Bringing down the cost of health insurance

The Chairman's Mark of the America's Healthy Future Act presents several laudable proposals, including encouragement of prevention, wellness, health improvement services for Medicare and Medicaid recipients and introduction of value-based purchasing reimbursement formulas. (In a separate communication we have suggested ways to strengthen these intended reforms.) The Chairman's Mark, however, has serious weaknesses that limit its ability to resolve the growing crisis of unaffordable health care. This report offers suggestions that could help bring down the cost of insurance.

As noted in the Executive Summary, we see **ten problems with the proposal that need to be addressed:**

1. Nothing in the proposal restrains the constant increase in the cost for private health insurance.
2. It explicitly excludes an employer mandate. Its alternative provisions could invite a massive exodus from employer-provided health insurance.
3. Premium costs of 13% of AGI plus additional out-of-pocket expenses will make it unaffordable to many households.
4. A premium ratio of 5:1 for older pre-Medicare eligible groups will continue to make health coverage inaccessible to many within this age group.
5. The plan does not assure that cooperatives have the authority to negotiate price with health care providers. Without this, they will have no ability to restrain costs. Moreover, cooperatives must have a large enough share of the market to motivate providers to negotiate seriously.
6. Cooperative health plans will only be available to small businesses and individuals. Thus their impact on health insurance and provider reimbursement costs will be limited.
7. Proposed excise taxes on highest-cost health insurance policies are insufficient to bring down the cost of health insurance more generally.
8. Excise taxes and fees leveled on health insurance companies, manufacturers and importers of branded drugs, medical devices, and clinical laboratories are unlikely to generate sufficient funds to recoup government losses from tax credits to individuals and businesses that purchase health insurance in the private market.
9. There is no requirement that private insurers accommodate lower income enrollees through means-adjusted premium charges.
10. The net outcome of reforms will be large profits for insurance companies and other segments of the healthcare industry because of mandated expansion in insurance enrollment, with the federal government and taxpayers bearing these costs.

How could the Chairman's Mark proposals be improved?

We hope the Senate Finance Committee will apply the following **principles for choice** when considering the many reform suggestions and amendments that may be introduced:

1. *The legislation must include provisions to bring down <u>costs</u> of care and create market conditions that reduce the <u>price</u> of all health insurance.*

Healthcare costs are too high for everyone, not simply for small businesses and private individuals trying to obtain health insurance. U.S. businesses are at a competitive disadvantage, internationally, because of our health insurance costs. Entrepreneurship is limited by the high cost of health insurance. States and the federal government face enormous deficits caused in part by rapidly increasing healthcare costs. And many individual households—including those with health insurance policies—face financial hardship because of healthcare costs. Sixty-two percent of personal bankruptcies are medically related.[1] We must reduce both costs for care and the price of all health insurance. And we must do so in a way that does not destroy the vitality of one of the most vibrant parts of the American economy.

The health insurance industry and many members of Congress argue that a public insurance plan must not compete unfairly in the market. The Chairman's Mark proposes to create a cooperative purchasing group instead of a government-sponsored health plan and restricts its domain to providing health insurance to individuals and small businesses. This leaves the current insurance industry with no additional competition in the rest of the market, and relieves them of the most difficult market for which to write policies, although it leaves them free to compete there if they choose. This does nothing to bring down costs or prices for insurance in the rest of market, and may leave the cooperative plan unable to succeed.

Senator Schumer, in contrast, proposed standards for fair competition to create a level playing field for competition between public and private insurers. (1) The public plan must be self-sustaining, paying claims with money raised from premiums and co-payments rather than receiving tax revenue or appropriations from the government. (2) The public plan should pay doctors and hospitals more than what Medicare pays (which currently is lower than what private insurers pay). (3) The officials who manage a public plan should be different from those who regulate the insurance market. (4) The public plan should be required to establish a reserve fund, similar to what private insurers must have, and should be required to provide the same minimum benefits as private insurers.

