAOs--Jim Brexler, Erlanger Health System; Chuck Whitfield, Laughlin Memorial Hospital; Larry Kloess; TriStar Health System-HCA; Reginald Coopwood, MD, Nashville General Hospital; and Bob Gordon, Baptist Memorial Health Care Corporation--the members are Marlin Chapman, Nissan North America; Marilyn Dubree, Vanderbilt University Medical Center; Dan Elrod, Miller & Martin; Aubrey Harwell, Neal & Harwell; Tom Kinser, BlueCross BlueShield of Tennessee (retired); Kevin Lavender, Fifth Third Bank; Lynn Massingale, MD, Team Health; and Craig Becker, THA.

The group spent its first meetings studying the causes of the high healthcare costs in the U.S. and the value it receives for its huge investment in health care. It then reviewed other state and federal healthcare programs and reform initiatives. The group quickly agreed that no state could reform its system without federal restructuring since the impact of federal tax and ERISA policy was so pervasive. Ultimately, the group developed a plan for reforming health care in Tennessee within a reformed national structure that would allow for the changes needed in Tennessee.

The meetings of the group have been facilitated by Tom Scully, who was the Administrator of the Centers for Medicare and Medicaid Services (CMS) during the first term of President George W. Bush and served in health posts in the White House and the Office of Management and Budget under President George H.W. Bush. Also advising the group was Stephanie A. Kennan, whose experience includes working for AARP and a decade working for Senator Ron Wyden (D-OR) as his Senior Health Policy Advisor where she developed the Healthy Americans Act. Mary Layne Van Cleave, Chief Operating Officer of the Tennessee Hospital Association, also advised the group.

Unlike past efforts on the state level, the Rolling Hills Group's proposal provides comprehensive systemic reform and includes reforms that must be made on the federal level. This proposal is different from past state efforts because it acknowledges the need for changes in federal law in order to make the health care system sustainable.

WHY TENNESSEE

Healthcare reform proposals are being developed across the country, and reform is a major issue in the 2008 presidential election. The majority of the reform efforts and proposals focus on increasing healthcare coverage in the U.S. The recent experiences in Massachusetts, and Tennessee's own experience with TennCare, are evidence that only covering more people without reforming the overall reimbursement and delivery system can increase the cost of health care in the U.S.

Tennessee is unique in that, prior to the current state and national focus on healthcare reform and coverage for the uninsured, Tennessee was the first state to attempt to cover the majority of low income uninsured persons through a waiver to the state Medicaid program which became known as TennCare.

Not unlike the recent Massachusetts effort to require the uninsured to obtain coverage, TennCare extended coverage to 400,000 uninsured and uninsurable

Tennesseans through subsidized coverage. The program used a private managed care model. Disproportionate share hospital (DSH) payments were redirected to offer enhanced services to those eligible for the Medicaid state plan and to extend eligibility to low income uninsured and all uninsurable residents.

In 2005, to address sizable budget deficits, about 191,000 individuals were disenrolled from TennCare increasing the level of uninsured in the state and increasing pressure for systemic reform.

In an effort to provide health care for the individuals disenrolled, Governor Phil Bredesen implemented the Cover Tennessee program in 2007, which included three initiatives. CoverTN provides low cost access to limited benefits for employees of small employers. CoverKids provides coverage for low income children through the state children's health insurance program and AccessTN provides access to health insurance for uninsurable residents. One year after implementation, only about 44,000 of the state's 809,000 uninsured were enrolled in the program. The Rolling Hills plan can support the governor's goals for CoverKids which also will increase federal participation in the Rolling Hills plan. Clearly, there needs to be a new plan for covering the state's uninsured adult population.

Tennessee's extensive experience with healthcare reform puts it in a unique position to diagnose and discuss the enormous challenges of reform. Tennessee can build upon existing efforts and take advantage of lessons learned from the past.

Although one "standard" health reform proposal cannot meet every state's needs, state-based reform proposals can and should be evaluated on the basis of whether the proposal can provide access to care that is fairly supported by all who can afford to pay, improve quality and reduce the overall costs of health care.

Tennessee is influenced by the same parochial interests as Washington on healthcare issues, but the state's politics are more practical and less prone to the gridlock that has hindered action on healthcare reform in Washington. There is, and has been, support for reform in Tennessee, but a functional, middle-ground, bipartisan plan has not yet surfaced. It is the goal of the Rolling Hills Group to develop and promote such a plan.

THE NEED FOR HEALTHCARE REFORM

Healthcare reform has been discussed on a national level beginning with the Truman Administration. The problems of the U.S. healthcare system have been well documented and suggestions on how to reform it have been the fodder of books, papers and speeches. In short, the current system spends inefficiently and has become more expensive so that the basic structure, employer provided insurance, is declining and harming U.S. businesses' ability to compete. In addition, the performance of our healthcare system falls short when compared to other countries' systems.

Inefficient and excess spending: A McKinsey Global Institute report identified the amount the U.S. spends above other countries as \$477 billion. According to a PWC Health Research Institute, wasteful spending in the healthcare system has been calculated at up to \$1.2 trillion of the total \$2.2 trillion spent nationally, more than half of total spending. Not only does this spending increase costs, but it harms that ability of U.S. companies to be competitive globally.

The federal government estimates it will spend over \$800 billion on health care in fiscal year 2008. In addition, various tax provisions for health care create tax expenditures that are estimated to be \$175 billion. About 85 percent of that figure comes from the exclusion of employers' payments for their workers' health insurance premiums from taxable income.

The uninsured: According to the Kaiser Commission on Medicaid and the uninsured, nearly 77 million people in the United States will go without insurance

coverage in 2008 for all or part of the year with an estimated indirect cost to the U.S. economy of between 1 and 2 billion dollars. The U.S. Census Bureau estimated that 45.7 million Americans and 883,000 Tennesseans lacked health insurance for all of the year 2007. The cost of charity care and bad debt to all Tennessee hospitals in 2007 that results from lack of health insurance was over \$900 million.

Declining employer sponsored health insurance and increasing costs of health insurance: The traditional way of obtaining healthcare coverage in the U.S. has been through employers. Yet, employer-sponsored coverage is declining because of the cost of health insurance. The average worker contribution for family health insurance coverage has increased by 102 percent since 2000 (New America Foundation report).

