

Healthcare policy in an Obama administration: Delivering on the promise of universal coverage*



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Table of contents

The heart of the matter President-elect Obama's health reform vision must confront new fiscal realities.	1
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An in-depth discussion President-elect Obama's expansions would eliminate two-thirds of the uninsured at an estimated cost of \$75 billion a year.	3
What the new President faces	6
President Obama's big idea	11
Converting promises to practicality	18
<hr/>	
What this means for your business President-elect Obama's proposals could lead to lower margins for providers, pharmaceutical companies and health plans that increasingly depend on government payment.	21
Public-private collaborations: Five ideas that the new President should consider to make healthcare more affordable and sustainable	28

The heart of the matter

President-elect Obama's health reform vision must confront new fiscal realities.

An Obama administration and a Democratic Congress will face one of the most critical challenges of this century. Amid the economic crisis and the war on terror, Obama has pledged to take on the boldest challenge in healthcare today — universal healthcare coverage. Yet, his vision must conform to the new fiscal realities that will discourage additional deficit spending. The price of expanded access may be reallocation of existing spending or forced efficiencies of the more than \$2 trillion spent on health.

As this report describes, Obama has pledged to implement multiple changes in our healthcare system. He's talked about cost reduction, health information technology, personalized medicine, transparency and public health programs. However, a pledge of universal access is central to his proposals. While covering every single U.S. resident may not be possible, Obama's plan could get the nation closer to universal coverage than it has ever been and reverse a trend in the other direction. Universal healthcare is not a synonym for single-payer. However, achieving broader access could mean more government involvement in financing and regulating care.

What does that mean for the health industry, employers, and patients?

We recommend looking to Massachusetts, where many of the tenets of Obama's reform are now in process. States are often laboratories for change and Massachusetts has lessons to offer. This report presents one of the most comprehensive looks at how Obama's plan compares to reform in Massachusetts. The state has expanded healthcare access to 97% of residents, the highest rate in the nation. We explore how a collection of state-legislated reforms is affecting patients and the industry, what compromises were made to legislate reform, and the obstacles and opportunities of expanding this model nationally.

Everyone will have to ask how health reform will affect their own organizations and whether they are ready for the change. This report provides a beginning for that conversation.

An in-depth discussion

President-elect
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Key Findings

- President-elect Obama's promised reforms are aimed at providing tax subsidies for the healthcare disenfranchised: the 15% of Americans who are uninsured and those small businesses that cannot afford to offer health coverage to their workers. However, he has proposed new rules for insurers, which could impact the overall industry.
- Many of Obama's proposed reforms are being tested at the state level in Massachusetts, where they have resulted in the nation's lowest uninsured rate in what has been the most costly healthcare state.
- Based on the results in Massachusetts, PricewaterhouseCoopers estimates Obama's plan would provide coverage for two-thirds of the nation's uninsured at a cost to the government of \$75 billion a year.
- Of the 30 million Americans who would be newly insured under Obama's proposals, nearly 40% would obtain coverage through their employers. That would mean a reversal in the current decline of employer-based coverage. Most of the gains in coverage are likely to come from small employers.
- Not all of those who will receive subsidized coverage under the new plan would have been previously uninsured. PricewaterhouseCoopers estimates that about 4.5 million people would trade their current private coverage for insurance with higher government subsidies.
- Obama's reform plan does not include a requirement that individuals purchase coverage, an aspect that Massachusetts health leaders say has been important to reducing their uninsured numbers.
- Over one-third of the cost of Obama's plan could come from existing funding for the uninsured; much of that funding now goes to hospitals. The rest will have to be raised through repealing tax cuts, raising taxes, or limitations on other spending.
- Expanding coverage to more Americans will exacerbate current deficiencies in the health system, such as shortages of primary care clinicians.
- Unless successful cost containment strategies were put into place, growing healthcare costs will increase the costs of Obama's plan dramatically over time and reduce the effectiveness of mandates. This could make the federal costs unsustainably high.
- Obama's proposal is likely to lower margins for providers, pharmaceutical companies, and health plans that increasingly depend on government payment.
- Regardless of whether Obama's proposals are implemented, the health industry can improve care and lower costs through public-private efforts on five ideas:
 - Keep people well
 - Reorder treatment around collaboration
 - Simplify the system
 - Make interoperable electronic medical records a reality
 - Use genes to pick the lock on disease

About the research

Estimates for the President-elect's health reform policies are based on documents published by the campaign and data from publicly available databases. Research by PricewaterhouseCoopers' Health Research Institute (HRI) included more than 30 in-depth interviews with thought leaders and executives representing government agencies, trade associations, providers, pharmaceutical manufacturers, insurance companies, employers, legislators and consumer groups. Those who were interviewed and agreed to be acknowledged are listed at the back of the report. Additionally, HRI conducted a thorough literature review of reports and guidance from associations, regulators, and academia to gather insights on current challenges and best practices.

The advisory group for this report included 25 professionals from PricewaterhouseCoopers' health industries practice in advisory, tax and assurance.

What the new President faces

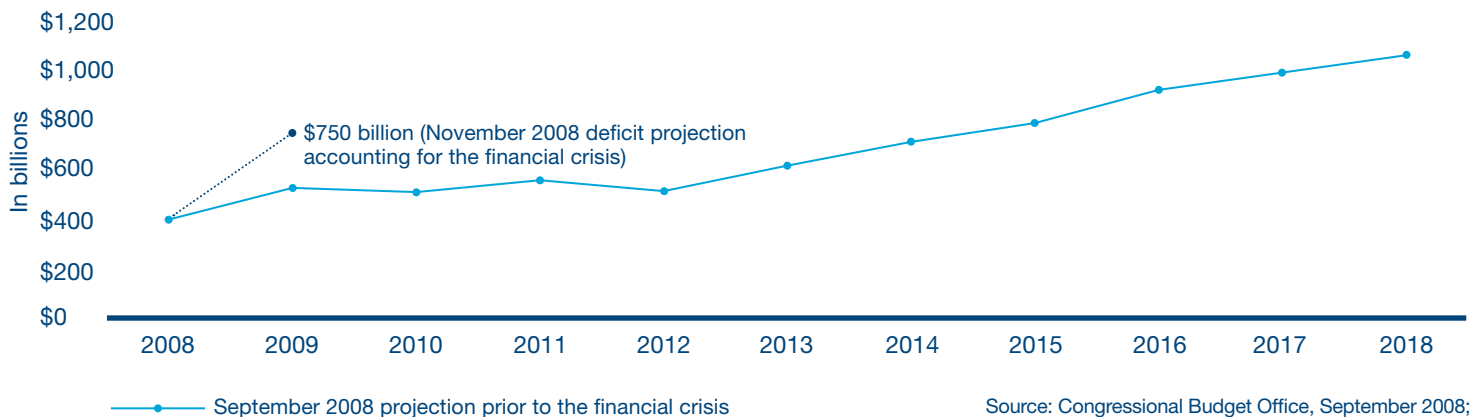
The likelihood that major changes to the American health system will be implemented under the new President has increased for three interrelated reasons:

1. Problems in the economy require addressing healthcare costs, which are at 16% of GDP and rising.
2. Health industry leaders agree that something needs to be done to solve the trio of problems in access, quality and affordability (but disagree over what should be done).
3. The President-elect has promised to do something major to fix the problems.

No new money available, so health reform may require reallocation

The new president will face tight budgetary constraints related to the national deficit, national spending priorities, and slow economic growth. That could mean no new funding for healthcare initiatives unless the initiatives themselves save money. In September, the Congressional Budget Office projected that the national deficit could reach \$407 billion in 2008, \$535 billion in 2009, and \$518 billion in 2010.¹ These estimates reflect extension of President Bush's tax cuts, AMT relief, discretionary spending growth with GDP, and Iraq troop drawdowns. The deficit in 2018 would reach 4.8 percent of GDP, a level that hasn't been seen since 1993. Recent financial market turmoil and economic downturn could make the outlook even worse, with deficits in 2009 rising to more than \$750 billion, or exceeding 5% of GDP (See Figure 1).

