Health Care Primer for Members

Rep. Michael C. Burgess, M.D.

Health Care Primer for Members

prepared by

Rep. Michael C. Burgess, M.D.
Health Subcommittee
Committee on Energy and Commerce

Contents

Introduction

Too often Republicans are criticized for their lack of enthusiasm or knowledge when it comes to talking about health care. Whether that critique is fiction or contains a kernel of truth, the fact remains that we must overcome this perception. *Health Care 101* aimed to provide Republican Members of Congress with the tools to communicate effectively about health care to their constituents and the media.

Throughout the four sessions, discussions focused on the development of our hybrid system of health care, which combines the public funding from the government and the funding from private insurance companies. More in-depth conversations centered on government health care programs Medicare, Medicaid, and SCHIP, and the private and employer-based insurance markets – how they work and how they can be reformed to best serve the American public. The final session used polling data to demonstrate what Americans are looking for with regards to health care policy.

According to a recent poll by Dutko Worldwide, 47% of Americans trust Democrats more to handle health care, where only 32% trust Republicans more to handle the issue. This document not only contains information from the four *Health Care 101* sessions, but I have also included additional information that Republican members and their staff can utilize when crafting your health care message. We have a common-sense plan to lower costs while improving access and quality. Now is the time for Republicans to step out of the shadow of the Democrats-led health care discussion and go forth with our message of more affordable, portable, and innovative care.

Rep. Michael C. Burgess, M.D.

A Brief History of U.S. Health Care

McCarran-Ferguson

The modern health care system becomes most recognizable following the 1944 Supreme Court ruling *U.S. v. South-Eastern Underwriters*. *U.S. v. South-Eastern Underwriters* classified insurance as an item of interstate commerce and would therefore fall within Congress' Constitutional authority to regulate.

The McCarran-Ferguson Act, however, delegates Congress' regulative power to the various States, who have established their own regulatory entities. Under McCarran, the insurance industry is exempt from *some* federal anti-trust statutes, and the exemption primarily applies to gathering data in concert for the purpose of rate-making.

Otherwise, antitrust laws prohibit insurers from boycotting, acting coercively, restraining trade, or violating the Sherman and Clayton Acts. Effectively, McCarran delegates authority to the states to the extent that the states regulate the business of insurance, creates and maintains a broad insurance regulatory system, and balances regulatory objectives against antitrust policy objectives.

Employer-Based Coverage

Even though examples of health insurance in the U.S. go back more than 200 years, most Americans did not have health insurance coverage until the latter half of the 20th Century. The demand for more workers during World War II and a wage freeze imposed by the federal government generated great interest in employer-sponsored insurance as a worker recruitment and retention tool. Buoyed by legislation and court ruling declaring the tax exemption of fringe benefits, and support from unions for work-based coverage, health insurance became a pervasive employment benefit.

In 1974, President Ford signed the Employee Retirement Income Security Act (ERISA) into law. ERISA outlines minimum federal standards for private-sector employer-sponsored benefits. (Public employee benefits and plans sponsored by churches are exempt from ERISA.) Passed in response to abuses in the private pension system, the act was developed with a focus on pensions but the law applies to a long list of "welfare benefits" including health insurance. The act requires that funds be handled prudently and in the best interest of beneficiaries, participants be informed of their rights, and there be adequate disclosure of a plan's financial activities. ERISA preempts state laws that "relate to" employee benefit plans. (In other words, the federal law overrides state laws affecting private-sector employee benefits.) This portion of ERISA was designed to ensure that plans would be subject to the same benefit law across all states, partly in consideration of firms that operate in multiple states.

Federal Health Programs

Why did the federal government get into health care?

Medicare was enacted in 1965 in response to the concern that only about half of the nation's seniors had health insurance, and most of those only had coverage for inpatient hospital costs. The new program, which became effective July 1, 1966, included coverage for hospital and post-hospital services under Part A and doctors and other medical services under Part B. As was the case for the already existing Social Security program, Part A was to be financed by payroll taxes levied on current workers and their employers. Payments to health care providers under both Part A and Part B were to be based on the most common form of payment at the time, namely "reasonable costs" for hospital and other institutional services or "reasonable charges" for physicians and other medical services.

Medicare

At a Glance

Who is served?
Anyone aged 65+, certain disabled individuals, and those with terminal kidney diseases. A total of 37.4 million elderly are covered and 7.3 million disabled.

How much does it cost?
In FY08, the federal government spent approximately $388.9 billion – 13% of the total federal budget and 3% of GDP.

What services are provided?
(Part A) inpatient hospital services, post-hospital skilled nursing facility services, home health care, hospice care; (Part B) physician services, laboratory services, therapy services, durable medical equipment, ambulance services; (Part C) Medicare Advantage

Medicare is the nation's health insurance program for persons aged 65 and over and certain disabled persons. In FY2008, the program will cover an estimated 44.6 million persons (37.4 million aged and 7.3 million disabled) at a total cost of $459.4 billion.

Federal costs (after deduction of beneficiary premiums and other offsetting receipts) will total $389.9 billion. In FY2008, federal Medicare spending will represent approximately 13% of the total federal budget and 3% of GDP.

Medicare is an entitlement program, which means that it is required to pay for services provided to eligible persons, so long as specific criteria are met.

Since Medicare was enacted in 1965, it has undergone considerable changes. First, program coverage was expanded to include the disabled and persons with end-stage renal disease (ESRD).

Over time, increasing attention was placed on stemming the rapid increase in program spending, which outpaced projections, even in the initial years. This was typically achieved through tightening rules governing payments to providers of services and stemming the annual updates in such payments.

The program moved from payments based on "reasonable costs" and "reasonable charges" to payment systems under which a pre-determined payment amount is established for a specified unit of service. At the same time, beneficiaries were given the option to obtain covered services through private managed care arrangements.

Most Medicare payment provisions were incorporated into larger budget reconciliation bills designed to control overall federal spending.

In 2003, Congress enacted a major Medicare bill, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). This legislation placed increasing emphasis on private sector management of benefits.

It also created a new voluntary outpatient prescription drug benefit to be administered by private entities. Further, it introduced the concept of means testing into what had previously been strictly a social insurance program.

Congress continues to register concern about the rapid rise in Medicare spending and the ability of existing funding mechanisms to support the program over the long-term.

A combination of factors has contributed to the rapid increase in Medicare costs. These include increases in overall medical costs, advances in health care delivery and medical technology, the aging of the population, and longer life spans.