Less than optimum performance: *The Commonwealth Fund Commission on a High Performance Health System* reported in July 2008 that across 37 core indicators of performance, the U.S. score was 65 out of a possible 100 and declined from 67 in 2006. The U.S. scored worse on almost every measure of performance when compared with other developed countries.

WHY FEDERAL REFORM ALSO IS NEEDED

In examining how different reforms might work at the state level, discussions highlighted that while states can move forward to address some issues related to increasing coverage and access, many reforms must come from the federal level. The group also concluded that any comprehensive reform effort must include both federal and state approaches. States cannot amend federal law. As California and Massachusetts have learned, it is hard to drive change when you cannot change the federal tax code or the Employee Retirement Income Security Act (ERISA).

Further, while states are neat geographic units to use for many purposes, they do not always fit for state-based health insurance reform. Often people live and

work in different states. If all residents in a specific state were required to have insurance, would individuals who reside in another state, but work in the state requiring insurance be affected? Tennessee's borders touch upon eight other states and any changes in coverage in Tennessee could impact those who live or work in those states, but are not Tennessee residents.

Federal laws related to taxes, ERISA health plans and the regulation of direct-to-consumer drug advertising are the three primary areas the Rolling Hills Group identified in which federal reform is needed to work in conjunction with state reform. In addition, the Rolling Hills Group recommends that the federal government place a high priority on funding research for evidence-based medicine and the area of comparison-effectiveness.

The employer-sponsored tax exclusion works as an upside-down subsidy. The largest subsidies go to high-income taxpayers who would be most likely to obtain employer provided insurance, while those with low incomes get little or no benefit. Individuals and families with the highest premium burden as a share of income receive the smallest subsidy value in the system. Higher income workers generally have higher cost coverage, and thus more expensive total subsidies. Those individuals and families with low incomes often do not have employer provided coverage, and often do not file taxes and therefore, receive no benefit. This results in an inefficient use of federal dollars. This inequitable distribution of the subsidy can be reformed to redistribute benefits and ease the transition into a universal insurance system.

The Employee Retirement Income Security Act (ERISA) is a federal law which permits what are known as "ERISA plans." These are health plans offered by employers who "self insure" and are not subject to each individual state's regulation. Usually, employers who offer ERISA plans are larger employers, and often are multi-state employers for whom meeting the varying standards of several state requirements would create obstacles in providing consistent coverage. ERISA plans offer employers the advantage of developing a plan that

can be used across state lines. It also allows those plans to opt out of state regulation and mandates. Further, by operating as an ERISA plan, these plans usually can lower benefit cost because companies “self insure” or carry the risk themselves rather than paying a health insurer to underwrite risk.

Yet, on a state level, the presence of ERISA plans also means a potentially large group of individuals is out of reach of any state-based reforms. Federal and state reforms should work cooperatively so the advantages and legitimate benefits of ERISA continue, while allowing states to include these large self-insured groups in their reformed structures.

Last, the federal government regulates direct-to-consumer advertising of prescription drugs. Since 2000, direct-to-consumer advertising of prescription drugs has continued to grow. While some argue that advertising helps patients identify health issues about which they might not ask a physician, others raise concerns that advertising increases the request for specific, higher cost drugs when lower cost alternatives may be as appropriate. In addition, it is well documented that drugs and medical supplies cost significantly more in the U.S. than in other developed countries. Any attempts to make significant changes to pharmaceutical or medical supply costs will require federal action.

Key Federal Reform Recommendations:

- Cap or remove the tax exclusion for employer paid premiums.
- Develop mechanisms by which states could include employees in ERISA plans in state reforms, while preserving the valid goals of ERISA.
- Restrict direct-to-consumer advertising that increases unnecessary utilization of prescription drugs.

GOALS FOR REFORM

The overall goal was to establish a reform plan for Tennessee that can serve as a structural model for other states and the nation. The Rolling Hills Group agreed that states, like Tennessee, can serve as a testing ground for the federal government to determine what proposals could gain bipartisan support and work best to expand coverage and control costs. The federal government should carefully watch and help fund the states' reform efforts before attempting to provide coverage to 45.7 million uninsured and reform a \$2.2 trillion dollar healthcare system.

The Rolling Hills Group determined the overarching goals of reform should be:

1. Universal insurance employing a mix of private and public structures and funding.
2. Health system reforms should produce higher value for the dollars spent on care and increase the use of best practices and evidence-based decision making.
3. Funded through changes to the federal tax code and the better use of existing funding and resources without adding new costs.

Universal insurance is healthcare coverage extended to every citizen and can utilize a variety of structures. *In the case of the Rolling Hills Group recommendations, it is intended to be an improved mix of private and public structures and funding.*

Assuring a higher value for the dollars spent on health care and increasing the use of best practices are key goals. To simply provide coverage will not ensure better outcomes, lower costs and better health. Demonstration projects to address key health issues, as well as payment reform, are some ways to further these goals.

Because the U.S. spends so much on health care, but does not have consistent high quality care or improved outcomes for those dollars, the group concluded these goals can be reached through reform at the state level, in conjunction with a series of federal reforms that work in concert with state efforts.

PHASING IN REFORM

Reform must make a serious commitment towards achieving universal insurance. However, to be truly practical, implementation should take place over a period of years, perhaps as many as 10 years, in order to allow for our complex system to adapt to those vast changes.

In permitting a multi-year, phase-in period, the plan should not be interpreted to be a piece-meal approach toward reform. There are specific dates for achieving universal insurance, and implementation includes a clear pathway toward achieving a completely reformed system.

In stressing active buy-in and participation of healthcare purchasers, providers and patients, this kind of model would enable the enforcement of transparency and accountability, encourage market stability and help collaboration for an improved use of healthcare resources in providing care.

As part of a phase-in, demonstration projects should be developed to test best practices, disease management and other critical healthcare issues that include a broad spectrum of healthcare providers. Ideas for demonstration projects the group discussed include: smoking; obesity; chronic disease management; payment reforms to better align payments for hospitals and physicians; and ways to ensure a patient's healthcare decisions are followed.

Key Recommendations for Phasing In Reform:

- Universal insurance using private and public structures must be achieved within 10 years of the enactment of reform.
- Both federal and state reforms need to be phased-in over a period of time

- to permit sustainable rates of change and correction of unintended consequences using a continuous quality improvement model.
- As part of the phase-in, geographic demonstration projects for best practices, disease management and other issues should be included in order to improve quality, provide access to information to improve outcomes while being cost-effective, and improve the health status of individuals.

