Committee On Finance
Max Baucus, Ranking Member

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For Immediate Release Contact: Diana Birkett/Wendy Carey
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Baucus Highlights Need for Health Care Reform

Senator Delivers Speech Discussing Major Health Care Proposals, Participates in Live Televised Summit

(WASHINGTON, D.C.) Today, U.S. Senator Max Baucus delivered a speech to the Society of Thoracic Surgeons and will be participating in a Health Care Summit with CEOs and other policymakers to discuss the rising cost of health care.

In his keynote address to the Society of Thoracic Surgeons, U.S. Senator Max Baucus laid out some health proposals to respond to Hurricane Katrina and ways to cut down on the cost of healthcare. The same principles will be discussed at the Health Care Summit hosted by CNBC. The event and will air from 2-3 p.m., with no commercial breaks, on CNBC and its partner stations.

As ranking member of the Finance Committee, Senator Baucus has been an outspoken leader on the need to invest on health information technology and reward Medicare providers based on the quality of service. This past summer, Baucus help introduce two measures to support the nationwide adoption of health information technology and base Medicare payments on quality.

Senator Baucus also expressed concern with effect of rising health care costs on America's businesses to stay competitive in a global economy. U.S. businesses are often at a disadvantage with global competitors because of high health care costs for their employees. Baucus says keeping the cost of health care down is key to keeping America's edge in today's world economy.

A copy of the speech to the Society of Thoracic Surgeon follows:

Speech of U.S. Senator Max Baucus

Keynote Address to the Society of Thoracic Surgeons

When I first planned to speak to this gathering, it was to discuss health care costs, quality, and pay-for performance. I still intend to do that. But before I do, let me say a few words about Congress' response to Hurricane Katrina.

We have all seen the pictures of Katrina's wrath. They are unprecedented, shocking, and shameful. We must learn from what went wrong in response to this tragedy. That will take some time.

But in the meantime, we must also agree to do what's right. And that means providing Katrina victims the means and support necessary to get their lives back together.

As soon as Congress returned last week, I worked with my colleagues on both sides of the aisle on a package of provisions to bring health care to the survivors of this crisis and support to the generous doctors, nurses, and hospitals that are caring for them. I want to move this legislation through Congress as soon as possible.

In developing this package, a couple of things became abundantly clear. First, while America is the richest country in the world, many among us have very little. Millions of Americans live in poverty, without access to health care or resources, food, or even shelter. Last year, the percentage of Americans living in poverty increased to almost 13 percent. Poverty has increased for 4 years in a row.

Second, fragmentation prevents us from getting the biggest bang for our health-care dollar. Looking for ways to provide Katrina victims with health coverage, some suggested Medicaid, others Medicare. Some said vouchers to purchase private insurance, while others said we should give tax credits to help employers provide coverage. Still others underscore the need for system of national health insurance.

We ultimately settled on Medicaid as the means to cover Katrina victims, and Chairman Grassley and I are working to find agreement on a package we can move through Congress. Medicaid exists in all 50 states and here in DC. It covers Americans of all ages, with a wide range of health-care needs. And it has been used as an emergency means of care in the wake of a national tragedy, such as the one that occurred four years ago Sunday.

But regardless of whether you favor Medicare, Medicaid or vouchers to provide health care, I think we can all agree on one thing: America's health care system is terribly fragmented. We have different insurers, different insurance forms, and different access. Depending on who your insurer is, access to care can vary a great deal. And if you're not covered at all – as is the case with over 45 million Americans – you're in even worse shape.

Even though 15 percent of our population lacks health insurance, we still spend $2 trillion on health care in this country. That's over $5,000 for every man, woman in child in the U.S. – 53 percent more than Switzerland, the next most costly country. And yet our health outcomes are typically worse. The average American woman can expect to live to age 79. The average

Japanese woman can expect to live 5 years longer, to age 84. People can expect to live longer in Canada, France, Germany, Sweden, Switzerland, and Britain. And all of those countries spend less per person on health than we do.

So what can we do about this? How can we ensure that America's massive $2 trillion health-care bill buys more? How can we achieve the paradoxical goals of cutting costs and improving Americans' health?

The answer is simple: take a few cues from the Society of Thoracic Surgeons. In the 15 years you have been reporting data on quality of care and patient outcomes, you have reduced your patients' mortality by 70 percent. Congratulations on these results! To follow your lead, we need to take advantage of health information technology throughout the health care system, and tie payment to the quality and value of care provided.

America often leads in the invention and adoption of medical technology. We are pioneers in the areas of drugs and devices, pills and procedures, science and surgeries.

But we have not complemented this innovation with the proper use of health information technology. The staggering cost of administering America's pen-and-paper system of health care claims proves the point.