The issues confronting the program are not new; nor are the possible solutions likely to get any easier. For a number of years, various options have been suggested; however, legislative changes have focused on short-term issues. There is no

Medicaid

In existence for 43 years, Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term care to more than 61 million people at an estimated cost to the federal and state governments of roughly $317 billion.

Of all federally supported programs, only Medicare comes close to this level of spending, and only Social Security costs more.

Each state designs and administers its own version of Medicaid under broad federal rules. There is significant variability in eligibility, covered services, and how those services are reimbursed and delivered among the states.

Medicaid was enacted in 1965 in the same legislation that created the Medicare program. It grew out of and replaced two earlier programs of federal grants to states that provided medical care to welfare recipients and the elderly. It has expanded in additional directions since that time.

In the federal budget, Medicaid is an entitlement program that constitutes a large share of mandatory spending. Two other federally supported health programs -- Medicare and the State Children's Health Insurance Program (SCHIP) -- are also entitlements, and are also components of mandatory spending in the federal budget.

All three programs finance the delivery of certain health care services to specific populations. While Medicare is financed exclusively by the federal government, both Medicaid and SCHIP are jointly financed by the federal and state governments.

Federal Medicaid spending is open-ended, with total outlays dependent on the generosity of state Medicaid programs. In contrast, SCHIP is a capped

At a Glance…

Who is served?
In general, Medicaid is targeted at individuals with low income and statute defines 50+ distinct population groups as being potentially eligible. Roughly 61 million people were enrolled in Medicaid at some point during the year in FY2007: 29.2 million were children, 16.2 million adults in families, 9.5 million individuals with disabilities, and 6 million people over the age of 65. Statute and regulations set forth who *must* be covered and who *may* be covered based upon financial requirements. Because Medicaid is a State-Federal partnership, states may request to cover more individuals through a waiver.

How much does it cost?
In FY2006, Medicaid spending totaled $314 billion, with a federal share of $179 billion and a state share of $135 billion.

What services are provided?
Primary and acute medical services and long-term care. Certain services are required, but states have some flexibility in requiring/providing additional services and benefits.

federal grant to states.

Even though Medicaid is an entitlement program in federal budget terms, states may choose to participate, and all 50 states do so. If they choose to participate, states must follow federal rules in order to receive federal reimbursement to offset a portion of their Medicaid costs.

SCHIP

The Balanced Budget Act of 1997 established the State Children's Health Insurance Program (SCHIP) under a new Title XXI of the Social Security Act. In general, this program allows states to cover targeted low-income children with no health insurance in families with income that is above Medicaid eligibility levels.

The highest upper income eligibility limit for children in SCHIP is 350% of the federal poverty level ($74,200), in one state, New Jersey.

Under SCHIP, states may enroll targeted low-income children in an SCHIP-financed expansion of Medicaid, create a new separate state SCHIP program, or devise a combination of both approaches.

At a Glance…

Who is served?:
SCHIP is intended to serve low-income children (up to age 19) without health insurance. However, states may choose to expand eligibility to children at higher income levels and adults.

How much does it cost?:
In FY2007, total SCHIP spending was $8.7 billion, with the federal government paying the bulk at $6 billion and states contributing $2.7 billion.

What services are provide?:
Many states simply expand their Medicaid programs with SCHIP dollars and are therefore required to provide the full range of mandatory benefits under Medicaid. Some states create separate SCHIP programs and typically cover hospital visits, physician services, and age-appropriate immunizations.

States choosing the Medicaid option must provide all Medicaid mandatory benefits and all optional services covered under the state plan. In addition, they must follow the nominal Medicaid cost-sharing rules or apply the new state plan option for premiums and service-related cost-sharing as allowed under the Deficit Reduction Act of 2005 (DRA).

In general, separate state programs must follow certain coverage and benefit options outlined in SCHIP law. While some cost-sharing provisions vary by family income, the total annual aggregate cost-sharing (including premiums, copayments, and other similar charges) for a family may not exceed 5% of total income in a year. Preventive services are exempt from cost-sharing.

Nearly $40 billion was appropriated for SCHIP for FY1998 through FY2007 in BBA 97, with the annual allotments to states determined by a formula using a combination of the estimated

number of low-income children and low-income *uninsured* children in the state, adjusted by a state health cost factor.

Four continuing resolutions provided appropriations through December 31, 2007, for SCHIP allotments in FY2008. The Medicare, Medicaid, and SCHIP Extension Act of 2007 appropriated funds to ensure no state's SCHIP program runs out of federal SCHIP funds before March 31, 2009.

All states, the District of Columbia, and five territories have SCHIP programs. The territories, the District of Columbia, and 8 states use Medicaid expansions; 18 states use separate state programs; and 24 states use a combination approach.

At the national level, approximately 7.1 million children were enrolled in SCHIP during FY2007, up from 6.7 million in FY2006. In addition, 14 states reported enrolling about 587,000 adults in SCHIP through program waivers in FY2007.

Spending was slow in the early years of SCHIP, but that trend changed in more recent years and led some states to exhaust their federal SCHIP funds. Congress appropriated additional SCHIP funds to address states' shortfalls in FY2006 ($283 million) and FY2007 ($650 million).

Congress passed two bills that would "reauthorize" SCHIP -- providing SCHIP funding through FY2012 and making other changes to both SCHIP and Medicaid.

Both H.R. 976 and H.R. 3963 were vetoed by the President, with the Congress unable to override these vetoes. MMSEA was enacted to provide federal SCHIP funds through March 31, 2009, and did not make changes to the program.

Public Health Service Agencies

Food and Drug Administration (FDA)

The FDA plays a central role in protecting the public health in the U.S. by regulating most of the food supply and vitally important medical products, including drugs, devices, and biologics that affect American lives on a daily basis. FDA regulates products valued at more than $1 trillion in the U.S. economy. In the area of health care, the FDA is responsible for the safety and the effectiveness of human drugs, vaccines, medical devices, and animal drugs. About 25% of American consumer dollars are spent on FDA-regulated products.

Centers for Disease Control and Prevention (CDC)

The mission of the CDC is "to promote health and quality of life by preventing and controlling disease, injury, and disability." The CDC is the nation's principal public health agency, providing coordination and support for a variety of population-based disease and injury control activities.

Approximately 75% of the agency's funding is spent extramurally through grants, contracts, and cooperative agreements to various stakeholders, including state, local, municipal, and foreign governments, non-profit organizations, academic institutions, and others. The CDC coordinates, analyzes, and disseminates public health information derived from a number of health surveys and disease surveillance systems that it manages.

National Institutes of Health (NIH)

The NIH is the primary agency of the federal government charged with conducting and supporting biomedical and behavioral research. It also has major roles in research training and health information dissemination.