In order to ensure fair competition a cooperative or public plan must meet the four principles mentioned above, and it should set policy prices so that it achieves a 5% surplus (or "profit" level). Five percent was the average level of profit achieved by for-profit insurance companies through most of the 1990s, before consolidation of the industry let them raise prices and boost profit levels to new heights. In the 1990s, 95% of premiums went to payment for health services; that proportion now has fallen to 80%. A public plan should then be allowed to compete in the entire market. If this were done, insurance premiums would likely fall across the board to meet the cooperative or public plan offerings, and competition would focus on quality of service and convenience of use. The 5% surplus could then be used to subsidize healthcare costs for lower income enrollees.

2. *We must end medically-caused bankruptcies by setting realistic limits on total health care expenditures for which individual households are responsible.*

Reforms should set a cap on the percent of a household's adjusted gross income that is spent on healthcare and beyond which they no longer are responsible for health care costs. Karen Pollitz, health policy expert and former undersecretary of Health and Human Services, testified this summer that total family expenditures for health care should not exceed 10% of their household's adjusted gross income in any year.[2] Current healthcare reform proposals would subsidize lower income households' health insurance costs on a sliding scale adjusted to household AGI relative to federal poverty levels. HR 3200 sets 11% of household AGI as the threshold beyond which government premium subsidies should be available to people at or below 400% of poverty. (That however, still leaves out-of-pocket costs for co-pays, prescriptions and other medical expenses.) The Chairman's Mark would set that limit at 13%, with caps for additional out-of-pocket expenses at $2000 for an individual and $5000 per family. This would leave too many American households with insurance costs they cannot afford. And if a 5:1 age-related ratio for premium pricing is

[1] Warren, Elizabeth, David U. Himmelstein MD, Deborah Thorne & Steffie Woolhandler MD MPH. "Medical Bankruptcy in the United States, 2007: Results of a National Study," (forthcoming) *American Journal of Medicine*, August, 2009. Eight percent of bankruptcies were health-related in 1981, but now comprise 62% of all bankruptcies.

[2] Karen Pollitz, Testimony at the House Ways and Means Committee Hearings, June 29, 2009.

allowed, many additional households between 45 and 64 years of age would not be able to afford health insurance premiums, plus out-of-pocket costs for care.

Surely we can do better than that. We need to bring down the price of health insurance so that more households can afford it. We also must find additional ways to lower costs for care that are currently a federal responsibility, redirecting these savings to subsidize healthcare costs of households who otherwise cannot afford healthcare services.

3. *We must find additional funds to subsidize households' healthcare expenses without adding to the federal deficit, and if possible, with minimal addition to the tax burden.*

Costs for disease-care diagnosis and treatment continue to rise. Finding more cost-effective ways to provide disease care, and shifting more of our resources toward health improvement and prevention of illness should be important parts of healthcare reform. The Chairman's Mark proposes specific ways to begin doing this with Medicare and Medicaid beneficiaries (Title II). We suggest ways to do this more broadly with the rest of the population. Both HR 3200 and the Chairman's Mark have similar strategies for encouraging innovation. HR 3200 sets up Trust Funds for trials of new approaches to primary care and community wellness, procedures for choosing promising innovations to test, gives AHRQ responsibility for evaluating outcomes for quality and cost-effectiveness, and instructs the Health and Human Services Secretary to develop reimbursement policies that create incentives to use successful innovations throughout the federally-funded healthcare system. The Chairman's Mark proposes creation of a National Strategy to Improve Health Care Quality, funds for innovation trials, and establishment of a CMS Innovation Center and a Patient-centered Research Outcomes Institute to evaluate innovations, including innovations in funding, and to recommend new reimbursement policies. We recommend broadening the Innovation Center's and the Patient-centered Research Institute's purview to include a wider range of innovations to improve health care quality. Ideally both bills would include innovation trials in the additional areas recommended here.

One of the most promising areas for demonstration/evaluation trials is targeted use of evidence-based wellness, prevention, lifestyle-based chronic disease management, and integrated medicine approaches in currently high-cost areas of care. Pilot studies show quality improvement and cost savings from several innovations. If cost savings continue as they are scaled up for wider use, and if they replace current treatment strategies, this could reduce healthcare spending by $500 billion to $1.7 trillion over ten years, plus save an additional $1 trillion in avoided cost inflation. Actual savings might be lower; nonetheless this identifies a here-to-fore neglected possibility for savings that could be redirected toward subsidizing healthcare costs for lower income Americans.