THE ROLLING HILLS PLAN DETAILS

INDIVIDUAL REQUIREMENT and ENFORCEMENT

Individual Requirement for Coverage

In its deliberations, the Rolling Hills Group determined that in order to truly achieve universal insurance, an individual requirement is essential. A significant number of people in the U.S. and Tennessee lack health insurance. Lack of health insurance impacts access to care and results in reduced use of primary care and preventive services and creates more use of higher cost services when the uninsured do access care. Lack of health insurance also results in a cost shift that primarily impacts those who do have health insurance coverage.

There are several benefits of an individual requirement, especially in a system that continues to use private payers to provide health insurance. Fundamentally, an individual requirement, coupled with other reforms, makes it possible to have both more efficient and fairer markets.

Under a voluntary system, many people – younger, lower-risk and lower income individuals-- will opt to not obtain coverage. A voluntary system has appeal disproportionately to those with health problems and higher medical costs, leading to higher premiums. Without an individual requirement, large numbers of individuals and families will remain uninsured, continuing inefficient spending and use of health resources and cost shifting from the uninsured to the insured. A January 2008 Urban Institute study concluded a voluntary system, using a

combination of increased subsidies, more affordable coverage options and other mechanisms to encourage enrollment, still would leave as many as 15 million people uninsured.

An individual requirement, much like auto insurance mandates, recognizes that in order to create a system in which costs are spread across the largest pool possible, all individuals must be included to minimize cost-shifting from payer to payer. An individual requirement alone will not make health insurance more affordable, but it facilitates the adoption of rules and mechanisms to assist in making coverage affordable.

Tennessee would not be the first state to adopt an individual requirement. Massachusetts enacted an individual mandate as a key part of its health reform initiative. In drawing upon the Massachusetts experience, the Rolling Hills Group believes there must be a specific time frame in which individuals can enroll in insurance.

In addition, the Rolling Hills Group discussion about individual mandates reflected on past experience with TennCare, in which low income individuals moved to Tennessee to gain access to coverage at the expense of the state. This provided the Rolling Hills Group with yet another rationale that federal reform should include a national mandate for individuals to obtain health coverage. A federal individual mandate also simplifies the federal government role of assisting in enforcement through the use of the federal tax code.

Employer Role in an Individual Requirement

An employer role is crucial, particularly during a phase-in period. The Rolling Hills Group envisions continuing an employer role consistent with the current employer and employee relationship. Employers not only develop and design insurance to meet the needs of their workforce, but they provide information and education on plan offerings and how to use the plan. In addition, employers enroll employees in the health plan.

Mindful that an employer role also would mean continuing some administrative functions, the Rolling Hills Group envisioned the employer role continuing, particularly in assisting individuals and families in making choices among plans and utilizing the system. However, the group does not envision the employers' role including enforcing the individual requirement. The Rolling Hills Group specifically recommends employers be exempted from being part of any enforcement mechanism for mandated coverage.

Key Recommendations for Implementing an Individual Requirement:

- All Tennessee residents, and U.S. citizens, should be required to have health insurance.
- The individual mandate needs to be part of federal reform in order to avoid inter- state migration to access subsidized insurance.
- The federal tax code and other mechanisms should play the central role in enforcement in order to ensure individuals purchase credible insurance, regardless of where they reside.

Enforcement of an Individual Requirement

Enforcement is necessary in order to achieve universal coverage under an individual mandate, but it also is important as a matter of fairness to the overwhelming majority of those who already have coverage or who voluntarily comply.

Because individuals interact with government in the course of carrying out normal activities (drivers licenses, state and federal taxes, enrolling for school, etc.), the Rolling Hills Group wanted to leverage existing structures at the state and local levels rather than create new bureaucracies to enforce an individual mandate for health coverage. In addition, many states also already have processes through which a person who had not enrolled in a health insurance plan could be assigned randomly to a health insurance plan.

Because most people file federal income taxes or can file for an earned income tax credit, the group identified the federal tax system as a key mechanism through which individual compliance can be enforced. If an individual had failed to pay premiums and/or lacked insurance, the tax system could be used to ensure payment, as well as coverage.

Ultimately, penalties will be needed to ensure compliance. Initially, penalties should be waived or phased in as the system is put in place, and initial implementation difficulties are resolved. In full effect, however, those individuals not complying with the mandate should be required to pay the premium they would have paid had they enrolled in coverage and be randomly assigned to a qualified insurance plan should they refuse to enroll in one.

Low income individuals, eligible for fully subsidized premiums, would incur no penalty, and those who would have been eligible for partially subsidized coverage would have lower penalties.

Key Recommendations on Enforcing an Individual Requirement

- Enforcement of a mandate should be accomplished primarily through an individual's regular interaction with existing government programs. Licenses, education and other public benefits would only be allowed upon proof of insurance.
- As the system is phased in, penalties should be modest. When fully implemented, those individuals not complying will be required to pay the premium they would have paid had they enrolled in coverage and will be randomly assigned to a qualified plan. Premiums and penalties would be collected, when necessary, via the federal tax system.
- An individual mandate alone will not provide affordable insurance. The overall system should create a progressive system in which lower income residents spend a lower percentage of their income on health care than higher income residents.

- The filing of federal income taxes also provides a logical opportunity to demonstrate proof of coverage. Self-certification on tax forms combined with cross referencing to insurer rolls would provide coverage information. Failure to have coverage could then, in turn, create a tax liability that would be applied towards health premiums.

Exemptions to an Individual Requirement

To broadly permit exemptions to an individual mandate would be to accept a level of chronically uninsured individuals. However, there may be situations in which a hardship exemption from penalties is warranted. The Rolling Hills Group is concerned there may be some rare set of circumstances that may exist whereby a hardship exemption may be warranted. Residents who may have the ability to cover the direct costs of their care should not be exempted from the mandate.

RISK POOLS AND INSURANCE REFORMS

Risk Pools

Reforms should be based on a statewide or regional risk pool through which individuals and businesses can obtain coverage that meets certain standard plan parameters. State or regional risk pools would not be only for high risk individuals. These risk pools would be for all privately insured individuals. By having the broader population included, the risk pools would provide a better representation of individuals at differing stages of health and help spread the risk among all individuals and businesses – which is the intent of insurance – having the healthy create a pool to cover the eventuality of illness.