NIH is the largest of the Public Health Service agencies with an FY08 budget of $29.2 billion and total employment of more than 18,000 people. The NIH is organized into 27 institutes and centers focusing on various diseases and organs, including the National Cancer Institute and the National Eye Institute.

Private Sector

Employer Based Health Coverage

Section 106 of the Internal Revenue Code states that employer contributions to employment-based health insurance are not included in workers' gross incomes for tax purposes.

This tax preference encourages workers to sign up for ("take-up") health coverage within the work setting. A separate ruling by the Internal Revenue Service clarified that such employer contributions are business expenses and, therefore, deductible from employers' taxable income.

Both parties benefit: employers use health insurance coverage as a means to recruit and retain workers, while workers typically get access to more services at better rates (see discussion below). However, workers generally receive reduced wages to compensate for richer benefits.

The tax exclusion of health benefits is one of the primary reasons why health insurance coverage is provided mainly through the workplace in the United States. Approximately two out of three nonelderly (under 65) Americans have employer-sponsored insurance. Moreover, of nonelderly persons with private health coverage, approximately nine out of 10 obtain it through the workplace.

Individual Health Insurance Market

The individual insurance ("non-group") market is often referred to as a "residual" market. The reason is because this market provides coverage to persons who cannot obtain health insurance through the workplace and do not qualify for public programs. Consequently, the enrollee population for this private health insurance market is small. Individuals in this market also include the self employed and those purchasing coverage between jobs.

Applicants to the individual insurance market must go through robust underwriting. Insurance carriers in most states conduct an exhaustive analysis of each applicant's insurability. An applicant usually must provide his medical history, and often undergo a physical exam. This information is used by carriers to assess the potential medical claims for each person.

Rigorous underwriting results in an enrollee population that is fairly healthy, thereby excluding persons with moderate to severe health problems from the private nongroup insurance market. In general, premiums are higher for individuals in the nongroup market and individuals do not enjoy the same tax benefits as those who purchase coverage through an employer.

Important Areas of Reform

Portability Because of the tax treatment of health insurance, a vast majority of Americans get their insurance through their employers. While most Americans are pleased with the coverage they receive through their employers, when they change jobs they are forced to get new insurance. Republicans should support efforts to make individuals' health care portable from job to job.

Tax Equality The current tax code is heavily slated towards promoting an employer-based system, providing tremendous tax relief to employers who provide coverage for their employees. While employer-based coverage is important and popular, the tax system should be changed to provide equality for those wishing to buy their own insurance. With many Americans self-employed or periodically unemployed, it is nearly impossible, due to cost, for them to purchase their own health insurance.

Strengthen Hybrid System The American health care system is a hybrid system – financed by both public and private funds. Liberals are calling for the U.S. to abandon this system and move towards one run by the government. This would be a tragic setback to American medical innovation.

Cost Sharing With spending on entitlement programs like Medicare and Medicaid on the rise, one measure to save money in these programs is to get beneficiaries to share in the cost.

The Problem with Nationalized Medicine

Democrats wish to expand culture of dependence on the state while Republicans want to expand the number of individuals who can direct their own health care. A system fully funded by a payroll tax or other policy has no reason to seek improvement, and as a consequence faces stagnation. Additionally, in such a system if there becomes a need to control costs, that frequently comes at the expense of the provider.

Then there is the issue with the Democrat-proposed health care mandates. According to a recent poll by Dutko Worldwide, more than three-fourths of those polled oppose financial penalties for those who do not comply with a health insurance mandate.

Think of the largest mandate Americans are faced with today – taxes. Roughly 85% of Americans adhere to this mandate and pay their taxes. Currently 85% of Americans have health insurance coverage of some sort. Why should be believe that mandating health care would motivate that final 15% - the same amount of Americans who refuse to adhere to the other nation-wide mandate – to obtain health care insurance? This is an important question that we must be asking.

That same Dutko poll showed that Americans would rather pay higher costs for health care and have more choices. Senator Obama and Senator Clinton's plans would do just the opposite – costs would likely lower but choices would drastically decrease. The fact is, the United States is not Europe. American patients are accustomed to wide choices when it comes to hospitals, physicians, and pharmaceuticals.

Because our experience is unique and different from other countries this difference should be acknowledged and embraced when reform is contemplated in either public or private health insurance programs within this country.

A news story by a national Canadian television broadcaster showcased a Canadian member of Parliament who sought treatment for cancer in the United States. The story itself is not particularly unique but the online comments that followed the story I thought were particularly instructive.

As one writer summed it up, "She joins a lengthy list of Canadians who go to the United States to get treated. Unfortunately, the mythology that the state-run medicine is superior to that of the private sector takes precedent over the health of individual Canadians." The comments of another individual:

> "'The story here isn't about those who get treatment in the states. It's about a liberal politician that is part of a political party that espouses the Canadian public system and vowed to ensure that no private health care was ever going to usurp the current system. She is a Member of Parliament for the party that

relentlessly attacked the Conservatives for their "hidden agenda" to privatize health care. The irony and hypocrisy is that position supports the notion that the rich get health care and the rest of us wait in line, all because liberal fear mongering that does not allow for a real debate on the state of the healthcare system in Canada."

One final note from the online postings: "It's been sort of alluded to but I hope everyone reading this story realizes that in fact we do have a two tiered health care system. We have public care in Canada, and for those with LOTS of cash, we have private care in the United States, which is quicker and in many cases better."

The United States is indeed at a crossroads. It is incumbent that every one of us who believes in the private sector involvement in health care in the United States of America (and believes in the inevitable failure of government-run health care) to stay educated and involved and committed to being at the top of our game.

