

Testimony of J. Randall MacDonald
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Health Reform in the 21st Century:

AN AGENDA FOR MUTUAL RESPONSIBILITY

Good morning, Chairman Rangel, Ranking Member Camp and members of the Ways and Means Committee. My name is Randy MacDonald and I am the Senior Vice President for Human Resources for the IBM Corporation. In the United States during 2008, IBM provided health coverage for 118,500 employees, 93,200 retirees, and 235,000 dependents – a commitment of some \$1.27 billion in 2008 alone.

In addition to leading IBM's global human resources organization, I also serve as the Chairman of the Board of the HR Policy Association (HRPA), a group of the chief human resource officers of more than 260 of the largest corporations in the United States. Representing almost every industry, HR Policy companies employ more than 12 million persons in the United States.

IBM is also working to create smarter health systems, with an increasingly more personalized experience. A "smart" healthcare system will be better instrumented, interconnected and intelligence-centered around the patient. In a smarter, IT-enabled health system, a networked, collaborative team of care-providers will work with individuals and families with children at the center to build strong trusting relationships which promote wellness and prevent and control chronic disease and disability. This smarter healthcare system will enable behavior change and vastly improved healthcare decisions to produce better health outcomes and greater efficiency by eliminating waste and needless administrative cost.

A successful health care reform agenda will build a patient-centered, accountable and competitive health care market place that delivers effective outcomes and improved unit costs. It will:

- build upon our employer-based system
- control costs and improve value in terms of quality and health status
- ensure all Americans have health insurance,
- enhance the focus on wellness, prevention and primary care, and
- accelerate the adoption of health information technology.

We believe the crisis in American health care is too complex for any one person, one organization, or one sector of our society to figure out *the* best option for reform. Our ideas are offered in the spirit of stimulating a discussion with Congress, the administration, and other stakeholder groups to determine the best solution. We look forward to building consensus to achieve the collective goal of transforming the nation's troubled health care system and improving the health and productivity of our population.

There is growing consensus among all key stakeholders, including large employers who purchase billions of dollars of health care products and services, that the current system of health care in the United States will be further stressed if we expand access without at the same time fundamentally reforming the system.

Large employers like IBM have become more active in this debate because we see pervasive deficiencies in the availability of comprehensive primary care; the lack of evidence-based use of medical technologies; insufficient transparency to allow consumers to make informed decisions; and inadequate adoption of information technology that would make care safer and more efficient.

Coverage Provided to IBM employees

Let me explain how IBM has worked to tackle some of these problems. IBM provides coverage to both full-time, part-time, and long term supplemental employees of IBM, as well as retirees and dependents. IBM and our retirees participate in the Part D Retiree Drug program sharing in any subsidies provided by the government – splitting the subsidy in proportion to their respective contribution to the retirees’ aggregate prescription drug costs.

We operate our plans nationally, and do not charge geographic differentials in employee/retiree contributions for our self-insured plans.

There are a number of innovative features in the coverage for IBM employees:

- Eligible full time employees have access to at least one health plan at no cost.
- Enrollees receive deductible-free coverage for preventive services
- Primary Care is covered deductible free and at a low coinsurance
- Employees are offered a Healthy Living Rebate Program (130K rebates earned in 2008) - employees earn up to \$300/year to complete healthy activities such as physical activity-nutrition, preventive care and the cutting edge Children’s Health Rebate for family-based activities to build healthy weight behaviors in children and youth
- Over 80,000 IBMers are now physically active and over half of our employees who were in a high health risk group have lowered their risk category
- From 2004 to 2008, IBM paid out over \$133 million to the Healthy Living Rebate program.
- IBM offers all employees an on-line Health Risk Assessment (64,000 completed 2008) and Personal Health Record