The recommendation to create state or regional risk pools envisions that these risk pools would offer plans in a manner patterned after the Federal Employees Health Benefit Program (FEHBP). They would provide access to approved private sector insurance choices that compete for individuals through benefit design, price and quality.

The risk pools could be run by each of the states, with additional federal technical assistance, or managed through a federal entity. A “Federal Reserve” structure has been suggested by many reformers, and Medicare Part D has already created 34 “Insurance Regions” that have been shown to work in that model. Either structure is viable. While states could create state risk pools on their own, the Rolling Hills Group identified this as an area in which the federal government should require all states to develop these types of programs.

Insurance Reforms

The way in which the private insurance market operates is a disadvantage for small groups, individuals with health problems and older individuals. In order to achieve affordable universal coverage, insurance must be both accessible and affordable to all. In the case of the Rolling Hills plan, because it requires an individual mandate, how insurance is priced and accessed are key to the success of the plan.

Pre-existing conditions and rating rules: In the existing market, in most states, insurers can limit coverage so pre-existing conditions are not covered. Pre-existing conditions keep individuals from seeking care for existing health problems because of concerns about the cost of care. Coverage can be denied if the insurer determines an individual is high-risk because of previous health problems, or the coverage can be offered at a premium level unaffordable for most people. Pre-existing condition limits can really only be abolished if there is a universal system of insurance. If everyone is in the system, insurance can be a guaranteed issue, and the costs and risks can be appropriately shared.

Pure community rating, where everyone is charged exactly the same premium, is also not the answer. Pure community rating works to encourage bad health maintenance and unfairly transfers costs to the young and healthy. However, modified community rating, in which price varies within a reasonable range by age, location, and health behavior could serve to reinforce a system of universal insurance by creating incentives for people to voluntarily enroll in a fairer system.

Risk Adjusters and Risk Corridors: The Rolling Hills Group identified other mechanisms that will assist in making insurance affordable. This includes risk adjusters and risk corridors, systems that made the implementation of Medicare reforms more equitable and manageable. The use of risk adjusters and risk corridors will assist in assuring that healthier individuals are not more attractive to insurers, and those insurers attracting sicker individuals will be paid appropriately to cover that group. Risk corridors have been used in Medicare as part of a structure that compares actual incurred health benefit costs to estimated costs. If a plan were to have sicker beneficiaries with costs that exceed expected bid levels by a sufficient degree, the plan would effectively receive reinsurance to cover a portion of the loss. Likewise, if the plan's actual spending were to fall short by a sufficient degree of the bid level, the plan would share some of the unanticipated profit with the risk pool. This model was effective in drawing new plans into Medicare Part D in 2006, when insurers were entering a new market with better data on patient risk and spending.

A risk adjustment methodology is a different mechanism designed to adjust a plan's monthly premium to account for differences in a health plan's enrollees' expected spending on health care. The adjustment methodology is based on age, sex and detailed health spending history. While not perfect as predictors of spending, risk adjusters have been effective in Medicare in identifying appropriate payments and increasing the incentives to insure sicker patients. A risk adjustment factor could be applied prospectively. In the Medicare Part C and D programs, risk adjusters are applied to the federal government's share of the plan's monthly premium paid to Medicare Advantage and drug plans. As a result of the risk adjustment, the federal government pays more for sicker beneficiaries who are expected to experience higher drug costs and less for healthier enrollees who have lower drug spending. Risk adjustments help mitigate the risk of adverse selection. This is accomplished by effectively making it difficult to medically underwrite insurance because it is less attractive for plans to find low risk patients and more attractive to insure high risk patients.

ERISA Plans: Under the Rolling Hills plan, ERISA plans would continue if the employer chose to do so. These plans would operate outside of the Federal Health Reserve system or state regulatory scheme, but would participate in risk pools via “risk adjustment methodologies” to avoid systemic medical underwriting.

Insurance Profit Targets: In addition to the creation of a pool through which insurance is provided, the Rolling Hills Group recommends the development of targets for insurer profit. The group did not support establishing specific targets, as California has. However, it supports the concept that currently works in the FEHBP. By negotiating plan design, clearly defining administrative costs and negotiating to achieve goals, state risk pools could establish guidelines for profit. For example, average profit for a plan currently in the FEHBP program is about 3-4 percent and about 5 percent for private plans in Medicare Advantage. These are informal but fairly consistent guidelines in both programs.

The group also recommended that loss-benefit ratios be made public as a way to ensure appropriate spending for the provision of health benefits by the participating insurers.

Key Recommendations for Risk Pools and Insurance Reforms:

- Reform should include statewide or regional risk pools that operate similar to the Federal Employees Health Benefit Program (FEHBP), using private sector insurer choices that meet specific standards and compete on the basis of benefit design, quality and cost.
- Federal reform should include the development of mechanisms in order for state or regional reforms to work in conjunction with ERISA plans.
- Statewide/regional risk pools should be phased-in over time.
- Insurance provided through statewide/regional risk pools should be guaranteed issue and without preexisting condition exclusions.
- Modified community rating should be used to determine pricing. Variations should be limited to geography, age, and health behaviors.

- Risk corridors could be used to mitigate the risk for insurers and encourage new market entrants. Risk adjustments should be used to encourage appropriate payment to insurers and to allow for appropriate participation by ERISA plans.
- Guidelines for participating payer profits should be established, and medical loss ratios and other information to characterize payer performance should be made public.
- Employers should be provided annual plan and group utilization reports that allow them to easily shop for the best coverage for their employees at the lowest cost.

RISK POOL FINANCING, CONNECTING PEOPLE TO INSURANCE AND AFFORDABILITY

Risk Pool Financing

Risk pools must be adequately financed in order to assure coverage is available and affordable. While those with economic means would purchase insurance through the pools (or via employer plans), adequate sources of funding the subsidies for low income residents who are not capable of purchasing their own insurance, must be identified.

The Rolling Hills Group acknowledged that current stakeholders in the healthcare payment and delivery system would benefit from all Tennesseans and Americans having health insurance coverage, and they should be part of the equitable funding for the pool. The following areas were identified as potential funding sources for risk pools:

1. Redirected federal dollars from a limit on the tax deductions for employers who offer health insurance.
2. Redirected federal dollars resulting from the taxation of excessive employer funded health benefits.
3. ERISA plans paying a risk adjuster into a state/regional risk pool if the ERISA plan had a healthier than average plan enrollment than in the state/regional risk pool.