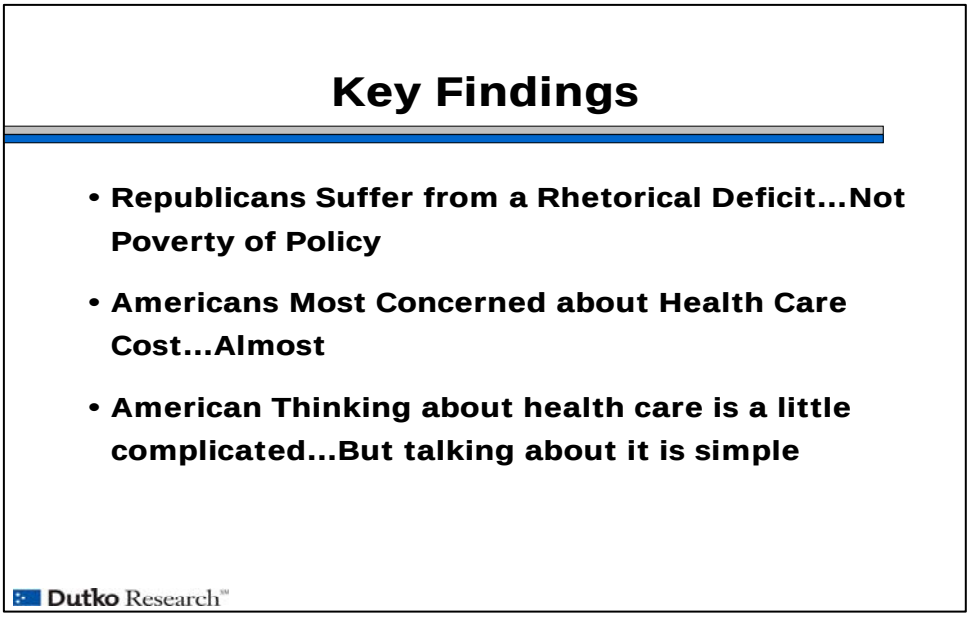
This is one of those rare instances where in it is necessary to be prepared to win the debate, even though we know we may lose the vote in the House of Representatives.

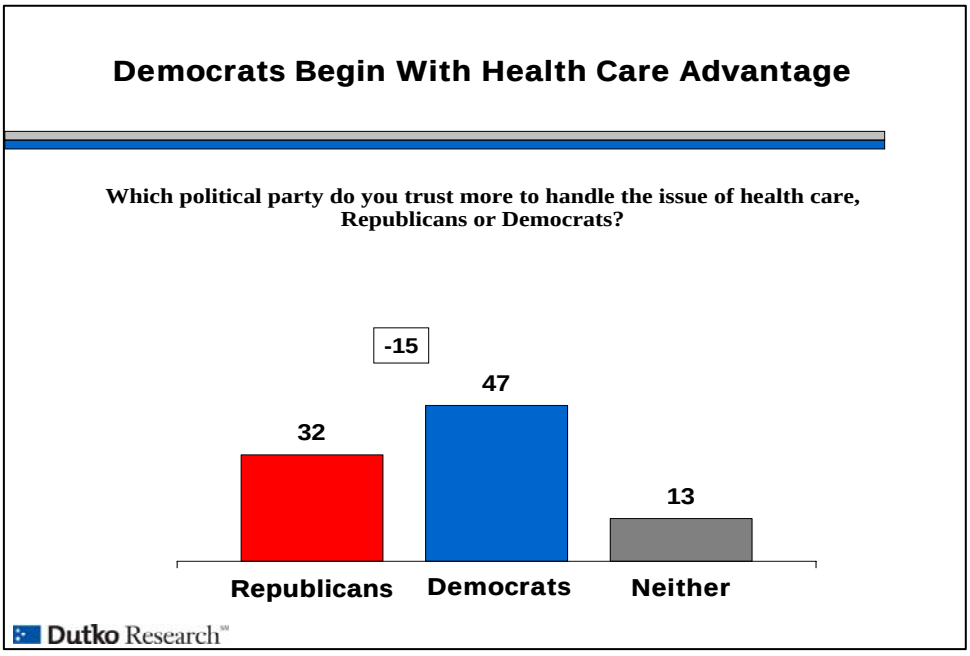
The Most Innovative Health Care in the World...

For 22 of the last 25 years, a Nobel Prize in Medicine was awarded to a researcher working in the U.S.A.

How to Talk About Health Care

Dutko Worldwide's aforementioned poll briefly touched on what messages resonate best with Americans. The message that fared best with those polled – over 50% - stated, "We should empower families, not bureaucrats…doctors and patients, not lawyers, to make health care decisions."





GOP Lagging Among…

Which political party do you trust more to handle the issue of health care, Republicans or Democrats?

	GOP Margin
Black Voters	-71
Unmarried White Voters	-26
Independent Voters	-24
White Women	-13

Dutko Research℠

GOP Stronger Among…

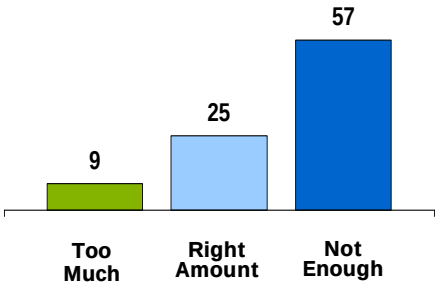
Which political party do you trust more to handle the issue of health care, Republicans or Democrats?

	GOP Margin
White Men	+6
Married White Voters	+4
Seniors	-3

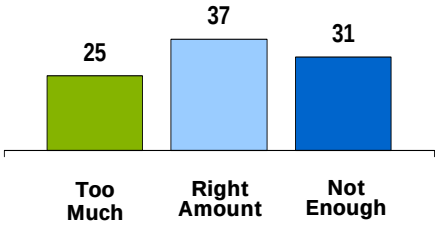
Dutko Research℠

Majority Says Republicans Do Not Talk Enough About Health Care

Would you say Republicans talk about health care too much, the right amount, or not enough?



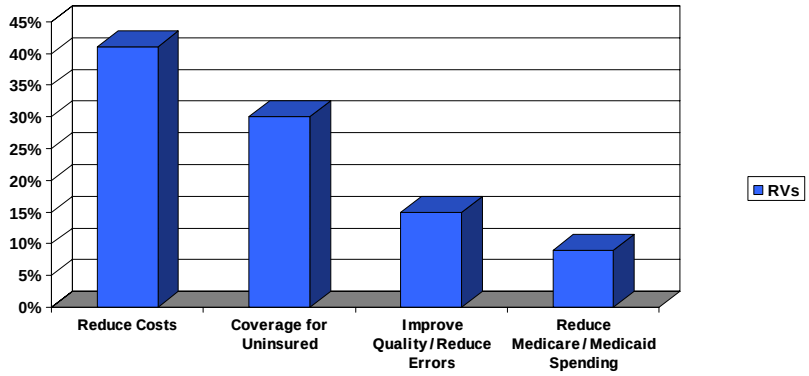
Would you say Democrats talk about health care too much, the right amount, or not enough?



Dutko Research℠

Reducing costs ranks as the number one issue among registered voters

Now thinking specifically about HEALTH CARE, which ONE of the following health care issues would you most like to hear the presidential candidates talk about?