Our efforts to improve IBMers health and reduce costs

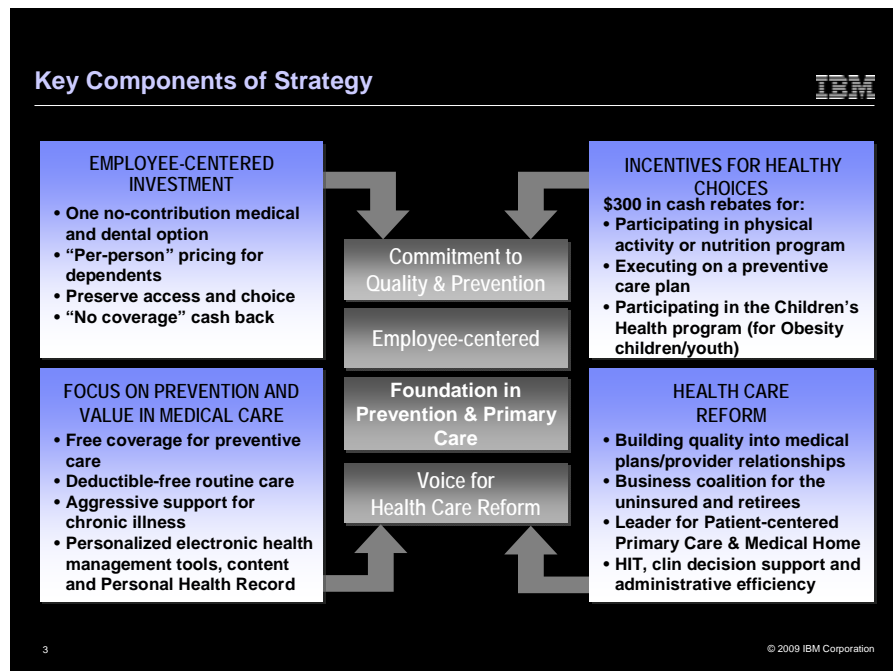
Earlier this decade, IBM was experiencing double-digit increases in health care costs in the U.S. The strategy we were using to contract with vendors was not optimized for quality, service, efficiency or price. Population health status and prevention, clinical care needs for chronic diseases, and coordination of care were absent in the marketplace. Accountability and transparency were non-existent for consumer decision making – meaning that real costs, prices and subsidies were hidden.

IBM addressed the problem through a new vision: Healthy People for High Performance.

Our strategy currently combines:

- Value (quality and cost)
- Meaningful choice
- Sustainable cost structures
- Prevention
- Primary care
- Smart decisions
- Privacy and HIT

Today, our employee population is healthier and our costs are lower. For both **cost** and **trend**, IBM is routinely at or below market. Employee costs remain lower than benchmarks. In 2008, our costs were \$8,585 per capita while the marketplace benchmark was \$8,895. Between 2004 and 2007, our internal health assessments showed dramatic declines in employee health risks. Participation in the wellness programs rose sharply and our employee population reduced risky behavior such as smoking, while increasing healthy behavior such as exercise and healthy nutrition. Over 80,000 IBMers participate in



our physical activity incentive program. Generic drug utilization has increased to 96% without reducing medication options. The reduction in health risks translates into savings in health care claims costs estimated at \$79 million between 2004 and 2007 alone.

But we are only one company. Systemic problems are at issue and we need to ensure we are all focused on the right problems

It’s not just a coverage problem; It’s also a cost and quality problem

While some health care reform advocates believe that we can reform our nation’s health care system by simply creating universal coverage through private insurance reforms or some form of a government-run single-payer system, we do not believe this would achieve our goals for health and health care. Above all, our society cannot afford to pay billions more into a fundamentally flawed delivery system to provide uninsured Americans access to the fragmented, episodic, procedure-oriented care that delivers poorer outcomes compared to other OECD countries. This is why we believe that broad, systemic reform is necessary. Our problems will only be exacerbated by bringing the uninsured into our current dysfunctional health care system.