4. Public funding that currently goes to providers for disproportionate share, some graduate medical education costs and other existing “indigent care” subsidies, that, over time, could be reduced as more people have credible health insurance.
5. A refundable health tax credit -- in effect a subsidy for low income individuals -- through the federal tax code would guarantee a subsidy for a low income individual and payment to the insurer because the credit would go directly to the insurer.

To address concerns that some ERISA plans could leave their healthier workforces out of reform, a fee could be assessed by the state if the ERISA plan had a healthier group than the average of those state residents included in the statewide risk pool. This fee would be applied toward the funding for the statewide/regional risk pool. Similarly, if an ERISA plan had a higher risk score than a state/regional score, it would draw a payment from the risk pool to compensate for keeping higher cost patients from the pool. This risk adjustment mechanism has worked in Medicare Part C and D to promote insurance equity and should be utilized as well to make state insurance pools function equitably.

The need for payments from public programs designed to currently pay for the lack of payment or underpayment for services by some payers will decline over time if universal insurance is achieved. Therefore, the group felt these funds should be redirected to fund low income coverage via the risk pool. Medicare and Medicaid spend \$45 billion on subsidies that are rebated to indigent care. The group’s view was that the portion of these subsidies that directly relate to indigent care should be proportionately captured as universal insurance is phased in and lowers the uninsured rates. Eventually at least 50 percent of these subsidies should be redirected to pay for low income benefits via insurance pools. However, in relation to this issue, a concern was raised about the inadequate reimbursement from government payers (Medicare and Medicaid) that will not be impacted by universal coverage. Measuring improvement in

coverage so the increased coverage is not used as an automatic proxy for reduced payments will be critical.

The group recommended that reductions in uncompensated care be demonstrated before existing subsidies for bad debt, DSH, or other programs are reduced. The group does not want providers to contribute to the new system under the theory that they are benefiting from the reformed system without clear evidence of improvement.

In addition, funding for public programs should be maximized. For example, uninsured children and pregnant women who qualify for the state's CoverKids program should be enrolled in that program to maximize the availability of federal and state funding to support universal coverage. CoverKids is comprehensive health insurance available to uninsured children under age 18 and pregnant women with household incomes below 250 percent of the federal poverty level (\$53,000 for a family of four/\$26,000 for an individual in 2008).

A related issue was discussed by the group concerning subsidies. An individual mandate alone will not provide insurance. Insurance pools must offer a standard health plan to all enrollees with sufficient subsidies to allow all to purchase an approved plan. A means-tested system of subsidies for beneficiaries above Medicaid levels, would provide support if subsidies were phased in beginning with uninsured persons whose family income is less than 100 percent of the poverty rate.

Key Recommendations Related to Financing the Risk Pool:

- Consistent with the need to make a commitment to universal insurance, the group determined that if coverage were phased-in by income, funding needs to be adequate to support appropriate subsidies for the phase in.
- Federal funding from limitations on the tax exclusion for employer-provided health insurance would be redirected to assist in the funding of risk pools.

- Because manufacturers, facilities, providers and other stakeholders would benefit from more individuals with healthcare coverage, all stakeholders, including self-funded ERISA plans, should be required to be part of the funding of the risk pooling mechanism.
 - ERISA plans should be required to provide a risk adjusted payment to the risk pool, if the individuals enrolled in the plan are healthier than those in the state or regional risk pool, or the ERISA plan may draw from the risk pool if sicker – thus participating, by proxy, in community risk pools.
- Funds from payments for medical education, bad debt and disproportionate share would be reduced only after there is proof that increased coverage is leading to more services being reimbursed.
- Because the need for current funding of bad debt, and other indigent care subsidies would decline if the vast majority of health care were reimbursed, these funds from federal programs could decline, achieving savings, and be redirected to help fund risk pools.

Connecting to Insurance

Massachusetts has pioneered the concept of a statewide “connector” to assist individuals and families in obtaining information, enrollment and other necessary functions. The connector acts as a clearinghouse for individuals to obtain private insurance that meets the insurance reform and benefit standards.

This concept should be expanded and adopted as part of reform to assist individuals and serve to standardize what is being sold in the market and ensure that plans meet parameters of reform.

Key Recommendations for Connecting to Insurance:

- A state or regional entity needs to be part of government to assist individuals in determining the appropriate plan to purchase.
- A connector-like entity needs to be state or regionally -based, under a federal reserve like model. In either case, it should negotiate with plans

as the FEHBP does, to ensure that adequate plans are offered via the risk pools in the state or regions.

- Employers can assist in enrollment and providing information.
- As with the FEHBP, the connector needs to be a source for comparable information.
- Insurance and benefit functions would all be provided by private insurers.

Affordability and Subsidizing Coverage

Even with an individual mandate and additional reforms to structure the market, the Rolling Hills Group recognizes that low income individuals will need additional assistance in order to afford premiums and out-of-pocket costs, including co-payments and deductibles.

A system of subsidies, or “transfer payments” via the tax code will guarantee payment of premiums for lower income individuals. A refundable healthcare tax credit would ensure that an individual, even one that owed little or no taxes would be eligible to receive the credit. The credit acts as a subsidy for the cost of health coverage purchased through the risk pool. In this proposal, the credit would go directly to an approved plan to count towards premium. The Federal Health Reserve would match individuals, insurers and the credit.

The Rolling Hills Group, while not defining affordability is concerned that in a basic plan designed with a large deductible, the out-of-pocket costs may not be affordable for many individuals. Mechanisms must be developed to ensure that out-of-pocket costs do not serve as a barrier to accessing care if individuals choose a plan with a high deductible.

For low income individuals who do not meet categorical eligibility requirements for public programs, subsidies would be provided through the state risk pool.

Subsidies for individuals in private plans through the risk pool would be available at income levels above those for existing state Medicaid or other public

programs. For example, Tennessee's CoverKids program is available to uninsured children under age 18 and pregnant women with household incomes below 250 percent of the federal poverty level. Additional subsidies through the connector pools would be provided to individuals and families below 350 percent of poverty not otherwise covered.