Figure 1. U.S. federal deficit projection (2008–2018)



Source: Congressional Budget Office, September 2008; PricewaterhouseCoopers' estimates, November 2008

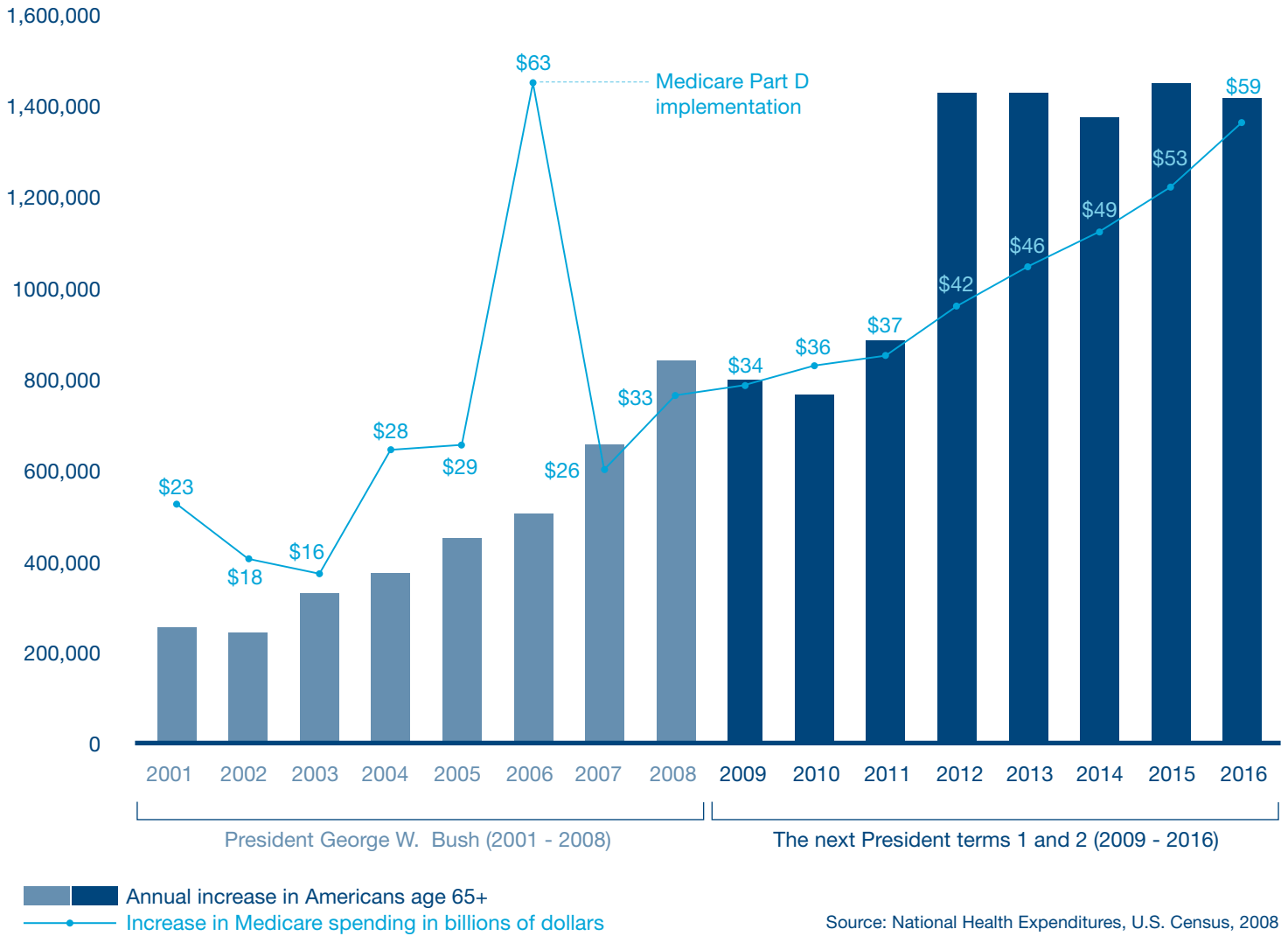
Rising healthcare costs have reduced affordability of coverage

Affordability will be the biggest healthcare challenge for the new administration. As purchaser for more than half of all healthcare — when Medicare, Medicaid, and the federal employees are included — the government can have a huge influence on healthcare costs. Although the growth rate for medical costs has been slowing the past five years, costs for private payers are still expected to grow between 9% and 10% in 2009, according to PricewaterhouseCoopers' research.² Increased medical management and the use of generic drugs have helped reduce the rate of growth, but that has been offset by a major building boom in medical facility construction, ongoing advances in medical technology, and the aging of the population.

More baby-boomers will reach age 65, adding to Medicare's fiscal burden

During the next two presidential terms, the number of Americans over the age of 65 will grow by 9.5 million — an average net increase of 3,255 new Medicare-eligible beneficiaries daily. This is nearly three times the net increase during the eight years spanning President Bush's term in office. (See Figure 2). Medicare was mentioned little during the campaign even though it's claiming an increasingly large part of the federal budget. Medicare Part A, which funds hospital care, is expected to exhaust its reserves by 2019; if the economy deteriorates, it could happen at the end of the new President's second term.³ In addition, more individuals will retire without employer-sponsored retiree coverage, which paid some of their costs in the past.

Figure 2. Projected annual increase in the number of Americans 65+ and changes in Medicare spending in billions (2001-2016)



New president faces some early tests on healthcare funding and reform

Specific legislative and regulatory health issues must be addressed by President-elect Obama shortly after taking office. They may take precedence over his health reform agenda, or they could complement it. Those issues include:

State Children's Health Insurance Program (SCHIP) expansion — March 2009 vote looms — \$5 billion to \$7 billion

Before April 2009, Congress will have to extend, expand, or find an alternative to SCHIP unless they choose to let the program expire. SCHIP provides insurance coverage to uninsured low-income children and families that do not qualify for Medicaid and do not have access to affordable healthcare. Established in 1997, SCHIP was up for reauthorization in 2007 and sparked a spirited debate. Obama co-sponsored the Children's Health Insurance Program Reauthorization Act (CHIPRA), which would have increased funding for SCHIP within five years. Congress agreed to a temporary extension of funding through March 31, 2009 so the next Congress will have to address the program as one of its first items. The current legislation funds SCHIP for \$5 billion in FY 2008 and 2009.

Health needs of veterans returning from war — \$3.5 billion and growing

The new President will face the rising cost of servicemembers and veterans returning from the global war on terrorism. The armed forces have deployed nearly 1.6 million troops to Iraq and Afghanistan since the war began in October 2001.⁴ By the end of FY 2007, nearly 800,000 servicemembers separated from the military after service in the Middle East. Of them, approximately 300,000 received medical care at a Veterans Administration (VA) medical center or clinic with about 120,000 receiving an initial mental health diagnosis.⁵ The majority of mental health disorders are related to post-traumatic stress disorder, major depression, or traumatic brain injuries. The Department of Veterans Affairs (VA) will open 23 new Vet Centers, which will increase the number of centers to 232 in 2008. In addition, the VA has increased the number of mental health professionals by 3,800, to nearly 17,000, in the last two and a half years. The VA has increased its financial investment in providing care from \$2 billion in 2001 to a projected \$3.5 billion in FY 2008. Additional amounts might be needed in the future years.

Medicare physician payment fix — \$10 billion annually and growing

Physicians are paid on a fee-for-service schedule of 7,000 different procedures or visit types that rewards volume. To control this incentive, Congress enacted the sustainable growth rate (SGR), which demands funding cuts if spending rises above predetermined targets. The two embedded incentives — volume-based reimbursement and caps on overall spending — work against each other. With some 500,000 physicians practicing in the United States, any individual physicians' behavior to control costs only reduces his or her income. As a result, spending has risen above

the targets, which would require cuts in physician payments. However, Congress has intervened every year since 2002 to prevent those cuts from going into effect. The current fix expires in December 2009. Delaying the program's automatic decreases means bigger and bigger reductions are projected each year. If this continues, the government would have to impose physician payment cuts of more than 50% by 2017 to maintain the current target fee schedule, according to PricewaterhouseCoopers' analysis. The House Committee on Ways and Means said it will address the SGR and payment methodology fix by 2010, although so far no alternative has surfaced.⁶ The physician-patient relationship is fundamental to Medicare, so reforming payment is important and sensitive. A fundamental change to payment, as was done in the 1990s with the resource-based relative value scale, would take several years to implement.