Objectives of health care reform

We support a national health care reform agenda that meets the following seven objectives:

1. Make Significant Improvements in the Voluntary Employer-Based System of Health Care In Order to Ensure Its Continued Existence

IBM and other HR Policy members have expressed a commitment to maintaining the nation's voluntary system of employment-based health insurance if and only if major reforms to improve value, efficiency, and transparency can be achieved. The majority of Americans – more than 160 million – receive health care through employment-based coverage, and most Americans who do so are pleased with it. Even with its existing flaws, we believe our mix of employer-based coverage, private market, and public safety-net programs is superior to shifting to a government-run, single-payer system. Because of the lack of choice and stifled innovation that would result from a single-payer system, we are committed to working from the foundation of our current system to make significant improvements.

I know that there are questions about the proper balance between public and private insurance options as we look at healthcare reform. It is a fact that the government has long played a vital role in providing coverage for difficult-to-cover populations. Indeed, many IBM retirees already participate in Medicare Part D—a public plan, and expansions in the CHIP program this year will provide much needed assistance for uninsured children and youth. The question is how to strike the right balance between providing public options for those who truly need them, without undermining the bedrock of our U.S. healthcare system, which is voluntary employer-provided private insurance options.

We need to identify a balance that avoids problems like adverse selection for private sector plans, and we must proceed quite carefully as we consider the impact to the voluntary employer-based system of proposals that expand public coverage to those who are uninsured or disadvantaged in the individual group market like small businesses and the self-employed. We need to be careful because public plans might change the pool characteristics of private sector plans in a way that could shift costs onto private, employer-sponsored plans that have been the force for many innovations in wellness and health promotion, care services, transparency and pay for performance.

The ability of large employers to continue providing voluntary coverage depends greatly on the near-term adoption of significant changes that would help contain skyrocketing costs, improve the effectiveness and efficiency of health care, improve health outcomes, eliminate waste, and transform quality processes and accountability throughout the health care system. Changes in the employer exclusion of healthcare costs would threaten that system by adding to the burden employers are already carrying in providing healthcare coverage without addressing the need for shared responsibility across all stakeholders.

2. Adopt a Comprehensive National Reform Agenda

While there is considerable experimentation underway at the state and local level, at present more than half of Americans are covered by employer-based health insurance; many of these workers are employed by companies doing business across state lines. Many large employers offer benefits that are regulated by the Employee Retirement Income and Security Act (ERISA),

which provides uniform rules for the health benefits enjoyed by millions of workers and their families. ERISA preempts state laws that relate to ERISA plans in order to ensure uniformity among the states.

Pressure on ERISA is constant. States and localities relentlessly search for ways to penetrate its protective shield. For example, some states and localities have recently started to attach benefits requirements to public sector contracts – threatening to create the benefits patchwork that ERISA and the courts have long prevented.

The nature of health benefits offered by multi-state employers makes it unworkable -- and unfair -- to reform health care using a patchwork of state and local solutions. Rather, our health care system should have consistent and uniform guidelines to ensure that affordable and comprehensive benefits can be delivered to all Americans.

3. Significantly Improve Wellness, Prevention, and Primary Care

A successful national reform agenda must focus on maximizing the health status of individuals, not just treating the sick. Costly chronic conditions such as diabetes, coronary artery disease, obesity, and asthma account for a disproportionate share of health care costs. Half of the population spends little or nothing on health care, while five percent of the population accounts for almost half of the nation's health care expenditures.

Health care reform must build a strong primary care foundation for the health care delivery system. Many health care providers, especially primary care physicians, share the frustration of payers and consumers about our current health care system's focus on the delivery of acute and episodic care, high volumes of procedures, intensive use of high-cost technology, specialty services, and administrative overhead. Primary care physicians want to provide accessible, continuous, coordinated and comprehensive care, but to do this through a payment model in which they do not have to suffer financially for providing evidence-based medicine and communicating and coordinating care that keeps their patients healthy. Payment reform and new models of care delivery with primary care providers, such as the kind that occurs within a "patient-centered medical home" model, can encourage providers to keep patients healthy and deliver timely, comprehensive, and appropriate care.