Key Recommendations for Affordability and Subsidizing Coverage:

- The subsidies and the individual mandate will create a progressive system, whereby lower income residents spend a lower percentage of their income on health care than higher income residents.
- The risk pool will include mechanisms to subsidize coverage for lower income individuals who cannot afford premiums, but are not eligible for public programs. The recommended mechanism is a transfer payment, implemented via the tax system (refundable health credit) that would be transferable only to a connector approved health plan.

BENEFITS

The group recognizes the need to have a comprehensive benefit package so needed health benefits can be accessed by individuals and families. However, there was recognition that to specify an exact benefit package would prevent or hamper innovation. The group believes in a Federal Reserve model, the FHR would design a minimum benefit package, while still encouraging the creation of varying comprehensive cost-effective benefit packages offered through the risk pool. These plans would be actuarially equivalent to the basic plan, but insurers could create co-payments, deductibles and other benefits designed to allow individuals a choice of plans best suited to their needs.

The group recommended having a standard plan with a range between \$750 and \$1000 individual deductible, indexed to inflation from 2009. The basic plan should further reflect the benefits of the basic FEHBP Blue Cross Blue Shield Standard option PPO.

The Group also determined there should be an annual update to the minimum benefits that incorporates new evidence-based knowledge to include those services and benefits determined to be effective.

The Rolling Hills Group recommends using the FEHBP structure because it allows a central point for individuals and businesses to obtain insurance that meets basic coverage standards. It works well to spread risk through the pool, and uniform rules can be used for marketing, rating and updating. The group felt strongly about incorporating a key feature of FEHBP that provides choice of private plans through a regulated insurance market that includes an annual process (open season) in which plans can offer changes to be approved or the entity overseeing the plans can require changes.

Key Recommendations for Benefits:

- Plans must provide benefits that include coverage for inpatient and outpatient services, including drugs, labs, etc., and encourage prevention.
- A variety of private plans based on the actuarial value of the minimum benefit plan should be available through the risk pool.
- To improve care, an update process should include a comparative effectiveness process to identify services and benefits that are determined to be more effective.

HEALTHCARE DELIVERY SYSTEM REFORM

An important reform that must work in tandem with universal coverage and insurance reforms is systems reform to increase quality and produce better health outcomes. Systems reform should be designed to produce high value, cost-effective care using best practices.

Incorporating evidence-based medicine and improving upon the knowledge base used to create evidence-based guidelines needs to be part of a reformed system. Evidence-based medicine combines the best research evidence with the patient's values to make healthcare decisions. These guidelines are not fixed

protocols, but are intended for healthcare professionals and providers to consider.

Health researchers and policymakers are beginning to understand that a variety of factors impact the care decisions made for or by a patient and those factors, in turn, impact the cost of care overall and create differences in care regionally. These factors include: how fast providers adopt best practices; how many providers are in an area; and how providers were trained. However, hampering the use of best practices and evidence-based medicine is the lack of evidence in a variety of areas. To encourage the use of evidence-based guidelines, participating plans should be required to adopt incentives for providers in their networks to use current guidelines.

Demonstration projects assisting in provider education and in adopting best practices more swiftly into their practice that can be completed and incorporated into reform should be allowed to exist while reform is phased-in.

On the federal level, the Agency for Healthcare Quality and Research (AHQR) has worked to help develop evidence-based practice guidelines, although its original emphasis on this has decreased. AHRQ currently provides information to the National Guideline Clearinghouse™ (NGC), which is an internet web site intended to make evidence-based clinical practice guidelines and related abstract, summary and comparison materials widely available to healthcare professionals.

Tennessee should capitalize on the resources in the state that exist through its medical schools and universities to develop an ongoing review of all elements of the healthcare system. Because healthcare payment, coverage, delivery of service and site of care can impact health status and outcomes, it is important that Tennessee develop a resource that can contribute to the ongoing review of the system's elements. This review could contribute to cultivating continued improvement while reform is phased in and once reform has been implemented.

In addition, these resources could be used to further comparative effectiveness research at the state level.

Federal funding for the AHQR should be enhanced so it meets its original intent, which is to assist in the increased knowledge of providers about what works and what does not, and help providers incorporate information into their practices.

The Rolling Hills Group also recommends that the state/regional structure, via a federal reserve-like system insulated from the political pressures that impact Congress and the Centers for Medicare and Medicaid Services, implement coverage decisions for all connector plans and use guidelines.

Key Recommendations for Healthcare Delivery System Reform:

- Participating plans would be required to adopt evidence-based guidelines by providers in their networks.
- The risk pool should not be a mechanism to develop standards for provider payment, but should include standards for administrative functions of the participating insurers.
- Best practices that can be documented to reduce overall costs and improve quality should be integral to a reformed system.
- Geographic demonstration projects should be created, particularly in the initial “phase-in” stages of reform, to assist in the development of ways to better manage chronic care, address chronic health problems, such as smoking and obesity, find ways to assist in incorporating best practices and improve provider knowledge about cost-effective care.
- Tennessee should use its existing medical schools and universities to develop a health policy institute to foster development of comparative effectiveness, best practices and other quality improvements. In addition, this cooperative effort would provide ongoing review and recommendations concerning all aspects of health care in Tennessee, including the effect of provider payment and ability to use insurance to affect better health status.

- The federal government should provide increased funding to AHRQ in order for it to meet its intended mission of assisting in the development of best practices and improvement in the practice of medicine and the care of patients. In addition, regional Federal Reserve like organizations should also be required to assist in the improvement in the practice of medicine through the use of and funding of research that improves care.

PAYMENT REFORM

The current payment system contains many distortions that often lead to the use of high margin services and increased utilization of certain services over others. Incentives between varying segments of the healthcare system are not aligned to provide high value, efficient care.

In reviewing current payment models, the group found no current payment model that aligned incentives without raising other concerns. Some have viewed the use of pay-for-performance as a solution. These programs, sponsored by health plans and employers, are mostly intended to reward providers with additional monies for quality performance demonstrated by evaluation of structure, process and outcomes of care. There is some evidence these programs, aimed both at hospitals and physicians, are producing some improvement on the parameters measured. There also are real questions about their sustainability and true impact in terms of their costs of implementation. There also are questions about their applications in the broader context of a payment system, whether fee for service, capitation or any of their variants, that otherwise have failed to produce the quality of care patients and providers would want.