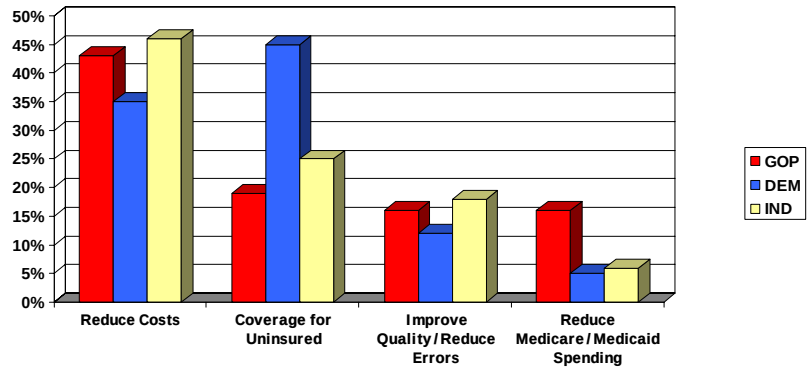


Dutko Research℠

Kaiser Tracking Poll April 3 – 18, 2008, 2003 Adults.
Margin of error =/- 3%

GOP and Independents align on reducing costs as being most important issue in health care.

Now thinking specifically about HEALTH CARE, which ONE of the following health care issues would you most like to hear the presidential candidates talk about?

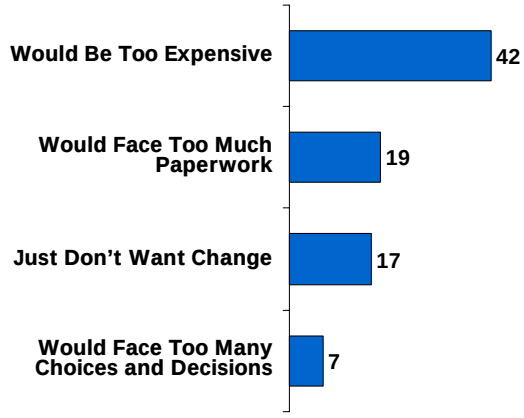


Dutko Research℠

Kaiser Tracking Poll April 3 – 18, 2008, 2003 Adults.
Margin of error =/- 3%

Voters Worry About Expense of Shifting from Employer-Based System; Significant Percentage Just Don't Like Change

Which one of the following would be your greatest concern about changing to a system where Americans own their health insurance rather than purchasing it through an employer…

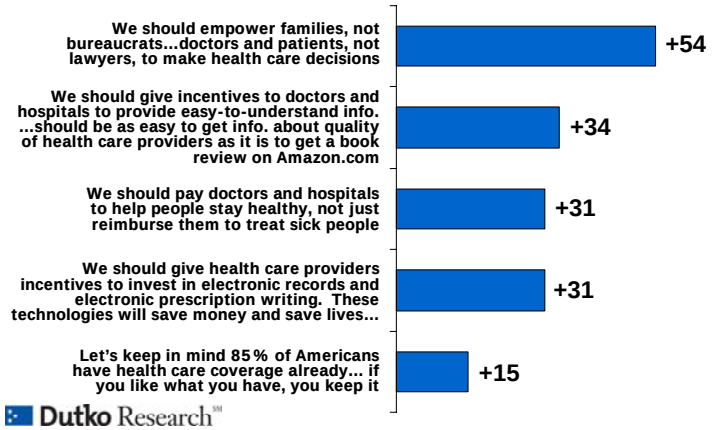


Dutko Research℠

Empowering Families and Doctors
Most Effective Candidate Statement

Now I'd like to read to you statements about health care from political candidates. Please tell me if each statement would make you more likely to vote for that candidate, less likely to vote for that candidate, or if it would have no effect on your vote…?

Ranked by Net "More Likely"



Dutko Research℠

A Health Care Glossary

AHRQ (Agency for Healthcare Research and Quality) The lead Public Health Service agency charged with supporting research designed to improve the quality of health care, to increase the efficiency of its delivery, and to broaden access to the most essential health services.

ATSDR (Agency for Toxic Substances and Disease Registry) Tasked with investigating and reducing the harmful effects of exposure to hazardous substances on human health. Most of the administrative functions for ATSDR are provided by CDC and the Director of CDC serves as Administrator of ATSDR.

biologics A preparation, such as a drug or a vaccine, that is made from living organisms (*see also, follow-on biologic*).

CDC (Centers for Disease Control and Prevention) The nation's principal public health agency, providing coordination and support for a variety of population-based disease and injury control activities.

CDHC (Consumer Driven Health Care) A broad spectrum of approaches that give incentives to consumers to control their use of health services and/or ration their own health benefits.

CMS (Center for Medicare and Medicaid Services) Organization within HHS tasked with handling both Medicare and Medicaid. CMS is responsible for implementing and enforcing regulations.

community rating Insurance reform proposal that would require insurers to charge the same price to every policyholder, regardless of age, sex, or any other indicator of health risk; modified community rating allows for difference based on age and sex.

DME (Durable Medical Equipment) Certain types of equipment, like oxygen supplies, hospital beds, and wheelchairs, that will be paid for by Medicare for those who require them.

DSH (Disproportionate Share Hospital) A program designed to offset uncompensated costs incurred by no-pay patients and un-reimbursed Medicaid claims assumed by hospitals.

ERISA (Employee Retirement Income Security Act 1974) Established minimum standards for pension plans in private industry and provides for extensive rules on the federal income tax effects of transactions associated with employee benefit plans.

FDA (Food and Drug Administration) Regulates more than $1 trillion worth of products, which account for 25 cents of every dollar spent annually by American consumers. It regulates the safety of foods (including animal feeds) and the safety and effectiveness of drugs, biologics, and medical devices.

follow-on biologic Similar but not identical to the brand-name, or innovator, product made by the pharmaceutical or biotechnology industry.

GME (Graduate Medical Education) Clinical training in an approved residency program following graduation from schools of medicine, osteopathy, dentistry, and podiatry; Medicare, and in some states Medicaid, make payments to teaching hospitals for GME costs.

group market Health insurance provided to groups of people drawn together by an employer or another organization, like a trade union.

guaranteed issue Insurance reform proposal that would require insurers to issue a policy to an individual regardless of health status.

HSA (Health Savings Account) Tax-advantaged medical savings account available to individuals enrolled in High Deductible Health Plans (HDHP, *see below*); funds contributed to the account are not subject to tax at the time of deposit and funds used to pay for certain medical expenses are exempt from federal tax liability; important component of Consumer Driven Health Care.

HDHP (High Deductible Health Plan) A health insurance plan with lower premiums and higher deductibles than a traditional plan; also known as a catastrophic health insurance plan; requirement for Health Savings Accounts; minimum deductible is $1,100 for individuals and $2,200 for families.