Stem cell funding — pledge for unspecified new money

Federally funded stem cell research is likely to move forward quickly with the new president's support, a contrast to the previous administration, in which research was limited to fewer than two dozen embryonic stem cell lines. While the U.S. leads the globe in medical research investment, the U.K., Israel, China, Singapore, and Australia have surged ahead in producing stem cell research.⁷ New research in the United States has been funded primarily by states, including California and New Jersey, and by private capital. Proponents of stem cell research, specifically embryonic stem cell research, cite the potential for the development of cures related to health problems such as juvenile diabetes, Parkinson's, Alzheimer's, spinal cord injury, and heart disease. The \$3 billion California fund is the largest source of funding for stem cell research in the world. However, most funding comes with strings. For example, some California activists are demanding that the state get assurances that treatments produced by tax-supported stem cell research will be reasonably priced so patients will have access to them.

New FDA leader will set tone on drug discovery

President-elect Obama will nominate the Food and Drug Administration (FDA) commissioner. During the Bush administration, FDA lacked a full-time commissioner for nearly four and a half years, which contributed to challenges and criticisms faced by the agency. For example, the FDA has experienced staffing shortages, has allegedly prioritized drug and device industry initiatives over consumer protection, and has been questioned about its ability to oversee food safety during the salmonella outbreak of 2008. The newly appointed commissioner will face decisions that may change the structure and image of the FDA. Some advocates propose splitting the food safety division from the drugs and devices branch of the FDA, creating separate entities under the Department of Health and Human Services (HHS). Decisions on diagnostic testing and drug re-importation will be key issues for the new commissioner.

President-elect Obama's big idea: Expand Massachusetts to the nation

A fundamental healthcare system dysfunction is that some pay more, others pay less, and some do not pay at all for the services they receive. This creates inequities and inefficiencies in care delivery. President-elect Obama proposes to implement a set of policies that provide coverage to those without the means to buy insurance. Unlike the broad scope of the 1990s Clinton health plan, Obama's would not significantly disrupt coverage for the 85% of Americans who have health insurance. He has promised to reduce premiums by \$2,500 for the typical American family through a broad range of insurance reforms.

The most concrete and significant proposal is to broaden access to health insurance. Obama's plan bears a striking resemblance to the healthcare plan enacted and implemented in Massachusetts in 2006 (see Figure 3). Many of Obama's reform proposals are being tested at the state level in Massachusetts, where they have resulted in the nation's lowest uninsured rate in the most costly healthcare state. Massachusetts recently reported that the percentage of uninsured has dropped to 3%, compared with 15% nationally. Prior to reform, Massachusetts ranked as the most expensive state in the country in per-capita health costs, \$6,683 compared to \$5,283 nationally, according to 2004 figures from the National Health Accounts.

“We now face an opportunity — and an obligation — to turn the page on the failed politics of yesterday's healthcare debates. ... My plan begins by covering every American. ... If you are one of the 45 million Americans who don't have health insurance, you will have it after this plan becomes law. No one will be turned away because of a pre-existing condition or illness.”

Barack Obama, May 29, 2007, Iowa City, Iowa

Figure 3. Comparison of Obama and Massachusetts health reform tenets

Obama’s proposal	Parallel Massachusetts reform
Increase eligibility for Medicaid and SCHIP to 300% of poverty level.	Eligibility for MassHealth, the state Medicaid program, increased up to 300% for certain populations.
“Pay or play” system in which large employers must provide health insurance for their workers or pay a penalty.	Same pay or play system. Large employers must have 25% of their workers enrolled or pay 33% of the premium. [†] Employers that do not make the “fair and reasonable” contribution to employee healthcare premiums are required to pay a \$295 annual “fair share contribution” for each full-time employee. This amount is pro-rated for part-time employees.
Provide subsidies for low-income consumers to purchase health insurance.	Subsidized premiums for individuals with income below 300% of poverty.
Parents must enroll their children in public or private health insurance.	Adults must enroll in either public or private coverage if it’s affordable for them; those who don’t enroll pay higher taxes through the loss of exemption. Children are not required to have coverage but low income children would be covered under SCHIP or Medicaid.
Provide subsidies for small businesses and individuals who can’t afford coverage.	Small employers are not required to provide coverage.
Create a National Health Insurance Exchange that would allow consumers to purchase health insurance from a range of private and public insurance options.	Massachusetts Connector establishes creditable coverage and links individuals, families, young adults, employees, and employers, with plans that are rated gold, silver and bronze. Small group and individual markets are combined into one group allowing both increased purchasing power and lower plan rates.
Required level of coverage: nothing specified, but there likely will be a minimum level of coverage set. In addition, his health insurance exchange will likely have certain minimum standards included.	Minimum creditable coverage (MCC) determines the baseline benefits an individual must obtain to avoid tax penalties, including: <ol style="list-style-type: none"> <li data-bbox="824 1234 1487 1320">1. Comprehensive coverage including preventive, primary, emergency, ambulatory patient, and mental health services along with prescription drug coverage; and <li data-bbox="824 1333 1487 1388">2. Maximum deductible, annual and life benefits, coinsurance, and out-of-pocket spending.
Create a national insurance plan for consumers to purchase individual coverage.	Nothing similar.
Reinsurance subsidy for employers’ catastrophic healthcare costs.	Nothing similar.

[†] In 2009, Massachusetts employers with more than 50 full-time workers must have 25% of them covered and pay 33% of their premiums. Employers with between 11 to 50 full-time workers must either have 25% of them covered or pay 33% of their premiums.

PricewaterhouseCoopers estimates that President-elect Obama's plan would reduce the number of uninsured in the United States by 30 million people, nearly two-thirds of all uninsured.

Figure 4 demonstrates the expansions in coverage that lead to this reduction in the uninsured. Almost half of those who receive coverage do so through federally subsidized coverage. Roughly 16% are covered through Medicaid or SCHIP and another 27% receive subsidies to help with the purchase of individual insurance plans. An estimated 38% gain coverage because of the employer mandate. Approximately 19% buy unsubsidized coverage in the marketplace.

In total, 13.1 million previously uninsured individuals would obtain insurance coverage with the help of the government subsidies, either in the non-group market or Medicaid. We estimate that another 4.5 million individuals who currently have insurance would drop their current insurance to take advantage of the government subsidies. In total, 17.6 million individuals would receive government subsidized coverage.

Cost: Obama's expansion would cost about \$75 billion in 2009, or more than \$1 trillion over 10 years

Assuming full implementation in 2009, the budgetary costs of the Obama plan would grow from about \$75 billion in 2009 to roughly \$130 billion in 2018 based on the assumption that Obama's plan is similar in operation to the Massachusetts plan. The total cost over 10 years would be more than \$1 trillion. The estimates assume that spending under the new program would grow about 3% faster than the combined growth of the consumer price index (CPI) and population. This estimate does not reflect potential savings from the yet-unspecified savings package that Obama discussed during the campaign.

Figure 4. Number of newly insured Americans under Obama's proposal

Category of coverage	Reform	Millions insured	Percent of newly insured
Medicaid/SCHIP	Expand to 300% of poverty level	5.0	16%
Non-group (Subsidized)	Credits for low-income individuals	8.1	27%
Non-group (Non-subsidized)	Individuals purchasing insurance because of mandate on children	5.7	19%
Employer-sponsored	Mandate on large and medium-size employers to provide coverage	11.6	38%
		30.4	

Source: PricewaterhouseCoopers' estimates based on Massachusetts' reforms and coverage changes

The \$75 billion in spending would not merely replace what would have been spent on the uninsured under the outgoing administration. In fact, some of the spending would fund coverage for people who are currently insured and some would cover increased spending by the currently uninsured. About a third of the spending, or \$27 billion, under Obama's plan would replace spending on those who currently have insurance. The other two-thirds, or \$48 billion, would be spent on the currently uninsured. Of that, roughly, \$34 billion would be spent to replace what others are currently paying for — \$12 billion in out-of-pocket spending by the uninsured, \$2 billion paid by private plans through cost shifting, \$13 billion in new government subsidies, and \$7 billion in lost taxes from new employer deductions of health insurance costs. New government spending associated with increases in utilization by the previously uninsured would amount to \$14 billion.