Targeted use of evidence-based wellness, prevention, lifestyle-based chronic disease prevention and management, and integrated medicine with Medicare and Medicaid patients in areas currently of highest cost is a quite different use of prevention and wellness approaches than currently is proposed in either the House or Senate HELP healthcare reform bills. The large potential cost-savings from such targeted uses (possibly $400 billion over ten years) make the best, evidence-based approaches appropriate candidates for trials and, if successful, for incorporation into "preferred best practices" reimbursement formulas.

We believe such trials would be consistent with broader CBO advice this summer: Previous CBO analysis of probable effects of the specific wellness and prevention measures proposed in House and Senate HELP healthcare reform bills found no budget-relevant cost-savings from their use. (We agree.) In an August 7, 2009, letter to the Honorable Nathan Deal, Douglas W. Elmendorf, director of the Congressional Budget Office (CBO) cited *New England Journal of Medicine and Circulation* articles summarizing available evidence on how preventive care affects costs. A review of hundreds of previous studies of preventive care, he reports, show that slightly less than 20% of the services that were examined save money, while the rest add to costs. And he warns that prevention services that depend on increased use of pharmaceuticals to control blood pressure and cholesterol, while beneficial to the health of patients and perhaps preventing more expensive treatments later, must offset the increased costs to deliver such services with clear evidence that resulting cost-savings justify this expense. In an August 9, 2009, Director's Blog, Elmendorf wrote: "Evidence regarding the effect of wellness services on subsequent health spending is limited, and CBO is continuing to evaluate the evidence that does exist." Elmendorf notes that the cost-effectiveness record for conventional medical treatments is similar: only 20% of conventional medical treatments are cost-savers. If that is so, why not sponsor trials of the best evidence-based, high quality, cost-effective wellness treatments for use with Medicare and Medicaid patients in the highest cost areas of disease cost spending?

Applying these three principles for choice, **we recommend that seven specific changes be made to the Chairman's Mark proposals:**

1. ***Include an employer mandate.*** If we adopt an individual mandate without a corresponding employer requirement, we are likely to see a major shift of insurance costs from employers to their employees *and the federal government*. Both are already reeling from the cost shifting that has occurred over the past decade. Instead, add provisions that make the price of insurance more affordable (see suggestions below). Rather than exempting all small businesses from requirements, specify net income levels below which businesses are exempt. (Some small firms, law firms, for example, are quite profitable.) Make the "Play or Pay" option cover expected employer contributions, based on net income, rather than a flat $400 per employee payment in lieu of health insurance contributions from the employer. Otherwise responsibility for what has been the employer contribution will be shifted to the tax payer.

2. ***Modify proposals for Medicare- and Medicaid- generated economies, introducing a series of patient-centered cost control strategies.*** (These recommendations are explained in a companion memo, titled "Creating Patient-centered Cost Control in Medicare and Medicaid.") Briefly we recommend:

   - Timing the implementation of value-based purchasing remuneration to take advantage of lessons being learned in four state-wide demonstrations now underway before implementing this policy nation-wide. Phase in as implementation problems are resolved. Include assessments of patient satisfaction (or, where applicable, patient and family members) and quality outcomes when rating physicians and hospitals for value-based remuneration.

   - Developing additional demonstration/evaluation trials making targeted use of evidence-based and cost-effective wellness, prevention, lifestyle-focused chronic disease management, and integrated medicine approaches that have shown promise in pilot studies, using them in high-cost areas of Medicare spending. Potential cost savings over ten years, if all are successful and can be scaled up for nationwide use, would be more than $400 billion.

Specific proposals for use of wellness, prevention, lifestyle-focused treatment and integrated medicine approaches to areas of high cost in Medicare include:

- Lifestyle-focused post-emergency treatment of acute cardiac illness
- Follow-up programs of chronic disease management and health improvement for surviving Medicare patients who have had the most costly medical care
- Training for physicians and nurses doing geriatric work in how to counsel patients and their families to help assure that patient choices regarding preferred quality of care as they age are respected
- More effective wellness and prevention approaches to Medicare patients

Potential cost savings: $400 billion over ten years.

3. ***Correct overuse of medical specialists***, who are reimbursed at higher rates, by redirecting Medicare and Medicaid service provision toward greater use of primary care services.