Balancing Competition and Collaboration: The Rolling Hills Group expressed concerns about the consolidation of health plans and other entities reducing competition in the health market place. However, collaboration among entities can also improve health care by better aligning payment incentives. How competition and collaborative efforts to improve health care outcomes are balanced is important. The Rolling Hills Group decided joint ventures should be

encouraged as a way to improve the coordination of financing and delivering health care among providers and to develop new systems to address chronic care.

Because joint ventures are “virtual mergers,” they must comply with all antitrust requirements and related fraud and abuse enforcement and regulation.

Recommendation: Joint ventures among plans, hospitals and providers should be encouraged to develop new ways to align financial incentives, assure appropriate levels of care and manage individuals with chronic diseases in which all members of the venture are at risk.

Recommendation: The way in which antitrust laws are now enforced should be re-examined to allow for efficiency in the health market.

Payment System Reform

One of the primary goals of payment system reform should be to align incentives among providers. The current healthcare system is ill-equipped to handle a rapidly growing population of senior-aged baby boomers who will enjoy increased longevity, while living longer with chronic illnesses and diseases. It is estimated that, by the year 2015, 150 million Americans will have at least one chronic condition. This wave of new chronically ill patients will further tax an already strained system of healthcare provision and payment. At a time of increased demand on the system, there is strong evidence that there is a countervailing force at work on the delivery side. Fewer newly educated physicians are entering primary care and seasoned physicians, feeling pressure to see more patients in less time, are retiring or moving to other fields.

Because Medicare, administered by CMS, is a national program, it touches upon a variety of providers across the country and is in a position to impact change. CMS has and continues to develop and implement demonstration projects

examining payment methodologies and how to better align incentives to improve care for patients. Private entities also have experimented with payment and how it impacts care. In addition, the use of information technology by providers and individuals may also impact the way in which patient care is provided and monitored in the future. The Group reviewed payment systems in Arizona and Maryland, and examined how current payment impacts health delivery.

Key Recommendations for Reforming the Payment System:

- Payment systems should begin to develop mechanisms to pay for care that produces better outcomes. New models of payment that better align incentives among providers must be included.
- Because of the growing number of Americans living with chronic diseases, payment reform should include an emphasis on disease management, including incentives for providers who successfully treat chronic care patients, such as a medical home model.
- As the use of email and electronic and personal health records increases, payment systems should recognize care provided through communication systems that encourage regular review of patient care.
- Payers should be required to have payment systems evaluated to ensure payment does not deter the use of primary care and services that assist in disease management.
- Demonstration projects should test how Tennessee could adopt payment and care models that emphasize health and wellness.

TORT REFORM

It will be difficult to pass legislation to address tort reform directly in Tennessee because current data show that Tennessee does not have a significant problem. The June 2008 issue of the *State Litigation Guide* reports the following: "Moving up from 11th place in last year's rankings, Tennessee is now the top-ranked state. Pacific Research Institute's 2008 report listed Tennessee as the state with the lowest litigation risks in the country. While the state's liability climate encourages growth and job creation, it is also a state to watch because its tort

laws do not place limits on non-economic and punitive damages and there are plaintiff-friendly venues in Tennessee. The state Supreme Court is considered neutral on liability issues.”

The cost to the healthcare system of the threat of medical malpractice extends beyond the cost of lawsuits. According to the PWC Health Research Institute, one of the top three areas of wasted spending is defensive medicine, which results in the provision of unnecessary care at an estimated cost to the U.S. healthcare system of \$210 billion annually. A landmark study from *The New England Journal of Medicine* analyzed more than 1,400 malpractice claims and found that in almost 40 percent of cases, no medical error was involved. In facing an unpredictable malpractice climate, a physician's instinct is to increase testing. Trying to explain a medical catastrophe, the physician does not want to be in a position to defend why a specific test was not ordered. Unfortunately, patients often equate defensive medicine with more thorough care.

An additional benefit of evidence-based medicine is a potential reduction in malpractice liability. The engagement of patients on practice guidelines being used to treat them and transparency of the care should enhance the doctor-patient relationship. There now is evidence that physicians who do not follow clinical practice guidelines have a six-fold increased risk of being sued for malpractice. Over the last 30 years, the most effective risk management technique to prevent malpractice exposure has been a good doctor-patient relationship. This relationship also reduces the need to practice defensive medicine.

Recommendation: Tort reform should be studied as part of Tennessee reform, and at a national level, plans and providers should be incentivized to follow evidence based guidelines through the Federal Reserve Health System. Tennessee medical malpractice issues should be studied and documented by the state’s medical schools.

TRANSPARANCY IN THE HEALTHCARE SYSTEM

While steps have been taken to make some aspects of the healthcare system more transparent to patients and purchasers of health care, more needs to be done. To date, transparency has related to reporting provider costs, in large part, charge data and quality. However, even these efforts are in their infancy. Purchasers want to know what value they are getting for their healthcare dollars. Patients want to know who the best provider is for their particular problem. Information can help employers, consumers, providers, and payers shape improvement of the overall system.

Information about payer performance, including medical loss ratios, denial rates and percent of claims processed on initial submission, days in accounts receivable and other similar metrics, can help providers determine the most efficient processors of claims. All providers can benefit from information that allows them to create benchmarks.

The federal government is actively supporting transparency. On August 22, 2006, President Bush signed an Executive Order requiring four federal agencies that administer or sponsor federal health insurance programs to compile information about the quality and price of healthcare they pay for and share that information with their consumers and each other.

Under the Executive Order, local information on the quality and cost of care ultimately will be available from a collaboration of healthcare providers, public and private payers, and other stakeholders in different regions of the country. The goal is to create a broad, reliable foundation of information on the quality and price of services delivered by each healthcare provider.

State governments also have been active in the drive to increased transparency. Many states, including Tennessee, have web sites that provide information about hospital costs or charges operated by the state or hospital associations.

Key Recommendations for Transparency in the Healthcare System:

- Develop mechanisms through which patients and payers can choose providers based on quality standards.
- Provide cost information to patients, in addition to purchasers.
- Make insurer loss ratios public so comparisons can be made about the amount spent on medical care by insurers.
- Provide consumers and businesses easy-to-use information about the health plan's success in managing specific health problems, such as diabetes, out-of-pocket costs, ease in accessing providers and quality of providers.