Obama cites other sources to fund his plan and make health insurance more affordable. Reducing waste through better treatment protocols, more prevention and increased adoption of information technology are frequently mentioned as part of the overall reform. For example, Obama has proposed spending \$10 billion a year for five years to invest in health information technology. He also backs comparative effectiveness research, which would fund population-based studies on which treatments work best.

Funding: Some of the cost of Obama's plan could be paid for by redistributing existing funding and eliminating current patchwork of financing care for uninsured

Obama's plan could be funded through some of the multiple revenue streams that now pay for hospital care for the uninsured. A national, standardized strategy to cover the uninsured would repair a funding model that consists of largely uncoordinated public and private funding programs. Looking across the states, hundreds of revenue streams — federal, state and local — have historically paid for the uninsured. It's unclear how these could be redirected to pay for the newly insured. Uninsured patients pay out-of-pocket for about 40% of their own care.⁹ However, determining who pays for the rest is a complex task. Whether uninsured patients get care depends on where they live, what they need, and what organizations are willing to pay.

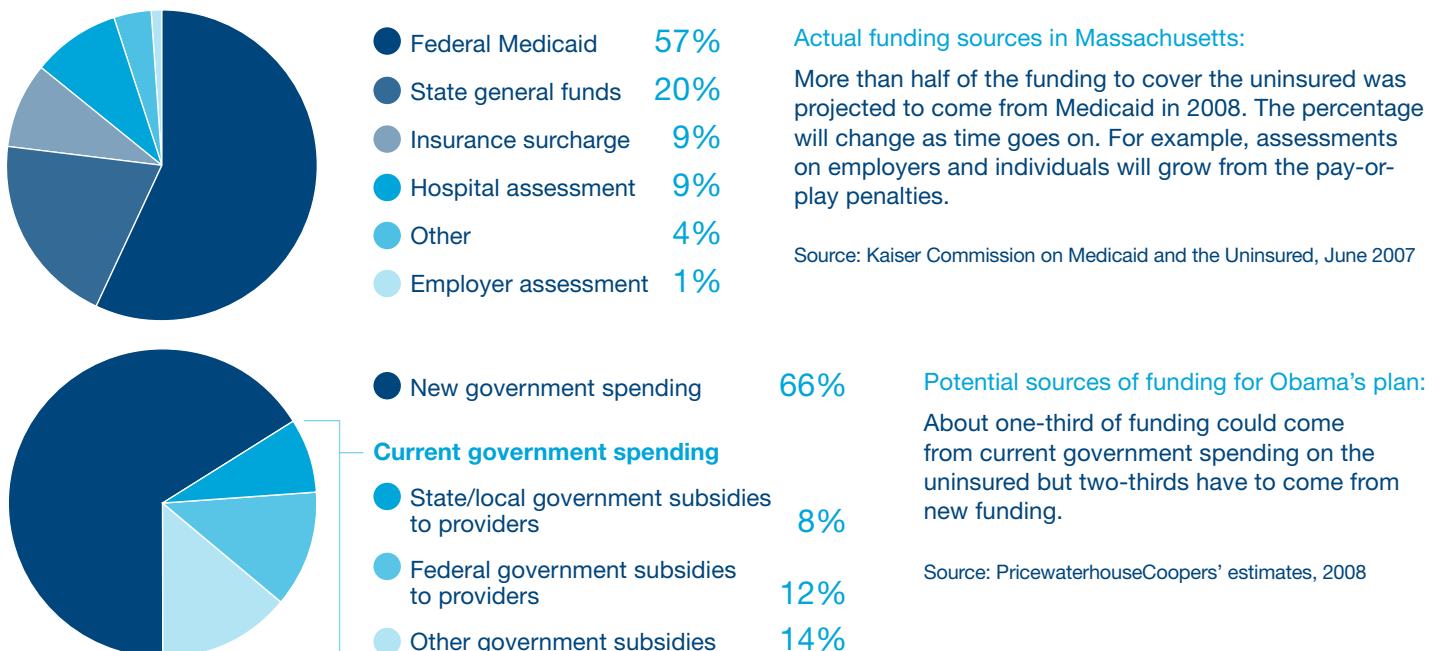
For example, poor, uninsured patients often seek care at safety net hospitals, which are funded through a variety of tax-based sources. In New York, \$3.5 billion was paid to safety-net hospitals and clinics in 2005; of that, \$1.3 billion was paid through four government programs, each with different rules and funding allotments.¹⁰ In California, money sources include tobacco funds, government disproportionate share (DSH) funding, safety net care pool and county taxes.¹¹ Dozens of separate programs pay for certain kinds of care for certain kinds of patients, such as one that pays only for mammograms for low-income woman.

In addition, the poor and uninsured also seek care at private, not-for-profit hospitals, which receive a variety of tax offsets and payments to treat those who cannot afford to pay. However, hospitals grant free or reduced care at their discretion. There is no national standard about how much care a poor, uninsured patients receives for free or at a reduced rate. Figure 5 below shows that 34% of the spending under the Obama plan will replace amounts currently spent by the government. The remaining amount will be new spending that will have to come from other sources.

As shown in Figure 5, Massachusetts has decided to fund its expansion largely through Medicaid as well as other funding, including an uncompensated care pool (See Figure 5). The state reasoned that it could reduce the uncompensated care pool, which reimbursed hospitals for treating charity patients, because more patients would have insurance. Indeed, Massachusetts' hospitals report their uncompensated care has dropped substantially since the reform passed. The state has reported that the volume of uncompensated care has dropped 37%. Most of the funding for the uninsured goes to hospitals.

Government expansions of health insurance tend to spark debates about crowd-out, which speaks to insured Americans who would drop private coverage to get subsidized government coverage. While the Obama plan would lead to a significant portion of uninsured getting coverage, some of the new money spent would fund those who had insurance before the reform.

Figure 5. Comparison of funding sources - Actual funding sources in Massachusetts and potential funding sources for the U.S. under Obama's plan



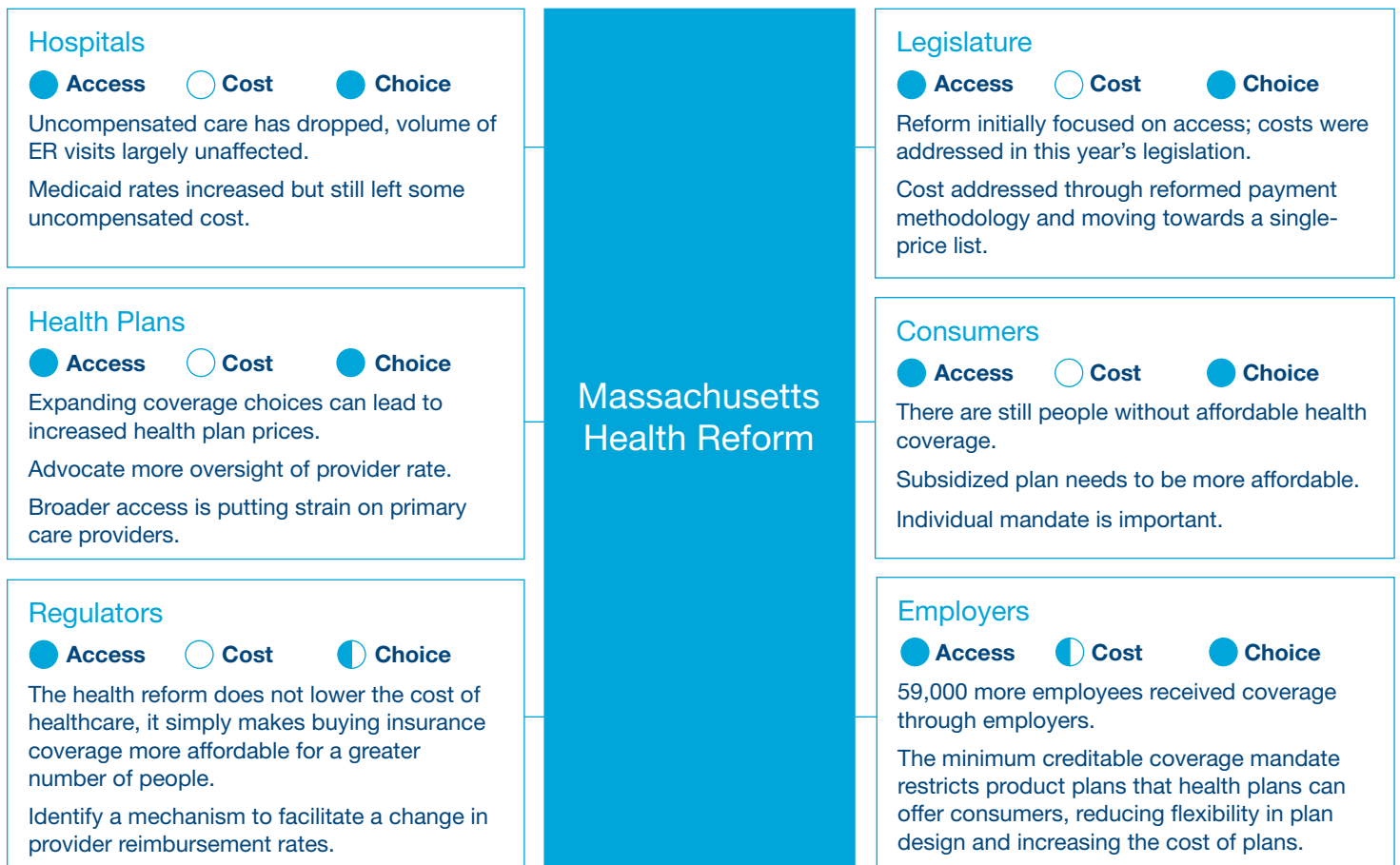
In addition to current funding that goes towards the uninsured, Obama has promised to tap other funding sources. For example, he pledges to work with Congress to cut payments to Medicare Advantage plans, which cost the government an estimated \$8 billion more than traditional Medicare. However, this may be politically risky since these plans now cover about a fourth of all beneficiaries and provide additional benefits over traditional Medicare.