Expand access to Medicaid, and increase providers' participation through "primary care-focused medical home" remuneration, and implement mechanisms to recruit and enroll Medicaid and Medicare enrollees in primary care-focused medical homes. **Incentives to use "Accountable Care Organization" medical homes will produce greater cost savings if the ACO medical homes are "medical homes emphasizing primary care."** Too many services that could be offered more cost-effectively by less expensive health care personnel now are provided by specialists reimbursed at higher rates. As now written in the Chairman's Mark, the Accountable Care Organizations might not change this practice. A hospital or other institution could declare itself an "accountable care organization" and assign specialists to care for these patients because of an imbalance in their specialist to primary care physician ratio. They might also use physicians for services that could be more cost-effectively delivered by other healthcare professionals. With slight rewriting of this proposal, it could work as intended.

- To correct the ratio of specialists to primary care physicians in the future, medical school training slot allotments should be adjusted to lessen the flow of medical students into specialties with the highest remuneration and to increase the number of physicians offering primary care. The present imbalance of specialists to primary care physicians may need more attention than assigning unused GME slots for primary care and general surgery training positions.
- Keep proposed revisions offering higher reimbursement rates for high quality primary care services.
- A commission should examine reimbursement ratios and recommend appropriate adjustments to be used in future reimbursement for Medicare and Medicaid services. (It might need more authority than is given this task by the Chairman's Mark provisions.)
- Medical students should be offered debt forgiveness for periods of service in primary care in underserved areas.

4. ***Lower the level of household AGI required for premium subsidies*** and for total household out-of-pocket expenditures to qualify for tax credits or subsidies.

If the price of insurance comes down, a higher proportion of households will be able to afford their health care costs. Ideally the maximum cost to households should be 10% of the household's adjusted gross income (AGI). The level of subsidy that would be required to achieve this at present would add substantially to the federal deficit. HR 3200 sets insurance premium costs at 11% of household AGI (plus out-of-pocket costs). The Chairman's Mark aims for 13% of AGI as cost of premiums to individual households. We may have to start at these levels, but should decrease the household AGI percentage as prices for premiums come down.

We believe that premium costs relative to household AGI would be a far better focus for making health insurance accessible to most Americans than a 5:1 ratio for premium charges based on age (which will make health insurance unaffordable for many aging Americans whose incomes are above 300% of poverty but whose premium costs would be far higher than 13% of their household AGI). It also would be preferable to encouraging the young to buy high deductible policies, at lower premium cost. That would leave the young who have medical emergencies unable to pay these costs, forcing many into bankruptcy. Removing the young from the experience rating pool would also increase premium costs for everyone else. The experience of the past two decades has demonstrated that when individuals self-select between high and low deductible plans, the cost of low deductible plans becomes prohibitive. Those expecting to have few medical expenses opt for a high deductible policy while those with preexisting conditions or who anticipate possible high costs for care opt for a low-deductible policy. This quickly makes experience-rated premiums for the low-deductible policy too high for most enrollees to pay. Including the entire potential risk pool in a low-deductible policy not only eliminates adverse selection. It also helps prevent the sixty-two percent of personal bankruptcies currently that are medically related. A good percentage of these families had health insurance that did not pay for the catastrophically high-cost medical treatments they received.

News reports say discussions within the Senate Finance Committee for dealing with this problem currently revolve around consideration of a reinsurance policy to ensure that affordable health insurance is available to everyone within a voluntary health insurance system, with lower overall costs for the package.[3] Whether or not the proposed individual mandate becomes voluntary, we recommend that there be serious consideration of reinsurance protection as a way to lower costs for health insurance: a National Healthcare Reinsurance Pool, with mandatory participation by all insurers who would purchase reinsurance that pays out if costs exceed a certain level. If the Reinsurance Pool were run by the federal government or by a non-profit cooperative, it could be budget neutral, simply redistributing over-run-risks among all insurers through the reinsurance premium charges to insurance companies. It could even include a small surcharge that would be used to finance primary care medical home creation and maintenance or community wellness projects that reduce the frequency or costs of disease care.