4. Create a Competitive and Accountable Marketplace

Two key elements that drive healthy markets – consumer information (transparency) and choice – are woefully lacking in our health care system. Providers operate under perverse incentives that reward the volume of services delivered, rather than the quality and efficiency of the care provided. Many consumers receive coverage through a third party that pays for their health insurance without knowledge of the cost of services being recommended or offered. Health insurers compete based on the avoidance of risk (*i.e.*, individuals who are most likely to generate medical bills), leaving many people with individual policies without access to coverage or unable to afford it. The U.S. must inject market-based principles that foster competition among health care providers and choice among consumers to help lower overall costs and increase value within our health care system.

5. Control Costs and Improve Quality

A successful reform agenda must control costs and ensure that our health care system delivers consistent high quality care to everyone. While the United States pays \$7,026 per capita on health care—more than any other nation—we rank near the bottom on a variety of health care indicators, including infant mortality, obesity, and potential years of lost life due to diabetes. Disparities in health care quality are pervasive, with minorities and low-income people often receiving lower-quality care across a variety of measures.

The business community has a record of banding together on quality and efficiency issues. For example, HR Policy's Pharmaceutical Coalition is made up of 60 member companies that purchase pharmacy benefits for more than five million Americans. In 2005, they launched the Transparency in Pharmaceutical Purchasing Solutions (TIPPS) initiative. TIPPS is an effort by the Coalition to ensure the interests of a pharmacy benefit manager (PBM) are aligned with those of their employer clients. The Coalition has developed a uniform set of rigorous transparency standards for PBMs when contracting with Coalition members. PBMs are certified annually by completing a RFP process to ensure they are willing to meet the TIPPS standards.

Our experience with the TIPPS initiative has demonstrated that in some instances market reforms can be successful. When the program was first launched in 2005, only three PBMs were willing to meet the standards. Today, 15 PBMs have been certified, representing more than 50 percent of the market that serves large employer clients.

Another example of businesses banding together to solve healthcare problems is HR Policy's Retiree Health Access (RHA). The Association developed RHA as an alternative solution to provide coverage to pre- and post-65 retirees. RHA was introduced in 2006 with five employers and 40,000 retirees participating.

At the time, carriers aggressively competed for post-65 retirees – a population that comes with significant employer contributions and government funding. However, no carrier would offer comprehensive, guaranteed issue coverage to early retirees without substantial employer subsidies and minimum levels of retiree participation.

As a result, the Association elected to place its RHA business out to bid in an effort to secure coverage for early retirees on a guaranteed issue basis without an employer subsidy or minimum enrollment requirements. The result of that bidding process was that a new RHA benefit offering guaranteed issue coverage for pre- and post-65 retirees became available January 1, 2008. This has proven to be a very popular solution. Since the new RHA solution was announced in 2007, more than 200 employers have expressed an interest in considering it. As of April 2009, 51 employers had decided to offer RHA with more than 76,000 retirees enrolled.

Reforms must include changes to the current provider reimbursement models within private reimbursement arrangements and in public programs such as Medicare and Medicaid to promote and reward value equitably.

In addition, the business community must sponsor and support quality initiatives such as requiring providers and health plans to be involved in collecting and managing quality data. Enabling innovation to find new ways to treat patients, balanced with research into the

comparative effectiveness and efficiency of various treatments, can be applied to improve care and lower costs.

6. Ensure All Americans Have Health Insurance

There is clear consensus that any successful health care reform agenda must result in the uninsured becoming insured. People who lack health insurance do not receive timely care and tend to use the most expensive care option – emergency rooms – when they are sick. Health care providers then shift the cost of the uninsured on to those paying for health care services, resulting in an extra \$922 per year for family health insurance and \$341 for individuals.

A successful solution has to take into account the different circumstances of those who are uninsured. This group includes low-income people eligible for public programs but who are not enrolled, those who make too much to qualify for public programs but still struggle to pay for coverage, employees of small businesses, individuals at high risk or with pre-existing conditions, and pre-65 retirees who are not yet eligible for Medicare. In addition, people who can access and are able to afford coverage, yet choose not to purchase insurance, make up another segment of the uninsured that must be addressed.