By following Massachusetts' lead where local stakeholders give reform high marks, Obama could move quickly

Massachusetts provides a reasonable prism to view Obama's healthcare reform plan. Interviews with the state's leading stakeholders indicate that the plan has increased access but costs have increased more than expected. As shown in Figure 6, most leaders surveyed by PricewaterhouseCoopers' Health Research Institute gave access a high rating, with cost control rated lowest.

Figure 6. Stakeholder perspectives

Access cost choice: ● Very effective or effective ◐ Not sure ○ Ineffective or very ineffective



However, it’s important to note that Massachusetts’ results may not necessarily replicate nationally. While Massachusetts provides a good working laboratory for expanding access, it is unlike the rest of the country in many ways. “I think it will be different in every state because they come from a different starting point,” said Peter Markell, CFO of Partners, the largest hospital system in Boston. “The real question is whether to do it (reform) on the state or federal level.”

Without national reform, states or cities may follow the lead of Massachusetts, which could force large employers to comply with a series of new state-based regulations.¹² “We need a national program so we don’t have 50 different plans,” said Massachusetts State Rep. Martha Walz. “If you’re a multi-state employer, compliance with 50 state plans is, at best, challenging and expensive.”

Figure 7. Ways in which Massachusetts is different that may affect implementing national health reform

Difference	Impact on Obama’s plan
<p>Massachusetts does not look like other states:</p> <ul style="list-style-type: none"> • Median annual income in Massachusetts is 16% higher than the national median • Average per-capita health costs in Massachusetts are higher than the national average, \$6,683 compared with \$5,283 respectively • HMO enrollment is high and not-for-profit • Mostly urban — 98% live in metropolitan areas, compared to 84% nationally • Small, cohesive group of health and business leaders 	<p>Negative — It will be more difficult to implement and pay for reform at the national level because of economic and social issues.</p>
<p>State reform has limited effect because of Employee Retirement Income Security Act (ERISA). So far, no one has challenged the ERISA aspects in Massachusetts.</p>	<p>Positive — The Obama proposal strengthens the employer-based model that is not impacted by ERISA requirements. However, the federal government may not be prepared to regulate it.</p>
<p>Massachusetts depended on a federal Medicaid waiver and existing funding for indigent care.</p>	<p>Unclear — Congress has the authority over the distribution of funds for healthcare reform at the national level. However, more partisanship in Congress (vs. within a state) may make it difficult to get bills passed.</p> <p>On the other hand, state Medicaid funding matches depend on the economic health of states, which can rise and fall.</p>
<p>Containing costs is difficult within one state because federal influences such as Medicare and the FDA affect costs.</p>	<p>Positive — Cost containment initiatives can be national.</p>
<p>Massachusetts has 43 coverage mandates.</p>	<p>Positive — The minimum level of coverage could be less rich.</p>
<p>Reform was phased in. In 2006, the law focused on expanding coverage. Two years later, the state addressed reducing costs. In addition, Massachusetts had a running start towards health coverage with other reforms.</p>	<p>Unclear — It will be more difficult to tackle both aspects of reform at one time, but expanding access without addressing cost will lack support.</p>

Converting promises to practicality: Industry should be attuned to implementation details of Obama's proposals

There's a versatile nature to the details of Obama's plan that has yet to form. Learning from Massachusetts' experiment, following are key issues for which stakeholders will want to watch.

- **Enforcing a child mandate could require automatic enrollment or covering adults to encourage them to enroll their children.** Obama does not specify how the government would require parents to enroll their children for health insurance. Nationally, half of all children who are eligible for Medicaid and SCHIP aren't enrolled. Options may include leveraging the child tax credit or other government support, but that could penalize poor families with little effect on enrollment. In Massachusetts, uninsured patients are automatically enrolled if they show up at a hospital emergency room without insurance. The National Association of Children's Hospitals and Related Institutions has proposed a Children's Pathway to Coverage program in which babies are automatically enrolled at birth. Parents could opt out to cover their child through their employer-sponsored insurance or other creditable coverage. However, the child would continue to be in the Pathway program; and if the child lost coverage, he or she would automatically be reinstated.
- **Individuals and employers will lobby for exemptions.** Under Obama's proposal, some consumers and employers are exempt from the mandates. For example, small businesses may receive credits to encourage them to offer coverage. In Massachusetts, a large number of individuals are exempt from the mandate because coverage is deemed "unaffordable" for them. For example, families with incomes up to \$110,000 can be exempt from the mandate because premiums are considered too expensive.
- **Broader access exacerbates primary care shortages.** Waiting lists for primary care physicians have lengthened substantially, according to media reports. To solve this, Massachusetts passed a series of reforms, such as allowing patients to designate nurse practitioners as their primary care providers and requiring medical schools to designate a certain number of slots for primary care. Steve Lieber, CEO of the health IT trade association Health Information and Management Systems Society (HIMSS), points out that national primary care shortages resulting from expanding insurance coverage may drive more efficiency in physician practices. "Apply traditional economic principles, if you have an increase in demand, there should be some type of effort to address the supply side. It takes time to increase the number of physicians. As demand increases in that sense, it can be an economic incentive on the provider side to become more efficient."

- **Individual coverage mandate can set an important tone.** In Massachusetts, only 7% of the newly insured were those who paid for insurance on their own. The remainder were subsidized by government or employers. Despite this small percentage, several Massachusetts health leaders say an individual mandate is critical and sends an important message about responsibility. The state tried to change the psychology around coverage, which included ad campaigns that featured the Boston Red Sox saying, “Cover Your Bases — Connect to Health.” A similar education effort may be required nationally. Massachusetts is the only state that has a pay-or-play provision that requires adults to have insurance coverage.
- **State coverage mandates could be bypassed.** Obama’s national health insurance exchange may not be exempt from state insurance benefit coverage mandates, which vary by state and some say add unnecessary costs. Massachusetts has 43 coverage mandates, requiring that insurers cover certain dependents and types of care, such as chiropractic visits and prostate cancer screenings.¹³ The cost of mandates is widely debated in health policy circles. For example, some research has shown that requiring mental health coverage saves money, but others say it adds to cost.
- **Obama’s proposal could settle or stir up controversy over what determines minimum coverage levels.** In Massachusetts, the minimal creditable coverage is determined by the Connector — an independent state agency created to help people find affordable healthcare. Some say it’s too rich; others say not so much. Some employers that currently offer insurance to employees may not meet the minimum standards in one area but provide more generous coverage in another.
- **The National Health Insurance Exchange would provide individuals with new choices.** These new choices may benefit some but could hurt others. The proliferation of health plans adds administrative costs for providers and can be confusing to members. Having choices is a sophisticated shopper’s dream, particularly for workers at small businesses, which typically have only one choice of health plan. The Massachusetts Connector has 30 choices. Health policy researcher Grace-Marie Turner said the government needs to look more closely at choices and incentives: “When people are paying zero premiums and face little or nothing in copayments, they want the most generous coverage possible,” she said. “This provides few incentives for them to seek value in their health spending.” Turner said she would look at reducing coverage mandates and increasing consumer choices, incentives, and providing opportunities to spend the money wisely. “Getting more people insured also could be an opportunity to advance transparency, but it’s wasted if consumers aren’t motivated to seek information to engage in decisions about their healthcare and health spending,” she added. If the debate widens beyond the industry, consumers may need to examine what they really want out of insurance.