HHS (Department of Health and Human Services) Cabinet-level department with the goal of protecting the health of all Americans and providing essential human services; oversees Public Health Service Agencies.

HIPAA (Health Insurance Portability and Accountability Act 1996) Guarantees the availability and renewability of health insurance coverage for certain employees and individuals, and limits the use of patient information.

HIT (Health Information Technology) Allows comprehensive management of medical information and its secure exchange between health care consumers and providers; broad use of HIT will improve quality, prevent medical errors, reduce costs, increase efficiency, decrease paperwork, and expand access.

HRSA (Health Resources and Services Administration) Provides leadership and support for health services and resources for people who are uninsured, isolated, or medically vulnerable; also known as the Access Agency.

IHS (Indian Health Service) Provides, or funds the provision of, direct health care services to members of the nation's 562 federally recognized Indian tribes (totaling about 1.8 million Indians in 35 states).

individual market Consumers not associated with a group purchase their own insurance in this market; consumers in the individual market usually face rigorous health screening; also know as the non-group market.

IPA (Independent Practice Association) An association of independent physicians, or other organization that contracts with independent physicians, and provides services to managed care organizations on a negotiated per capita rate, flat retainer fee, or negotiated fee-for-service basis. IPAs are generally risk-bearing entities and regulated by the FTC.

Medicaid Federal-state partnership to provide health coverage for primarily poor adults.

Medicare Federal program to provide health insurance for individuals age 65+.

MEDPAC (Medicare Payment Advisory Commission) An independent Congressional agency established by the Balanced Budget Act to advise the Congress on issues affecting the Medicare program.

MEI (Medicare Economic Index) Measures the weighted average annual price changes in the inputs needed to produce services; updated by CMS annually; more accurate than SGR (*see below*).

NHSC (National Health Service Corps) Committed to improving the health of the nation's underserved by uniting communities in need with caring health professional and supporting communities' efforts to build better systems of care. Part of HRSA.

NIH (National Institutes of Health) Primary agency of the federal government charged with conducting and supporting biomedical and behavioral research. It also has major roles in research training and health information dissemination.

PBM (Pharmaceutical Benefits Manager) Negotiates drug discounts with manufacturers and act as the intermediary purchaser of prescription drugs for businesses as part of the health benefits they may offer.

Physician Owned Hospital Hospitals partially owned and run by physicians; concerns exist about conflict of interest and self-referral.

Substance Abuse and Mental Health Services Administration (SAMHSA) Supports states' efforts to enhance prevention and treatment programs for substance abuse and mental health disorders through block, formula, and discretionary grants.

SCHIP (State Children's Health Insurance Program) Federal-state partnership intended to provide health coverage for poor children.

SGR (Sustainable Growth Rate) A volume-based payment mechanism that adjusts Medicare physician payments on an annual basis. Because the volume and intensity of physician services often exceed the targets established by SGR, negative payment updates are scheduled for Medicare physicians on an annual basis.

SNF (Skilled Nursing Facility) Nursing homes; commonly called "sniffs"; Medicare pays for a beneficiary's SNF services if he or she has been discharged from a hospital after a three day stay and/or per a doctor's orders.

supplemental coverage Usually a product sold to cover benefits not included in a primary health plan. Prior to the implementation of Medicare Part D, for example, supplemental policies would provide seniors with drug coverage.

Communications Resources

These are some op-eds you may use as a template when writing on the issue of health care.

Building Something Worth Building for All Patients
By Rep. Michael C. Burgess, M.D.
March 24, 2008

To paraphrase the great American architect, Frank Lloyd Wright: no man should write about building who has not himself built something worth building. As a physician who helped build an Ambulatory Surgery Center, I conform to Mr. Wright's formula and am glad to pen some thoughts about my personal experiences with the facility.

Let me begin by stipulating that I am neither a statistician, an economist, nor an academic. I have, however, practiced 25-years worth of medicine. My experience is far-ranging: from a multi-specialty practice, to a solo practitioner, and then in a single specialty group. It was as a part of this single specialty group I helped organize and start an Ambulatory Surgery Center in my Texas hometown. And now, by virtue of the fact that I have been elected to Congress, one could argue that I've become an expert in almost anything. Therefore, I am grateful to have the opportunity to provide some alternative insights into the conclusions outlined in Dr. Iglehart's piece entitled "Where Do I Send Thee? Does Physician Ownership Affect Referral Patterns to Ambulatory Surgery Centers."

While the overall piece is thoughtful, I take issue with some of the conclusions. First and foremost, it is unfair to assume that self-pay patients fall into one of two categories: those seeking cosmetic surgery or those who are wealthy. There are also those who lack health insurance.

Like other patients, the uninsured require and request surgery as well. In my own practice of Obstetrics and Gynecology, it was in dealing with patients who lacked health insurance where the payment disparity among different facilities became most apparent. Many times I encountered patients who desired operations, such as Tubal Ligation, but lacked health insurance. If they chose to pay for this operation, our local hospital would ask them to pay upfront between $8,000 and $12,000. If, however, they were to make the same inquiry at an outpatient surgical center, they would find the total facility fee to be in the range of $1000. My own modest fee for this procedure was in the neighborhood of $400, which would be unchanged whether the surgery was performed in a hospital facility or an Ambulatory Surgery Center. In response to these facts, I would simply ask the rhetorical question: in which scenario was I more likely to be paid my fee? That in which the patient had paid $1000 for the facility or a figure about 10 times as high? Invariably the patient's finances would be depleted by the hospital charge, and the physician's fee would often go unpaid.

Thus, if a patient with no insurance presented to my practice for an elective procedure, my likelihood of receiving compensation might, in fact, be increased if the patient were referred to an ambulatory surgery center, regardless of ownership.

Payment disparities are certainly a challenge. But, there are many other health care con-

cerns today, including the issues of quality care and payment for performance. One of the most controversial and complex subjects is physician ownership of medical facilities, as evidenced by Dr. Inglehart's discussion. There is an old axiom that says no one ever checks the water in the battery of a rental car. There is a lot to be said for pride of ownership in any facility, including one's own office or one's Ambulatory Surgery Center.

Paperwork and policy are also problems when it comes to modern-day health care. In my own 25 years of clinical practice, I had multiple struggles with hospital administration. Indeed, sometimes the conventional wisdom was my local hospital behaved like an absentee landlord. I recall very vividly a five-year effort to get filtered drinking water for my hospitalized patients. It is not a battle I would like to relive at any point in the future.

Additionally, timing and schedules are critical parts of any medical practice. I was fortunate to have a robust roster of patients. So I began scheduling minor procedures on a day that I typically took out of the office. If I were to do four procedures at my local hospital, turnover time after each case would approach one hour. As a consequence, I could complete those four extra cases each week, but it would consume a large amount of time.

