Cincinnati USA
Regional Chamber

August 14, 2006

Citizens' Health Care Working Group
citizenshealth@ahrq.gov

Attn: Interim Recommendations

RE: *Comments on Interim Recommendations*

Dear Citizens' Health Care Working Group:

These comments on the Working Group's *Interim Recommendations* are submitted on behalf of the Health Care Committee of the Cincinnati USA Regional Chamber. We have reviewed the *Recommendations* as they are presented in the Federal Register, June 14, 2006; our references are to that version.

General Comments:

- The *Values & Principles* section (p. 34371) establishes a context that was not part of the original request for comments and answers. Such a context may be a good idea, but a *Values & Principles* section should have been an original preamble with the Four Questions. To use it as an after-the-fact reference implies that some comments are now off the mark or, worse, devalued.

- The Interim Recommendations are not linked directly enough to the Four Questions. One would have hoped that the Recommendations would reference, or cite, at least generally, the Four Questions *and* the answers presented by the American public at the community meetings. For example, consider Recommendation 1:

  > *It should be public policy that all Americans have affordable health care.*

  On its own, the Recommendation is confusing, but particularly so when one reviews the Four Questions – which seek answers regarding benefits and services, health care delivery, finances and tradeoffs. Recommendation 1 would draw added standing if it was given at least some reference to the public meetings or written commentary. As presented, it seems almost random.

  Another example: Recommendation 4 seeks support for "integrated community health networks." It's hard to tell if this recommendation stems from public comments about health care *delivery*, or *finance* it or whether such networks are an acceptable *tradeoff*.

- Granted, the Interim Recommendations are primarily a narrative report, not meant to serve as a "legal" document. Nevertheless, some definitions would be helpful. For example, Recommendation 1 references "affordable health care." That can mean hands-on care by a provider, implying a certain set of costs and conditions. But elsewhere, the document references affordable health care "coverage", perhaps a reference to health *insurance*, which, of course, presents quite another set of costs and conditions. Throughout the document there are terms and concepts that need sharper focus.

- None of the Recommendations specifically deals with the concept of "trade-offs". That's unfortunate because the "trade-off" question is difficult and contentious, yet it must be addressed. We suggested that, at least among individuals, the Working Group should await further research. But we added that health-care trade-offs are impacting the US now, that health related trade-offs are inherently part of real-world economic and policy issues. Surely, many others must have made suggestions about trade-offs, yet the word never appears in the Interim Recommendations except when the Four Questions are reprinted. We suggest a renewed attention to this critical concept before the Recommendations are sent to Congress and the President.

Specific Comments:

Recommendation 1: *It should be public policy that all Americans have affordable health care.*

- Who says it should be public policy? To validate this command, the Working Group needs to clearly cite the public comments that prompt it. These references should document broad support for such a fiat, i.e., support that is neither factional nor polemical, but support that can draw consensus, compromise and cooperation.

- *Affordable* is a relative term. Many people say they cannot *afford* health insurance when it is offered through an employer or other source. At the same time, those individuals or families may own more than one automobile (with multiple insurance, maintenance and operating costs), have cell phones, cable television, Internet service and similar luxuries, sometimes even purchasing expanded or upgraded versions of these services.

  In our comments on the Four Questions we suggested that the Working Group expand discussion about why people don't purchase health insurance. Affordability is certainly a factor, but a broader perspective needs to compare health care affordability with other living expenses. To be sure, some health care and health insurance are rightfully subsidized. But clarity and perspective are crucial if elected officials are going to set policies that seek to make health care "affordable" to all Americans.

The Interim Recommendations link affordability with a health care system "where everyone participates." *Participation* surely includes a requirement that everyone pays for health care and health insurance, even if, for some, contributions need to be subsidized.

As noted, this is one of a number of critical concepts and terms that demand clear definition if they are to support future policy recommendations.

- After Recommendation 1, in text that starts on page 34372, the Working Group writes that the Recommendations "will require new revenues to provide some health care security for Americans who are now at great risk." Then, there are references to "additional financial investments" for expanding and providing care.

  Calls for additional revenue are premature. The Working Group reports that America spends $1.8 trillion – $1,800,000,000,000 – on health care. The Working Group also raises disturbing questions about whether we are getting our money's worth for that huge sum. We suggest that before devising new ways to add money to a challenged system, let's explore the opportunities that may result when programs are changed or managed better, when efficiencies improve and when there are new or different expectations for resources invested vis-à-vis outcomes.