- **Rising costs are not sustainable.** Healthcare costs are not sustainable at the current rate of growth, and covering the uninsured is likely to increase costs unless the issue is addressed more broadly. On average, an uninsured individual uses only about 60% of the medical services of an individual with insurance. The Massachusetts' reform has been criticized as unaffordable, which is why this year's legislation more aggressively addressed costs.¹⁴ As the government pays for more of the cost of care, as in Massachusetts, more regulation around the industry is likely to follow.
- **Obama's promise of \$2,500 in cost savings for a family insurance premium may not be possible for 10 years or more.** Obama has discussed several ways to lower healthcare costs, such as comparative effectiveness, investing in health information technology and focusing on prevention. However, such programs take years to implement and reap savings, and only part of those savings will accrue to government. Obama will also have to specify more details about his savings plans. For example, how would disease prevention and wellness programs be encouraged? As for possible savings, five types of policy proposals — comparative effectiveness research, health IT, medical liability reform, value-based reimbursement, and disease management and wellness — could save 9% on healthcare costs by 2025, according to a PricewaterhouseCoopers' study for America's Health Insurance Plans.¹⁵

What this means for your business

**President-elect
Obama's proposals
could lead to lower
margins for providers,
pharmaceutical
companies and health
plans that increasingly
depend on
government payment.**

Obama has laid out a menu of reforms that could have positive and negative implications for industry stakeholders.

Following are the reforms that Obama proposes, with a grid of implications on the subsequent pages.

Current Public Program Modifications

- Expands Medicaid/SCHIP to an unspecified level

New Sources of Health Insurance

- Creates the National Health Insurance Exchange
- Establishes public insurance program that parallels the Federal Employees Health Benefit Plan
- Reinsurance pool for catastrophic costs

Coverage Requirements and Responsibilities

- Mandates that all employers provide coverage except for start-ups and very small businesses
- Mandates that all children obtain coverage
- Reimburses a portion of premium cost to employer when reimbursement is used to lower premiums for employees

New Tax Incentives or Penalties

- Creates an unspecified penalty for employers that do not provide coverage
- Creates an unspecified penalty for parents who do not obtain coverage for children

Low-Income Subsidies

- Provides an unspecified income-based subsidy for health premiums on coverage purchased in National Health Insurance Exchange or new public program

Quality and Research Improvements

- Supports independent institute to guide reviews and research on comparative effectiveness drugs, devices, and procedures to improve medical decision making
- Offers funding to nursing schools
- Offers potential tuition assistance for nurses
- Accelerates efforts to develop and disseminate best practices, and align reimbursement with provision of high-quality health care
- Requires hospitals and providers to collect and publicly report measures of healthcare costs and quality, including data on preventable medical errors, nurse staffing ratios, hospital-acquired infections, and disparities in care and costs
- Eliminates Medicare overpayments

Health Information Technology

- Allocates \$10 billion annually to health IT for five years
- Adopts standards-based electronic health information systems
- Establishes phase-in requirements for health IT implementation

Pharmaceutical Regulations

- Allows for reimportation of safe drugs when prices are lower than in the U.S.
- Enables government negotiations with drug companies
- Increases the use of generic drugs in government programs
- Prohibits large drug companies from keeping generic competition out of the market

Wellness and Prevention Programs

- Requires coverage of preventive services, including screenings and smoking cessation
- Expands school-based screening programs, clinical services, physical education, and health education programs
- Promotes expanding and rewarding work site programs
- Provides unspecified funding for community-based initiatives, such as sidewalks, biking paths, walking trails, and restricts tobacco and alcohol advertising to children

Malpractice Reform

- Strengthens antitrust laws on malpractice insurers

Providers

What They're Facing	Positive Implications	Negative Implications
<p>Hospitals have seen relatively healthy margins, but all are seeing rising levels of uncompensated care in a disrupted economy.</p>	<p>More Americans with health insurance means less uncompensated care.</p>	<p>A shortage of primary care doctors could lead the federal government to follow Massachusetts' lead in allowing broader authority to nurse practitioners and other alternative providers. Many physicians oppose broadening the scope of service for non-physicians.</p>
<p>Payers continue to focus on reducing inpatient utilization, which could leave newly renovated and constructed hospitals with empty beds.</p>	<p>More Americans with health insurance means more healthcare services will be delivered.</p>	<p>Retail clinics may proliferate to fill the primary care gap, which could draw income from doctors and hospitals without relationships to these clinics.</p>
<p>Hospitals' best payers are commercial health plans, which are losing private customers, a situation that might increase if consumers flock to Obama's national health insurance plan.</p>	<p>Less cost-shifting could result in more rational pricing, which in turn could lead to more transparency in pricing, benefiting some providers.</p>	<p>Academic medical centers may see a decrease in dedicated funding streams, as the population becomes more broadly insured. Many of the funds currently dedicated to covering the uninsured now flow to these institutions and other safety net providers.</p>
<p>Medicare may funnel more funding to primary care physicians, but in the current budget climate, it could be at the expense of specialists and hospitals.</p>	<p>A \$10 billion annual investment in health IT is likely to improve provider operations and reduce costs over time. For example, it could be funneled to small physician groups so they can take advantage of electronic medical records (EMR) and e-prescribing.</p>	<p>Putting more people on Medicaid means more reimbursement at Medicaid rates, which are often below costs. In Massachusetts, the state raised Medicaid hospital payment rates to 95% of costs, but the rate is much lower in other states.</p>
<p>Medicare may funnel more funding to primary care physicians, but in the current budget climate, it could be at the expense of specialists and hospitals.</p>	<p>There could be incentives for physicians to organize themselves into larger groups — to improve efficiency of administrative infrastructure and knowledge management to improve quality.</p>	<p>If payment rates for a national health insurance plan are set at Medicare levels, hospitals may receive lower average reimbursement, since common commercial payment rates are higher than Medicare.</p>
<p>Medicare may funnel more funding to primary care physicians, but in the current budget climate, it could be at the expense of specialists and hospitals.</p>	<p>Retail clinics may proliferate to fill the primary care gap, which would benefit providers already in this business.</p>	<p>Some revenue may be lost as improved technology reduces the need for duplicative tests.</p>

Insurers

What They're Facing	Positive Implications	Negative Implications
<p>Consolidation of commercial insurers continues and could accelerate.</p> <p>In a tough economy, the number of privately insured is likely to drop.</p>	<p>More insured means more premium revenue, which could mean higher margins than the fee income earned on administration of self-insured business.</p>	<p>Obama's proposal favors guaranteed issue and community rating, which rewrite the rules that many insurers now use to operate.</p>
<p>Congress may again look to reduce Medicare Advantage rates, which will lead some insurers to drop coverage in some regions.</p>	<p>New markets could open up through the National Health Insurance Exchange by creating incentives for commercial insurers to offer innovative products.</p>	<p>Plans in the Massachusetts' health exchange were limited to a 5% increase the first year. Similar rate restrictions may be established in a national exchange.</p>
<p>Plans may have to compromise on details of Obama's reform, which includes guaranteed issue and community rating.</p>	<p>Larger plans may be able to purchase smaller ones, which may increase market share.</p>	<p>If the national health insurance plan pays providers Medicare rates, hospitals will see revenues drop and private plans may be pressured to pay more.</p>
	<p>By insuring more Americans, fewer may depend on hospital ER treatment which should reduce cost.</p>	<p>The national health insurance exchange could reduce the role of brokers. While this would decrease commissions paid by insurers, it could cause more work for health plans in marketing and member relations if services currently provided by brokers aren't re-established through other sources such as the national exchange.</p>
	<p>Health reform spawns new winners and losers, which could spark merger activity.</p>	
	<p>National reform could pre-empt state reform, creating more uniform standards.</p>	
	<p>Additional health IT funding</p>	