If, however, those four cases were performed in an ASC, turnover time was much shorter. It allowed me to place the patient safely in the recovery room, speak with her family, and dictate a procedure note before it was time to start the next case. This meant those four cases could be accomplished by midmorning and I could be off about other pursuits. Turnover time was reduced because the correct incentives were in place to make the facility run smoothly and safely.

While I disagree with several of Dr. Inglehart's assertions, I do concur with the statements about the difficulty in interpretation of data because of the lack of public information about physician owners of ambulatory surgery centers. In fact, without this relevant data, any conclusion drawn becomes suspect -- relying on broad generalities, or merely reinforcing preconceived notions. It is frequently hard to correct for observer bias.

Additionally, the statements on the difference between Medicaid and Blue Cross Blue Shield, in other words those ranging from the lowest to the highest payer, were somewhat confusing. As a clinician, why would I want to invest more of my most valuable commodity (time) to treat a patient for which my reimbursement is lowest? In the interest of precious time, it seems that the incentive for treating the Medicaid patient would be tilted toward the ambulatory surgery centers, so that it could be done more efficiently. Whenever confronted with a set of medical choices my first default question is always "is it safe?" Secondly I might consider, "what is the least complicated option for me and my patient?" And third, "what are the clinical as well as the business outcomes?" Thus, if I found myself recommending a procedure for a patient, and it could be safely performed in a surgery center, regardless of the amount of available compensation, the ease of scheduling and the rapidity of performance would tend to influence toward the outpatient facility.

There also might be a case to be made in terms of differentiation by specialties. Generalists such as gynecologists or general surgeons will typically have a broad mix of patients. Their diagnoses might reveal a different pattern than physicians who were more narrowly focused within a more well-defined specialty.

Finally, within the discussion section for this piece, perhaps the focus should not be on why the lowest reimbursement patients (Medicaid) were referred least often to an ASC. Instead, we should determine why Medicaid is the lowest payer. We should also explore what this says about those who want to expand the government's role in paying for health care.

The paper talks about 11 a.m. on Sunday morning. The statement is made that this is the most segregated hour of the week. I am not certain about the source of that data, but I do wonder

THE HILL

The Cure to the Physician Crisis
By Rep. Michael C. Burgess, M.D.
June 6, 2007

If your concern about the status of healthcare in this country only extends to the 2008 election, please turn to another part of this newspaper.

If your concern about the status of healthcare in this country is about solutions, then I invite you to read on, offer feedback and participate in what may be the most important, yet underregarded problem we face today, and will face in the future.

No matter if you favor consumer directed healthcare, or a single payer government-run system, a commitment to finding workable solutions should be our pledge to the American people.

Currently Congress plays a role in about 50 percent of healthcare spending in this country. The other half is comprised of for-profit insurance, out-of-pocket expenses, and charitable or otherwise uncompensated care.

For those favoring a single payer system, a questionable ability of the government as proprietor certainly argues against an expanded role for this side of the equation. Simply stated, are our priorities correct? Every healthcare dollar controlled by government has the potential for further distortion of the marketplace, whether it is the unintended effects of price controls, unequal antitrust laws or an overly burdensome regulatory environment.

In short, is the government a good steward that deserves an expanded role in our nation's healthcare?

Regardless of where one comes down in the public/private debate, system-wide reform seems to be a common thread. And here it is critical to keep priorities in order.

About 18 months ago, just prior to his departure as chairman of the Federal Reserve board, Alan Greenspan was speaking to a small group on the Hill. He was asked about the future of Medicare, and his response was somewhat surprising. He was less concerned about the overall solvency of the program as he was about "having anyone there to provide the services required."

Clearly workforce issues concerned the fed chief over a year ago, and nothing has happened in the interim to mitigate that concern. And it may have gotten worse.

As a leader in the nation's capital, if you see an impending train wreck, what is the correct course of action? Try to wake the switchman to avert the disaster, or secure a video camera to record the carnage and try to be the first to post it on YouTube?

My approach as a physician leader has been to attempt to preserve and strengthen the physician workforce, so that patient access in the future is not in crisis. Regardless of who is in charge.

And within this approach are three principles, all of which are important in their own right. To state it simply, we need to help the workforce of today, while we prepare the physicians for tomorrow, and ensure that new doctors yet to come can see a future in medicine.

For the physicians of today, there is no more important task than to fix the programmed cuts to Medicare that are the most pernicious and pervasive obstacle to preserving the medical workforce. Let me state again for emphasis, there is no more important task ahead of this Congress if we want to ensure our Medicare patients can receive care.

A solution to the problem has evaded members of Congress of both parties for decades, but the answer is so simple that it sometimes gets lost. Stop the cuts. Fix the formula.

The impediment has been and remains the "cost" as constructed by CBO which runs into

hundreds of billions of dollars, and more destructive, becomes larger every year it remains unsolved.

Restoring equity to the method that Medicare uses to pay doctors has become an annual rite here in Washington. Over the years, cuts to Medicare physician payments have been averted by creative legislating, and Congress will once again need to find a solution to halt a cut of 10 percent to the physician payment rate in 2008. In 2009, it only gets worse, as by doing so the window of opportunity in which we can actually reform the system only becomes smaller and smaller. The current payment system, in an attempt to control the volume growth of services by bad actors, punishes the good actors. The system doesn't work for physicians, patients, public officials or the American taxpayer, yet we allow it to persist.

The first principle of sensible physician workforce reform will require Congress to immediately halt any cuts in Medicare physician reimbursement. Allowing these scheduled cuts to go into effect would create a chain reaction in the medical community and diminish the quantity and quality of healthcare available to all Americans and not just Medicare beneficiaries. Congress must also address this in a long-term nature or face future catastrophe because the problem only becomes more expensive if it is allowed to persist. Allowing this situation to smolder will result in fewer physicians accepting Medicare patients, reduced access for beneficiaries, and a constriction of the physician workforce pipeline over a period when demand for medical services is projected to explode. Fewer students will pursue medicine as a career. Even fewer will choose primary care fields within medicine. And all of this will happen while the baby-boom generation begins to grow older and faces more and more medical challenges.

The second and third principles will require Congress to make needed investments in medical students through loan and scholarship assistance as well as make important financial assistance available to smaller rural and suburban hospitals to kick-start new residency training programs. Today, I have introduced three pieces of legislation that attempt to address the issues facing the current physician workforce and the physician workforce of the future. We owe it to Americans to be proactive before this situation careens out of control. As my physician colleagues are ready to note, an ounce of prevention is worth a pound of cure.