END OF LIFE CARE

The tragic case of Terri Schiavo raised many Americans' awareness about end of life care and the many complex social and emotional issues related to it. The ongoing media coverage assisted many in discovering their state laws on advanced directives and other ways in which to legally make a patient's wishes known before they could not speak for themselves. However, as more distance occurs from those events, many have not updated or reviewed those wishes or put the documents in places where they cannot be found by family members or failed to have conversations with family members.

In 2008, the Dartmouth Atlas of Health Care released information that demonstrated wide variations in the amount and cost of care that Medicare patients receive in their last two years of life. While the national average was \$46,412, the cost of care among the top five ranked teaching hospitals (by *U.S. News & World Report*) ranged from a high of \$93,842 at U.C.L.A.'s Medical Center to \$53,432 at the Mayo Clinic's St. Mary's Hospital in Rochester.

In this research, the Dartmouth Atlas found variation in spending is largely due to the supply of hospital beds and physicians. Where medical decisions are discretionary, hospital admission rates are strongly correlated with the local

supply of hospital beds, and in regions with more physicians, the frequency of visits is higher. In the region that used the most “supply sensitive” care, terminal patients had an average of almost 60 visits during their last six months; in the lowest ranked regions, that average was about 15 visits.

However, the Rolling Hills Group recognized that there may not be one answer that is easily adoptable in all states related to communicating and following patient wishes.

Tennessee should use the resources of its medical colleges and hospitals to pioneer the collection of provider-specific data to assist individuals and families in knowing what providers are likely to follow their wishes for end of life care and continue to stress patient education about the appropriate documentation in order to ensure a patient’s wishes are followed. Also providers need to continue to develop ways in which to help patients and families have conversations about their care.

Numerous research points to variation in medical practice in a number of areas of health care, and end of life care is no different. Federal research concerning evidence-based medicine should place an emphasis on assisting providers with better information about end of life care that can be implemented in their practices.

Key Recommendations Related to End of Life Care:

- Evidence-based medicine research should emphasize assisting providers so they have better information and understanding about end of life care so patients and their families are able to access end of life care services at the appropriate time.
- Tennessee and the nation should have an ongoing education effort concerning living wills, advanced directives and healthcare proxies, and encourage conversations between providers and families about care at the end of life.

PRESCRIPTION DRUG AND MEDICAL SUPPLY COSTS

The Rolling Hills Group did not study the issue of prescription drug and medical supply costs in detail, but they were clearly identified as problems in many of the areas it did review.

In Tennessee alone in 2005, there were 103 million prescriptions filled at a cost of \$7.1 billion. Tennessee spending averaged \$1,192.56 per resident for 17.3 prescriptions per Tennessee resident. According to the Kaiser Family Foundation from 1994 to 2004, the number of prescriptions purchased in the United States increased 68 percent, while the population only grew 12 percent.

Retail prescription prices have increased, on average, 8.3 percent annually between 1994 and 2004, much faster than the average inflation rate of 2.5 percent. These prices include, in some cases, those of newer, higher-priced brand name drugs that have replaced older, less expensive drugs, and impact the movement from brand name drugs to their generic equivalents.

In analyzing the volume of drugs consumed per person (standard drug units per capita) for the nine major therapeutic areas in Germany, Canada, the U.S. and United Kingdom, McKinsey found U.S. patients consumed approximately 20 percent less prescription drugs than patients in these other nations. McKinsey also determined drug costs in the U.S. healthcare system are 70 percent higher than in peer nations. A comparison of branded drugs in the U.S. and Canada shows that in the United States, prices of branded products are 60 percent higher.

Pharmaceutical manufacturers make substantial investments in marketing to consumers and physicians, which may influence consumer demand and physician prescribing practices. Furthermore, the most heavily advertised products tend to be newer, more expensive drugs. This results in overall increases in spending.

Drug manufacturers obtain a form of legal protection as do other manufacturers of products from placing patents on their discoveries and innovations. These patents provide manufacturers with an exclusive right to sell new drug products for up to 20 years from the date of the patent filing. Once a patent expires, the drug or innovation may be used to create a generic drug. Drug manufacturers are able to charge relatively high prices during the period in which they are protected by the patent. This is in part because of the cost to develop and research innovations. There is much debate, however, about how patent laws work, including what is the appropriate period for exclusivity and the ability of manufacturers to extend the exclusivity period.

In addition, the Food and Drug Administration's rules concerning direct-to-consumer advertising were changed over a decade ago, resulting in an increase in direct to consumer advertising. A *New England Journal of Medicine* article (August 16, 2007) reported that total spending on pharmaceutical promotion grew from \$11.4 billion in 1996 to \$29.9 billion in 2005. The percentage of sales spent on promotion for the industry as a whole increased from 14.2 percent in 1996 to 18.2 percent in 2005. Yet, promotion to professionals still outweighs spending on direct-to-consumer advertising. In 2005, only 14 percent of total industry expenditures on pharmaceutical promotion were devoted to direct-to-consumer advertising.

Thirteen state Medicaid programs and the federal government have begun to fund drug comparison effectiveness studies. Whether or not this will control costs, this information can help policymakers and providers better determine what drugs should be reimbursed or made more available than others on formularies. It also will provide physicians and others better information when making healthcare treatment decisions about what drugs to use. However, this work has only begun and while making progress, head-to-head comparisons are not available for many drugs.

Key Recommendations:

- The federal government should return to its original rules concerning direct-to consumer-advertising, which required that an ad running on television or other electronic medium, also be published in a publication including detailed product information that would reach a comparably sized audience. This significantly limited direct to consumer advertising.
- States and the federal government should make comparison effectiveness research a priority and develop mechanisms to assist providers and consumers in having objective information about drugs and medical devices and their effectiveness. In a Federal Reserve model, the fed-like entity should make drug coverage recommendations that would guide plan formularies for cost and effectiveness.
- Pharmacy Benefit Managers should provide increased transparency concerning drug costs and utilization.

Health Information Technology

The health sector is behind other sectors of the American economy in using information technology. While the value of using information technology has been well documented, the slowness in developing standards and addressing interoperability issues as well as privacy concerns is greatly hampering the U.S. health care system. All stakeholders would benefit from an information system through which providers could share necessary health information, reduce the number of tests and allow patients better information about their health status and care options. While Congress and the Department of Health and Human Services discuss health IT initiatives to address interoperability and privacy concerns, a reformed health care system must have information technology as a working component. The Rolling Hills Group strongly urges that standards be developed and a viable informational technology system be put in place as health care reform is phased in.