One of the greatest advantages of the employer-based system is that employees typically form large and diverse risk pools – an important factor that, when combined with significant employer subsidies, results in relatively stable and affordable premiums for workers. However, individuals faced with purchasing coverage on their own in the individual market, especially those who are sick or high-risk, can face challenges in securing affordable coverage due to unaffordable premiums and policy denials. People without access to employer-sponsored coverage should be able to have guaranteed access to private coverage and comparable tax breaks to purchase coverage on their own.

7. Assure Adoption of Health Information Technology

Health care information technology (HIT) needs to be widely adopted by health care providers to improve patient safety, increase efficiency, and produce significant savings throughout our health care system. The potential for HIT to improve care and lower costs has been well documented when it has been put in place. It is clear that the technology is available. Other industries such as the airlines, finance, and consumer electronics have been able to achieve a level of interoperability for years, despite rapidly changing technology and constant innovation. Although the health care industry is not perfectly analogous to other industries, there is significant room for improvement to expand the adoption of HIT. Health systems can connect people to information, to experts and to each other and can act proactively to better manage and deliver preventative and therapeutic care. Strong incentives need to be put in place to encourage providers to consistently adopt this technology in a manner that benefits patients through safer and more convenient care, and in a way that lowers administrative costs.

Achieving the Objectives through Mutual Responsibility

To achieve true reform of the health care system in the United States, we have adopted an approach of Mutual Responsibility. All key stakeholders must compromise and accept added responsibility, and share in the burdens as well as the benefits of reform. Our HR Policy comprehensive national reform agenda includes the following mutually complimentary elements:

- **Federal Government**. Public spending on health care, primarily for Medicare and Medicaid, accounts for approximately 46 percent of total health spending. Therefore, the federal government must play a critical role in health care reform. The federal government should, among other things, maintain the ERISA framework to enable the continuation of the employer-based system and not erode the employer-based system by capping the employer exclusion of healthcare expenses; eliminate cost shifting from public programs to private payers; restructure public programs to move away from traditional fee-for-service reimbursement that pays providers based on volume of service toward value-based purchasing; stimulate the growth and availability of comprehensive primary care; pay providers to reward prevention and the delivery of evidence-based medicine; facilitate and promote prevention and wellness programs in the public and private sector; and; adopt uniform interoperability standards for health IT.
- **Individuals**. The Congressional Budget Office estimates that 13 percent of the nonelderly accounts for 68 percent of health care costs. We will not realize higher quality and lower costs within our health care system without individuals being more responsible for managing their health. Individuals should:
 - maintain health insurance coverage through a private plan or a public program if eligible;
 - take greater accountability for their health care by living healthier lifestyles and participating in available prevention and wellness programs in order to receive public and private subsidies for health care; and
 - take steps to manage chronic conditions to avoid acute illnesses where possible.
- **Health care providers**. Most health care in the United States is paid on a fee-for-service basis, which encourages providers to deliver a higher volume and intensity of services instead of providing the most effective treatments as efficiently as possible. Health providers should:
 - publicly report on quality and cost measures using uniform standards adopted by the federal government;
 - treat patients based on evidence-based medicine in accordance with uniform standards and the specific circumstances and needs of each individual patient;
 - transition away from fee-for-service reimbursement and embrace new reimbursement models that require accountability and reward superior quality and efficiency; and
 - focus on improving individual and population health and the delivery of high quality, cost-effective, evidence-based care.
- **Insurance carriers**. Health insurers play an important role by covering people in fully insured arrangements or as third-party administrators for self-insured plans. Insurers are in a position to change misaligned incentives, disseminate quality and cost information,

and give individuals access to the most cost-efficient benefit plans via individual and group coverage solutions. Insurers should:

- cover all individuals seeking coverage on a guarantee-issue or modified guarantee-issue basis without regard to preexisting condition or risks;
 - shift away from fee-for-service reimbursement to pay providers to encourage quality and efficiency; and
 - report cost and quality measures for health care providers using national standards.
- **Employers.** Nearly 160 million Americans under age 65 receive coverage through an employer-based plan. While employer-sponsored coverage, especially coverage offered by large employers, provides some advantages over individual health insurance – including relatively lower premiums, more stable premium increases, and guaranteed access to coverage for eligible beneficiaries – there are steps that employers can take to improve our health care system. Under our plan, employers should:
 - design and offer benefit plans that encourage individual and population health by creating incentives to encourage individuals to establish continuous care in primary care practices, seek timely preventive care, participate in health assessments, and participate in prevention and wellness programs; and
 - push for benefit plans that reward providers for delivering high quality and cost-effective care.