Pharmaceutical and biotech companies

What They're Facing	Positive Implications	Negative Implications
<p>Big pharma continues to restructure, coping with challenging research and development (R&D) pipelines, slower sales growth, increasing generic substitution, and rising research costs.</p> <p>An estimated \$60 billion in sales of brand-name drugs in the United States will be lost because of expired patents over the next four years.</p> <p>Research firm Sanford C. Bernstein estimates that generic erosion will knock between 2% and 40% off the revenues of the top 10 companies by 2015.</p>	<p>More insured means more demand for drugs and less need for free drug programs.</p> <p>Obama said he supports continuing the R&D tax credit.</p> <p>Obama sponsored personalized medicine legislation and could provide more incentives and funding for research.</p>	<p>Direct negotiation of drugs for Medicare is expected to erode profits.</p> <p>Comparative effectiveness may cut into revenue for branded drugs, especially for high-cost prescriptions. Similarly, pressure could rise to adopt bio-equivalent drugs.</p> <p>Pressure to reduce premium growth may prompt insurers to move some drug costs now in the medical benefit to the drug benefit, where cost-sharing tends to be higher.</p>

Employers

What They're Facing	Positive Implications	Negative Implications
<p>The small employer market in health insurance is eroding as fewer small employers are providing health insurance to their workers.</p>	<p>Fewer uninsured could mean less cost-shifting to employers and private plans.</p>	<p>Employers will be leery if the National Health Insurance Exchange conflicts with ERISA pre-emption of state insurance laws and forces them to comply with state coverage mandates and to pay premium taxes.</p>
<p>Large employers say they want to continue providing health insurance benefits, but companies that compete on the global market say healthcare makes them increasingly uncompetitive.</p>	<p>Low-income subsidies for families with incomes up to 300% (or 400%) of the federal poverty level could mean that workers who are now uninsured get government-subsidized coverage. More coverage could lead to healthier workers and higher productivity.</p>	<p>The pay-or-play proposal for employers could raise costs and create more administrative work.</p>
<p>Large employers are challenged by growth in health benefit costs that outstrip the growth in other expenses in the face of global competition.</p>	<p>Employers may be able to piggyback on government savings measures such as comparative effectiveness, health IT, new payment models, and evidence about comparative effectiveness, wellness and prevention.</p>	<p>The national health insurance exchange could change the broker relationship.</p>
<p>Many are saddled with large retiree health benefit liabilities.</p>		

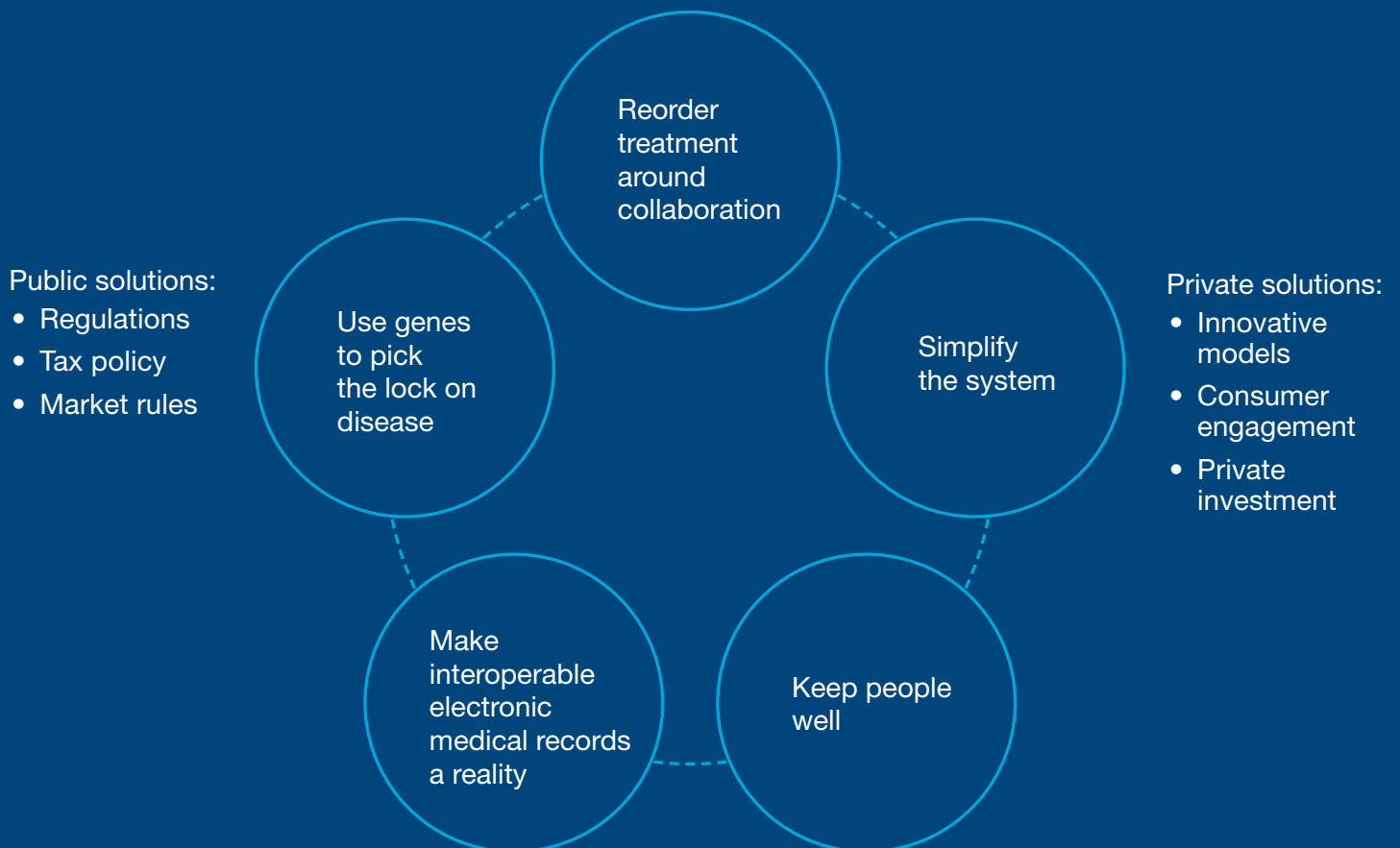
Public-private collaborations: Five ideas the new President should consider to make healthcare more affordable and sustainable

Making healthcare affordable in the long term demands structural changes in delivery, payment, priorities and incentives. “It’s not so much about the \$100 billion [cost to expand access], it’s about rearranging the \$2 trillion [we already spend],” said Jon Kingsdale, executive director of the Massachusetts’ Commonwealth Connector. To reallocate spending, the government might have to engage in a *Jack and the Beanstalk* trade in which it sells the cow for a bag of beans that will yield fruitful results. In the meantime, to deliver the affordable healthcare everyone wants, the new president should look to reforms that are already under way.

The following five health reform ideas are a starting point for the new administration, building on the positives in the public and the private sectors. David B. Snow, Jr., chairman and CEO of Medco Health Solutions, Inc., one of the nation’s largest pharmacy benefit management groups noted: “The private sector is best at innovating and operating. The public sector is good at promulgating and regulating.”

Any solution will require a dose of expertise, an ability to scale working models, and some unconventional, perhaps controversial, ideas.

Here’s our prescription:



Five ideas

1. Reorder treatment around collaboration

Payers are focusing on value-based reimbursement systems, reducing variation in treatment, and eliminating waste.

Public sector efforts

- Medicare will now pay for telemedicine for rural and medical shortage areas.
- MedPAC, which advises Congress on Medicare, has proposed an approach to bundled payments for physicians and hospitals.
- Some European countries are looking at drug pricing based on outcomes.