ROLL CALL

Let Congress Walk a Mile in the Shoes of the Uninsured

By Rep. Michael C. Burgess, M.D.
December 3, 2007

A checkup of the American health care system reveals a troubling trend: 48 million Americans lack health insurance. And the side effects are worrisome for everyone as costs rise, care is compromised and confusion reigns in doctors' offices and operating rooms.

In many ways reducing the number of uninsured Americans is like armchair quarterbacking Dallas Cowboys football. We're all authorities on the subject, but expertise is just talk when you aren't calling the game firsthand.

In Washington, D.C., both sides share sad statistics and tell heart-wrenching tales of families coping without coverage. Rhetoric about reform is rampant in our marble hallways. Unfortunately, common ground is rarely sought to find a prescription to remedy the problem.

Here's an interesting idea. What if Members of Congress were to get out of the armchair and actually walk their talk in health care? In other words, what if all 535 Members actually joined the ranks of the uninsured and called the proverbial insurance game firsthand? My guess is our attention would be focused like a laser beam on the problem, partisan politics aside.

Former Speaker Newt Gingrich (R-Ga.) is famous for saying "real change requires real change." Well, what if real change in health care begins with Members of Congress losing the health insurance provided to them?

On Nov. 15, I introduced H.R. 4190, a bill to end health care coverage for Members of Congress. A little unconventional? Sure. But, thought-provoking nonetheless. After all, if you really want to arrive at an answer, walking a mile in someone else's shoes can help get you there.

Taking ownership of the health insurance issue actually may lead to some new and innovative solutions, which for too long have been overshadowed by the speeches and sound bites. In fact, if you drill down into the statistics, you would see that some of the solutions don't have to be all that radical.

We rarely look beyond the headlines to see a breakdown of the 48 million people who are uninsured. We all cite the overall number, but few of us have investigated who really makes up this population.

One-fifth of the uninsured earn more than $75,000 a year and could afford insurance if we incentivized coverage. We could do that by simply changing some tax policy and mandate reform. That translates into nearly 10 million people dropping from the ranks of the uninsured.

Combine these folks with a similar number who are eligible for existing programs to help low-income individuals, such as the State Children's Health Insurance Program or Medicaid, but for whatever reason have not applied. If we could find the courage to help the states get this population enrolled and covered, we could add another 10 million to the country's coverage rolls.

Additionally, by crafting sensible policies that focus on more reasonable pricing, we could pick up some of the 2 million to 5 million uninsured who currently are university students or very recent graduates. This should be a pretty easy lift as this population is one of the healthiest and least expensive to cover.

If you add these numbers up so far, you will realize we've quickly reduced the number of uninsured by half, to around 25 million. Then consider that at least 10 million of the remaining uninsured are likely here without the benefit of citizenship and the figure is far more manageable. And all we needed to do to write the prescription for real change is to give Members of Congress the clarity of thought that results from finding themselves without their own health insurance.

The results of these kinds of reforms would be popular and profound as they greatly would improve affordability and access, while keeping medical advancements alive and well at the same time.

If more people are covered, more people will have access to the care they need and the system will be healthier for everyone. Health care also will be more affordable. Some of the country's leading insurance executives estimate a 9 percent savings across the board in health care costs if more people had access to affordable insurance coverage.

Additionally, reform could help generate more competition in the insurance market itself when it comes to individuals, which would help drive down cost by increasing choice. In fact, maybe, just maybe, we would see health insurance available on an individual basis over the Internet, where it would be easier to find and select a policy that fits your particular needs and budget. And finally, we can make sure that advancements in medicine remain the hallmark of health care in America.

Now, there is a risk to this type of approach. Thinking of Members of Congress as part of the uninsured population could lead to unintended consequences like socialized medicine and rationed care because they appear to be a quick and easy fix.

Don't be fooled. Band-Aid solutions to health care eventually shrivel and expose the chronic condition beneath. We need long-term solutions for what ails us in health care, and the sooner the better.

Now, I don't see a line forming outside my door to sign up as co-sponsors for this unusual legislation. After all, next year is an election year and we've got other things to think about.

But, as a doctor with nearly three decades of in-the-trenches experience, I know the system is broken and needs to be fixed. I'm ready and willing to make meaningful changes, and I hope my colleagues will get out of the armchairs and help me do just that. As we say in medicine, take two of these reform pills and call me in the morning.

Talking Points

Here are some talking points you can use when giving a speech on health care.

- Freedom is the foundation of life in America. Unlimited options and opportunity are what make this country great.

- Innovation goes hand-and-hand with choice. Think about how quickly we evolved from mobile phones… to Palm Pilots… to B-berries… to I-Phones.

- These same kinds of options & inventions are what make health care great too.

- While innovation and options are the hallmarks of our health care system, doesn't mean we can't make a good thing even better.

- It is a **Transformational Time in Medicine**. We are moving toward a system that is:
  Personalized, Predictive, Participatory and Preventive

- Shouldn't Federal policies reflect these goals for medicine?

- That is the key question for policy makers focused on changing health care at the national level.

- The promising news is the Presidential candidates have brought this question to the fore-front of political discourse, setting stage for a referendum on health care this November.

- If you look at the Presidential candidates you will see there are two distinct prescriptions for how to change health care.

- Prescription A is More Government. Prescription B is more Freedom and Choice.

- Limiting choice by putting the government between patients & doctors is not the answer to what ails us in Health Care.

- The Federal Government already controls 50% of the health care market, and they are not doing such a good job.

- Doctors are small businesses. It is difficult to build businesses and pay the bills when fed-eral policies are constraining and even penalizing.

- After all, health care begins & ends with doctors. Without us there is no care.

- In the long-term, we need to lead the discussion about overall health care reform and answer key policy questions like:
    - How do we keep the doctor-patient relationship sacred?
    - Are mandates a good thing?
    - How do we create programs people want and bring value to their lives?

- In the short-term we must work to pass forward-looking, long-lasting legislation dealing with doctors first

- I took an oath as a policymaker to serve patients and people to the best of my abilities.

- Unfortunately, I can push policies like this until the cows come home. If I don't have the strong support of my fellow Americans, doctors, and you, it is really tough to get done.

- I'm ready, willing, and able to take the lead in this process here in the Nation's Capitol and on the national level. I would be honored if you would join me here AND at the state and local levels.

Prepared by
Representative Michael C. Burgess, M.D. (TX-26)
Health Subcommittee, Committee on Energy and Commerce
229 Cannon HOB
Washington, D.C. 20515
202-225-7772