Employer Play-or-Pay Mandate

We strongly believe in the voluntary nature of the employment-based health care system. Only when all other reforms discussed in HR Policy’s reform position have been undertaken should Congress consider the possibility of implementing some form of a **federal** play-or-pay mandate for certain employers to contribute to the cost of providing coverage for certain full-time workers. The mandate to contribute a specified minimum amount toward the cost of coverage should apply only for W-2 employees who work more than 30 hours per week. Under no circumstances would it be acceptable to pursue a state-by-state or local play-or-pay mandate scheme. Moreover, any employer mandate should not discourage employers from designing and offering cost-effective health benefit plans. For example, an approach that requires employers to spend a minimum percentage of payroll on health care benefits could cause many employers to abandon efforts to contain costs.

Even under a uniform federal standard, there are instances in which unintended consequences might occur if employers were required to provide coverage. For example, companies that employ large numbers of low-wage, part-time, and seasonal workers may find it economically burdensome if subjected to an employer play-or-pay mandate. As such, Congress may carefully weigh all factors when considering proposals that include a play-or-pay mandate.

In reviewing those recommendations, we cannot stress too strongly that we see the interplay of all elements of the package necessary for reform. We do not intend for this reform position to be a menu for policy makers and other stakeholders to select the items they find most appealing. Highlighting individual elements without reference to the entire position would result in a misunderstanding of the systemic nature of the problems we are facing.

Mr. Chairman, we believe the crisis in American health care is too complex for any one person, one organization, or one sector of our society to figure out the best option for reform. Our ideas are offered in the spirit of stimulating a discussion with Congress, the administration, and other stakeholder groups to figure out the best solution. I hope the IBM experience I have discussed here today, and our ideas for reform, will be helpful to you and the Committee as you take on this most important task.

Thank you.

IBMs Employee-centered Healthcare Innovations

2004

- **IBM defines contribution for healthcare (50/50 share of trend)**
- **Employee-centric subsidy allocation strategy**
- **“Free” PPO & Buy-Up options**
- **Focus on prevention: no deductible, disease management, healthy living rebates : smoking cessation, physical activity**
- **Move toward strategic plan mix: eliminate Indemnity Plan, opt out credit**
- **Employee-focused subsidization**

2005

- **Improve purchasing efficiency via best in market vendor strategy**
- **Reach strategic plan mix (all PPO based)**
- **Introduce Health Savings Account**
- **Enhanced web-based total health management portal with quality, plan/provider and self-managed tools**

2006

- **Offer 100% coverage for prevention benefits (no co-pay)**
- **Primary Care: deductible-free**
- **Introduce new Healthy Living Rebate driving preventive care**
- **Update dollar features of plans (Deductibles, Out-of-Pocket Maximums, etc.) in keeping with cost inflation**

2007

- **Care coordination program to assist with rapid, effective services access**
- **Behavioral health care advocacy program**
- **Expanded Healthy Living Rebate program**
- **Maintain full coverage for routine preventive services**
- **Patient-centered primary care pilot in Mid-Hudson Valley NY**

2008

- **Children's Health Rebate, helping parents & families with healthy nutrition, meals, physical activity for healthy weight**
- **Women's and Men's Health resources optimizer tool added to Preventive Care Rebate Program**
- **Primary care: reduced coinsurance employee pays for primary care**
- **Expanded flu shot coverage**

2009

- **Patient-centered primary care (medical home) pilots in Arizona, Vermont**
- **Generic drug Incentive Program**
- **Generics Advantage program drives efficient use of generic pharmaceuticals**
- **Program introduced to optimize safe usage of specialty medications**