Private sector efforts

- Walgreens is making primary care more convenient. It will have more than 800 in-store and worksite clinics open by the end of fiscal 2009. However, Walgreen Co. senior vice president and president of Walgreens Health & Wellness division, Hal Rosenbluth says resources are limited: "If there's any type of universal health insurance, there's not enough providers today to handle those who are insured. We're provider of choice for our clinicians."
- Prometheus Payment has developed evidence-informed case rates, designed to create fair payments for providers delivering care to a patient for conditions such as diabetes and heart attacks.
- Some private plans are paying doctors for e-mail consults to reduce office visits.
- Manufacturers of expensive specialty drugs are looking at new pricing terms based on outcomes or a percent of a patient's adjusted gross income.
- Geisinger Health System has developed outcomes-based pricing for heart surgery.

Bold moves to consider

- Allow nurse practitioners and physician assistants to do routine care and well-care check-ups.
- Skew payment to benefit physicians who practice in groups.
- Pay those who care for disabled and/or elderly family members in their homes.
- Create competitive bid in Medicare capitation payment models for chronic disease, such as diabetes and congestive heart failure.
- Allow Medicare to follow the lead of private health plans that allow members to be treated at accredited hospitals in other countries.
- Set up local centers of excellence in primary care.
- Set up an equivalency program that allows foreign medical graduates to practice in the U.S. without going through a U.S. residency program.
- Adapt payment/reimbursement models that encourage adoption of remote devices/sensors and related services.

Advice on public-private collaboration:

Dr. Barbara Rudolph, director of leaps and measures, Leapfrog, says most of the performance measures developed by both government and private payers have focused on increasing the number of preventive services. It's time to look at the other cost drivers. "If we don't cut down on overuse and misuse, the current payment systems may collapse under the weight of additional services."

Five ideas

2. Simplify the system

Neither payers nor providers can eliminate the complexity and duplication on their own. It requires a broad effort of compromise and concessions, which could be kick started by government payers. At the same time, consumers need better, simpler information to navigate the system.

Public sector efforts

- Several states are posting prices and outcomes for providers, enabling consumers to have more information to make choices.
- Medicare has published price guides online.

Private sector efforts

- Health plans are collaborating on standard claims processing rules through an initiative by CAQH. Some providers are now able to get information on patient deductible balances from health plans at the point of care.
- Several states are posting prices and outcomes for providers, allowing consumers to have more information and make informed choices.
- In California, some health plans allow members to use their driver's license as a membership card. When swiped, it ties into coverage and eligibility information.

Bold moves to consider

- Encourage single pricing lists.
- Reduce regulations that require plans to mail paper copies of EOBs, EOCs, and provider directories.
- Mandate that claim forms are static.
- Provide tax incentives and reduce regulatory hurdles so that patients can easily monitor their health through digital tools that feed into their personal health records.

Advice on public-private collaboration:

In Massachusetts, the Connector prompted private health plans to simplify their own websites, making it easier for consumers to shop for insurance.

Five ideas

3. Keep people well

Improving Americans' poor health behaviors will take thousands of small public and private initiatives at the community level. The good news is a lot has already started.

Public sector efforts

- Measurable goals have been set through CDC's "Healthy People" agenda.
- 44 states and the District of Columbia have increased cigarette taxes since 2002, and tobacco use is dropping.
- An individual mandate in Massachusetts prompted more patients to seek preventive care. Opposition to the law was expected, but State Rep. Martha Walz said: "I did not get a single constituent call to repeal the mandate."
- Some Medicaid programs are offering "medical homes."

Private sector efforts

- Miniature devices and wireless networks help people and their clinicians monitor their health beyond the clinical setting.
- Two-thirds of large employers offer wellness programs even though they're not sure they lower costs. More research could confirm which programs work best.
- Value-based design programs offered by some employers lower out-of-pocket costs for chronic care medications.

Bold moves to consider

- Replicate the success of some chartered schools by giving private groups funding to tackle key public health issues.
- Allow consumers to order certain laboratory tests, such as cholesterol, a prostate-specific antigen test, or hemoglobin H1C for diabetes, without a physician's order.
- Provide tax incentives to small businesses for on-site prevention programs.
- Adopt Japan's new law that employers must measure their workers waistlines and penalize those that are too big.
- Require kids to show proof of health insurance as well as immunizations when they enroll in school.

Advice on public-private collaboration:

While in office Kentucky secretary of health and family services Mark D. Birdwhistell launched a statewide fitness initiative that partnered with YMCAs and other community partners. This includes the construction of walking trails and playgrounds. Birdwhistell, who's now with University of Kentucky Healthcare system's office of the Executive Vice President, said: "I would include in any reform efforts a pivotal role for the public health system. The public health system provides an infrastructure for each and every county in the nation."

Five ideas

4. Make interoperable electronic medical records a reality

Connecting electronic health records is a prime opportunity for public-private collaboration that could boost efficiency and quality.

Public sector efforts

- Physicians will get extra Medicare pay to e-prescribe in 2009. SureScripts-RxHub will connect physicians to pharmacies, allowing them to view the patient's insurance coverage and prescribing history.
- Medicare has selected 12 group practices to participate in an electronic health records demonstration project.

Private sector efforts

Janet Marchibroda, CEO of eHealth Initiative: "We're making a lot of progress with the exchange of data through community-based exchanges. Based on our 2008 survey results, a majority of operational exchanges are reporting both reductions in costs and improved care delivery, and for the first time, a majority are reporting a positive ROI for either providers, plans or labs." The number of operational health information exchanges expanded from 32 to 42 this year.

John Glaser, CIO, Partners, board member for American Health Information Community: "We rolled out an EMR to primary care physicians, and they said they liked dealing with specialists who were using EMRs too. That drove the specialists to adopt [EMRs] to get referrals."

Bold moves to consider

- Link Medicare provider payment to adoption of EMRs and e-prescribing; audit to ensure base level of functionality.
- Work through public-private agreement on a federal privacy framework for data exchange.
- Develop outcome-based contracts to pay local medical societies or not-for-profits to assist physicians with implementation.
- In the U.S., 35% of all hospitals have EMR systems. Academic medical centers leading the way, but only 15% of medical groups use EMRs. There is a direct correlation between size and EMR adoption; smaller systems may require more payment incentives.

Advice on public-private collaboration:

Steve Lieber, CEO of Healthcare Information and Management Systems Society (HIMSS): "The certification process for IT was a textbook example of how you can get acceptance by the vendor community to get it into the marketplace. The Certification Commission for Healthcare Information Technology is qualifying which vendors providers should use."

Five ideas

5. Use genes to pick the lock on disease

To make accurate diagnoses, physicians must accurately understand their patients. Although genetic screening is now widely available, many physicians don't understand what to do with the information. That will change, and accelerate, with the proper regulatory framework.

Public sector efforts

Medco Health Solutions, which provides pharmacy benefit services to a fourth of all Americans, is working with the FDA to develop a series of studies that looks at how patients' genetic information can potentially predict their response to a wide variety of drugs. One example is Coumadin, a blood thinner that works differently in patients depending on their genetic profile. About 22% of patients who are prescribed Coumadin are hospitalized in the first six months because they're given the wrong dosage, said Medco's David B. Snow, Jr. The genetic test can reduce that, but physicians don't know to give it, he added. "The real value is using our enormous database to bring value around protocol and what works and doesn't work," he said.

Private sector efforts

As disease becomes more specialized based on a patient's genes, researchers and clinicians will look to companies like Sigma-Tau Pharmaceuticals, Inc., which develops highly targeted drugs for rare diseases. "Oncology has become a rare disease because each cancer is being sub-typed and specific drugs are being developed for each type," said company CEO Gregg Lapointe.

Bold moves to consider

- Extend patent life for drugs with gene-based markers so that pharma companies can recoup investment
- Require genetic testing for certain drugs
- Fast-track diagnostic testing approvals through FDA
- Link physician payment to genetic testing processes
- Require physicians to participate in registries for top cancers and other rare diseases
- Balance funding on comparative effectiveness with funding to determine which diagnostics can predict which diseases

Advice on public-private collaboration:

Raymond L. Woosley, M.D., Ph.D., president and CEO of the Critical Path Institute, which was created to support the FDA's Critical Path Initiative: "Most drugs have a 50% to 60% response rate. Diagnostic tests of when to use the drug is the only way to get it to 90%. Trials cost \$20 million to \$50 million to compare two or three therapies. By the time the trials are done, they're irrelevant. Medicine moves much quicker than clinical trials."

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