Recommendation 2: *Define a "Core" Benefit Package for All Americans*

- Recommendation 2 is a good idea if the "core" reference is to a **basic** or **minimal** set of provisions or services that must be *paid for through public taxation or subsidies*. After all, private individuals and groups, spending their own money, can assemble a benefit package that is as lean or as rich as its participants can afford. It is unfortunate that this distinction – between paying for subsidized care versus private payment for care or insurance – is not highlighted and stressed in the Interim Recommendations.

- In our comments we suggested that the Working Group avoid trying to define or describe maximum benefits – again, particularly within taxpayer funded programs. However, we also suggest that reference to *minimum* benefits does require additional thought and effort, especially regarding health care coverage for children.

- The ideas in the 3rd – 5th bullets in this section are sound; they should remain part of the final recommendations.

- The final bullet calls for "immediate protection for the most vulnerable." What does that mean? Who are the most vulnerable and what kind of protection do they need?

Recommendation 3: *Guarantee financial protection against very high health care costs.*

- It is not clear here if the "guarantee" is for the cost of the "core" benefit package – which could be a very high cost for some people – or perhaps if extremely high costs arise from treatments or services even if they are covered within the "core" package.

- Also, Recommendation 2 references some kind of split between "high-cost protection" and "core benefits." In a way, Recommendation 3 seems to obviate Recommendation 2 because this 3rd Recommendation guarantees financial protection against very high costs. This is confusing; it needs further explanation.

- The final bullet references "financial protection for low income individuals and families." The "low income" reference needs clarification – does it include people who qualify for Medicaid?

Recommendation 4: *Support integrated community health networks*.

- This Recommendation seems to suggest an expansion of federal programs. Such an expansion needs further documentation.

- The specifics within this Recommendation are confusing. Many terms need greater clarification – terms such as "vulnerable populations" and "low income"; even the term "network" is unclear – it could, for example, refer to actual clinics or to new efforts to improve existing governmental and charitable programs for care and payment.

- Regarding bullet two, it would be difficult to identify within the federal government a single unit coordinating all federal efforts that support the health care safety net. Perhaps this text is a *proposal* to establish such an office. Again, clarity is needed.

- The third bullet establishes a think-tank, the second think-tank within the Recommendations. Currently, there is boundless creative energy, from a myriad of groups and organizations, focusing on health care issues, covering all imaginable points of view; most of this work is in the public domain. We suggest taking advantage of this thoughtful work that is already being done.

- A safety net concern is important and appropriate. But why the singular focus? The original Four Questions ask about health care benefits, delivery, finances and trade-offs for *all* Americans – some of whom need a safety net but most of whom are covered by private insurance. The document does not contain any recommendations for changing and improving the private sector portion of the health care/health insurance economy. This exclusion needs to be addressed.

Recommendation 5: *Promote efforts to improve quality of care and efficiency.*

These are all good ideas that should be expected in the dynamics of any business.

Building on that, we suggest an additional directive. As written, this Recommendation suggests that "the federal government will *promote*" (emphasis added) integrated systems, electronic records, fraud reduction and new education programs.

We would add a 7th bullet to this Recommendation. The new text might be the following:

- "The federal government will develop systems for documenting, monitoring, and otherwise describing, and then reporting, the results of these new efforts to improve quality of care and efficiency. This reporting must be both a narrative description of new or changed programs and a quantitative description of the financial and revenue benefits (or losses) that have accrued because of the new efforts."

The American public has been lead to believe that there are vast savings to be realized from more efficiently run health care programs. The daily press frequently describes costly inefficiencies from illegible prescriptions to paper medical records to vast bureaucracies to "defensive medicine" to improper use of emergency rooms. To the extent that Recommendation 5 can affect those problems, the full measure of that extent needs to be documented. It's possible that this could be found money. That's important on its own and it's also important for the Interim Recommendations because in Recommendation 1 there is a suggestion that "efficiency gains" should be re-invested in the system. This analysis is important. In our comments above we said that it is too early for the Working Group to call for new revenues; we need to determine how we're spending our money now and if we can spend it more wisely and efficiently.

Recommendation 6: *Fundamentally restructure the way that palliative care, hospice care and other end-of-life services are financed and provided, so that people living with advanced incurable conditions have increased access to these services in the environment they choose.*

We suggest that long-term care proposals be closely linked to recent federal budget language that allows state and federal funds to match private dollars invested in long-term care insurance.

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We appreciate the chance to participate in this critical national debate on health care provision and funding. If I can answer any questions or clarify any of the comments

contained herein, please do not hesitate to contact me at the number or e-mail listed below.

For the Chamber's Health Care Committee,

[electronic version unsigned]

Tom Ewing
Sr. Legislative & Policy Analyst
Cincinnati USA Regional Chamber
513-579-3176
tewing@cincinnatichamber.com