5. ***Healthcare reform must include a strategy to lower the price of health insurance premiums.***

More will be needed than a national reinsurance pool, however. In 2004 John Kerry proposed a similar measure; analysts of the reinsurance proposal of 2004 estimated that it would lower insurance costs by about 4%. Of course, lower premiums do not necessarily follow lessened costs to insurers. The market only brings lower premiums when there are enough players to guarantee genuine competition. Recent consolidation of the health insurance market has left too few players for workable competition, and in many states there are only one or two insurers. Reinsurance is a useful beginning, but given consolidation of the market, we need at least one credible competitor who can be relied on to remain in the market with a comprehensive product. That competitor must be one that cannot be eliminated through temporary price-cutting. Thus we need either a government-sponsored health insurance plan or a consumer-oriented cooperative health plan that cannot be undermined by temporary price-cutting from competitors.

Can state cooperative purchasing pools both reduce health care costs and provide competition to the insurance industry in a timely manner? If they cannot, we will be better served by a national public plan that could do so, while encouraging state experimentation with better ways to provide cost-effective service. In order to lower premiums we must do two things: lower health care *costs* and provide competition so that insurance premiums fall when health care costs fall. Reform must also include effective incentives to assure that those costs result in lower health insurance premiums to businesses and individuals.
Here are advantages that a public plan would have:

- A public plan increases competition in the insurance market, assuring that insurance premiums fall as health care savings are achieved. Health care savings will benefit both taxpayers as a whole and private employers who provide health insurance. If the plan is required to be self-sustaining, relying on its own revenues, this competition would be entirely fair to private insurers.
- A public plan with the power to negotiate would be able to bargain effectively with providers, as large private insurance providers and large employers currently do. If

[3] Senator Charles E. Grassley, quoted in the New York *Times* September 15, 2009, Robert Pear, "New Objections to Baucus Health Care Proposal", p A23

purchasing cooperatives are created instead, they also must have this authority and they must be designed to serve a large enough segment of the market to be able to achieve real cost savings.

- If the public plan were required to include a 5% "surplus" in its premium prices (the equivalent of earlier fair-market profits for private health insurance companies before consolidation of the market led to higher profits) this would level the playing field between public and private plans. It also would generate income that could be used to subsidize participation costs for lower income households.
- A public plan changes the incentives of the federal government to invest in public health, keeping people healthier and lessening the need for expensive disease-care. This, in turn, reduces the cost to the federal budget.
- A public option provides a mechanism for innovation in both health care practice and compensation, a location for pilot programs of path breaking proposals and a mechanism for scaling up the use of proven programs and for diffusing best practices.

What form might a public health insurance option take?

Ideally, a public option should be simple to put into operation with a minimum of new administrative costs or bureaucratic oversight. Two options seem worth exploring. The first (which might appeal to private insurers) would be the plan President Obama outlined during his election campaign: simply create a parallel risk pool within the current Federal Employees Health Benefits Plan into which all non-government employees would go. Non-government Employers in this pool would replace the government role as partial subsidizers of individual costs. The employee's (or individual purchaser's) share of the premium price would be 13% of their household's adjusted gross income (AGI) (with a cap on charges to higher income employees or individuals), unless a household's AGI is low enough to fall within the ranges already proposed for higher subsidies. Premium charges would include a 5% "surplus." (The 5% "surplus" figured into the premium cost would help balance costs for individuals or businesses where 13% of AGI did not meet actual premium costs.) By keeping non-governmental employees in a separate purchasing pool, the federal government would be protected against possible increases in costs for insuring federal employees, since each pool's "fair premium" would be figured separately. Such a proposal might appeal to private insurers, who already work with the FEHBP, offering policies within it. Health service providers already are available across the nation, who now service federal employees. The major disadvantage would be the relatively high administrative costs for the FEHBP: about 15 - 25% versus 5% for Medicare.

A second alternative would be to create a Medicare O plan whose enrollees buy into Medicare early, paying a premium similar to other health insurance. Except for the premium charge it would operate identically to current Medicare. Thus it would require no new administrative costs. Amendments to IRS tax reporting could provide the mechanism through which enrollment occurred and premiums were collected. As with the previous proposal, a "fair premium" price would be set annually based on actuarial experience for those enrolled in Medicare Part O. A 5% surcharge would be added, both to make Medicare O a fair competitor in the market and to generate revenue that would be used to help subsidize premium costs for lower income Americans. As in the first option, actual premiums paid would be set relative to household AGI (with caps on upper income premiums, and with provisions now proposed for subsidizing lower income Americans.) Simplicity of administration and lower cost for administering the plan (about 5%) would help keep the cost down. If the Medicare O public option is part of the competitive market, the government could also participate in the National Reinsurance pool, which would be budget-neutral. Thus the entire insurance market would have mutual protection from cost over-runs, and mutual incentive to encourage improved health for the entire population.

We believe a cooperative purchasing plan alternative should have to be able to meet the cost and administrative advantages of a public plan in order to be seriously considered as a preferred alternative.

6. Move toward a greater emphasis on health, thereby lowering costs over time by lessening the need for more costly disease care.

The Chairman's Mark provisions for Promoting Disease Prevention and Wellness among Medicare and Medicaid beneficiaries (Title II) has many excellent provisions. A companion document to this proposal suggests legislative language that could strengthen these provisions. We need similar encouragement for the general public to improve their health.

Community experience rating (or its equivalent) seems likely to be used in setting health insurance premium charges in the future, once insurance reforms require all insurers to accept all applicants, regardless of pre-existing conditions or other selective factors. We believe the use of community experience rating could create a financial incentive for businesses and the public to work together to improve health, to reduce the costs on which community-based premiums are based.

Fortunately strategies for encouraging health improvement are now well developed and tested, with large scale studies of their cost-benefits currently underway.[4] Legislation already has been introduced into Congress, with considerable bipartisan support, to set standards for worksite health promotion programs whose costs would qualify for federal tax credit by businesses. We recommend building such efforts into the proposed healthcare reform legislation, in a manner akin to that which would work most effectively for health improvement among the Medicare and Medicaid beneficiaries. In fact, the two ventures could be coordinated, increasing one another's impact.

Reducing disease-care costs by keeping people healthy: One example of the kind of combined disease-management/wellness program that could be scaled up for much wider use with an entire workforce or a local community is provided by Holtyn and Associates. Holtyn is a health and wellness program vendor. They work with a wide variety of industries with employees from diverse ethnicities and educational levels. They have worked extensively in Michigan and across the nation. Holtyn programs regularly achieve 75% to 80% or higher participation in health improvement efforts and 50% or more reduction in health risks in these populations within one to three years. Client organizations have found sharply reduced costs for health benefits, in contrast to peer organizations in their community. Holtyn was the recipient of a CDC grant to develop community wellness programs, and CDC recently sponsored an assessment of another of the Holtyn programs. Some additional Holtyn programs have won national awards. Currently, in cooperation with Blue Cross/Blue Shield, Holtyn has jointly developed a protocol to integrate disease-management with health promotion and wellness counseling at worksites. Holtyn's client organizations report cost savings from decreased hospital admission rates (by 11%) as employees improve their health. Holtyn is currently working with school system employees in several Michigan communities. As part of a systematic program evaluation by this client, in 2012 data from 12,000 participants will be analyzed by the client's health economists, using state-of-the-art assessment tools, analyzing changes in health status, disease-care utilization, and health benefits costs.

Key ingredients of the Holtyn programs include proactive outreach for health risk assessments; triaged follow-up for personalized health-improvement by counselors skilled in motivational interviewing; organization of activities that create a "culture of wellness" in a business, neighborhood, or other setting; use of the internet as part of instruction with clients; and sponsorship of low-cost incentives (e.g., "health lotteries") which motivate participants to participate in on-going efforts at health improvement in order to qualify for prizes. *Feasibility for wider use:* Holtyn's approach can incorporate a variety of health improvement goals for special population groups, and can be scaled up fairly quickly, with due attention to maintaining quality of the programs. Holtyn also worked closely with the Michigan Department of Community Health to design and implement a training and certification program for wellness vendors in Michigan. In this program, certified wellness

[4] The evaluation is being conducted by MESSA (the Michigan Educational Special Services Association).

vendors screened, counseled and provided education services to over 10,000 businesses and approximately 350,000 employees over a 12 year period. Personnel who developed and supervised this program are still working with the Michigan Department of Community Health. In larger demonstration/evaluation projects, **state health department** employees could train and certify vendors and assess outcomes. If participants in the demonstration were part of a public health insurance plan, federal evaluators could access data needed to compute cost-savings as well.

The Holtyn plan, of course, is but one of several vendor-offered plans that meet highest standards recommended for worksite health promotion programs by a CDC study commission and now officially adopted as "Gold standards" by the Health Enhancement Research Organization (HERO) a consortium with membership from seventy major businesses, vendors, and academic research programs.[5] We highlight the Holtyn plan here because it has developed an effective method for training vendors nationwide and for scaling up programs for much broader use. Scaling up the most effective wellness plans for use nationally, with assistance from State Departments of Public Health in training vendors and assessing outcomes, as they recommend, would cost about $18 billion per year, which could be done through private investment, rather than direct federal payments. If businesses could be offered tax credits for sponsoring such plans, return on investment for them, in terms of lower health care costs, would be three dollars for every dollar invested (or five dollars saved per investment dollar if chronic disease management is part of the wellness program). Companies who use "gold standard" wellness programs report that productivity also increases, as the health of workers improves. If hospital usage and costs for other disease care fall, as has happened in early trials, community ratings would improve, and the costs for disease care should begin to fall within one to three years. (Cost savings could be $54 billion to $90 billion per year, or $540 billion to $900 billion over ten years.) Thus these tax credits should return major benefits throughout the American business community and for communities at large. The tax credits could go into effect after cost-benefit analysis of current larger-scale wellness programs are completed in 2012, dependent upon the outcomes of this analysis. (That would also give a realistic time-frame for scaling up current programs for broader use.)

7. Cooperative health plan or public insurance policies should include pro-active chronic disease case management and health improvement assistance for highest-cost users of care.

Outreach to "catastrophic-cost" patients in a publicly-funded health care option: For an eight-year period during the 1980s, when health benefits costs were increasing at twice the rate of the general inflation, Federal Express discovered that the economist Pareto's prediction applied to their workforce, i.e., that 20% of any population will generate 80% of costs for service to it. Fed Ex hired Options and Choices, a benefits management vendor, to reach out to employees they identified each year as their "Pareto group." Specially trained nurses proactively reached out to them and remained in contact. The nurses helped these employees manage their disease more effectively, provided an impartial sounding board as patients thought through the advantages and disadvantages of various treatment options being recommended, and motivated these employees to work at actively improving their health, coaching and encouraging them as they attempted to do this. This program was well-received by employees. Result: Federal Express kept its health benefits budget increases equal to the general rate of inflation, during a period of time when health benefits costs elsewhere were increasing at twice that rate.[6]

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[5] The Health Enhancement Research Organization (Bill Whitmer, President and CEO) has a Think Tank with membership from thirty corporations, four research universities, five health benefits consulting firms, seven healthcare plans and provider organizations, 20 employee health management providers, the American Psychological Association, the National Pharmaceutical Council, and Finpro USA . The HERO organization has adopted "gold standards" for wellness programs and has created benchmark scorecards for assessing effectiveness of worksite wellness programs.
[6] M Heirich. *Rethinking Health Care: innovation and change in America,* 218-219.

We propose a pilot project targeting a subset of enrollees in a public health insurance plan (i.e., a subset of the 20% of enrollees whose care accounts for 80% of the costs of disease-care utilization). If this could be done with the Federal Express workforce, which is scattered across the country, a pilot project for those in a public health insurance plan should be feasible. Costs for pro-active disease-management/wellness outreach services to a "Pareto group" of highest cost users of disease-care services would range between $200-$400 per year per targeted high-cost user, depending on location and difficulty of contacting them. Savings could be substantial, and per-capita costs for the pilot group could be compared with per-capita costs of the catastrophic-cost group of enrollees in the same geographic areas who were not in the pilot study group. The proposed CMS Innovation Center or AHRQ could analyze results and decide whether to propose expansion of the program to more of the highest-disease care cost enrollees.

The Chairman's Mark was written in a wonderfully clear and simple style that makes it easy to understand. We congratulate the Chairman on using this communication strategy. If you find any of the seven proposals in this report to be useful, we suspect that you will have no difficulty crafting the legislative language that is needed. However if you want suggestions let us know. We want to help this process in any way we can.

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