Thirty to forty percent of American health care transactions still rely on paper claims, according to health economist Ken Thorpe of Emory University. These claims can cost from $5 to $20 each.

But administering health care claims electronically can cut those costs to as little as 50 cents each. Thorpe estimates that requiring automated claims processing would save the Federal Government nearly $80 billion over 10 years. Significant savings would also accrue to the private sector, if it fully automated claims. And proper use of health IT can prevent unnecessary medical errors, hospitalizations, and other health care services.

Each year, about 7,000 Americans die because of errors administering their medications. But technology can help ensure that medical professionals give the right drug to the right patient at the right time. We can help to do that by putting barcodes on all drugs. And we can help to do that by using health IT to link medication administration to a patient's clinical information.

The inability to exchange clinical data among providers often causes duplication of diagnostic tests. We can help by making it easier for one doctor to pull up the X-ray that another doctor took just the week before.

Why is America falling behind in health IT? Part of the reason is a lack of investment. The health care industry invests only about 2 percent of its revenues in IT. Other information-intensive industries invest 10 percent.

As a result, only about one in five physicians use health IT in their offices. Among small practices, representing nearly 80 percent of all physicians in the US, the frequency is more like one in twenty. In Britain, nearly all general practitioners — 98 percent — have a computer somewhere in their office.

We have to help ensure that health IT systems can communicate with one another. We need an agreed-upon set of standards so that health IT systems can work together. Otherwise, we will continue to have a tower of Babel, preventing communication of critical health information.

We also need to make a significant financial commitment to health IT. And that doesn't just mean the government. It means health plans, hospitals, physicians, and employers. One of the latest studies on the cost of implementing a national health information network shows that it will take a capital investment of $156 billion and $48 billion in annual operating costs to get that system up and running. The government cannot foot that bill on its own.

This year, I worked with my colleagues on the Finance and HELP Committees to introduce the Better Healthcare Through Information Technology Act. This bill will facilitate nationwide adoption of health IT systems. And it will help those systems to talk to one another. It will set up loans and grants to encourage the use of more health IT.

This bill will move us in the right direction, creating system-wide efficiencies, improving quality, and reducing cost. But it will also let us take the next step – building a case for quality directly into the way we pay for health care.

Medicare is the dominant payer in American health care. But today, Medicare is at best neutral, and at worst negative, toward quality. Medicare pays for the delivery of a service, not for the achievement of health.

And we see the effects. Patients receive recommended treatments only about half the time. And more care is often not producing better care.

Among the 50 states, levels of cost and quality vary greatly. In my home state of Montana, for example, Medicare spends about $5,000 a year per beneficiary. Quality of care ranks near the top. By contrast, some states spending around $7,000 a year per beneficiary have quality that ranks near the bottom.

I have introduced a bill with my colleagues Senators Grassley, Enzi, and Kennedy that will build value into the way that Medicare pays for services. The Medicare Value Purchasing Act of 2005 will begin paying for value in the health care system – good care, better outcomes, evidence-based medicine, and increased transparency. I deeply appreciate the Society's contributions toward our legislation.

We hope that taking a step forward in Medicare will drive the entire health system toward a system of high-quality health care. But Congress should not determine how quality of care is

measured. You know more than I do about the procedures you perform. And you should be involved in the process. That is why my bill sets up a system of stakeholder involvement at every step – in choosing measures for each provider group, in setting up a data collection system, and in updating measures as science changes. Providers, payers, patients, and many other groups are the experts who should be involved in the details of a health care quality system – not Congress.

Our bill sets up a two-phase approach to quality improvement. First, providers would continue to get their full annual reimbursement update only if they report data on quality to CMS. Later, providers who demonstrate high-quality care, or who show that they are improving, would get a higher payment rate based on quality.

I know that cardiothoracic surgeons may feel the first step – paying for reporting – is a step in the wrong direction. You already report data on a number of measures to a national database. As I have said, you are ahead of the game.

We set out to design a system that would reward quality and had the potential to "lift all boats." Because this system rewards quality, you will benefit from being ahead of the pack. But we must ensure that other specialties can move in the same direction. We have to get the ball rolling.

I also know that many physicians are concerned that our bill does not fix the existing problems with the physician payment system. Ongoing significant cuts to the physician fee schedule – which will take effect if current law is not changed – are unsustainable.

I want to work with you to find a sustainable solution to the problems with the fee schedule. In turn, I ask that you continue to work with me to move Medicare in the right direction. Ultimately, better quality and value means better health care, better coverage, and a stronger system for all.

Together, these two bills stand to improve American health care and reduce unnecessary health costs. But for these bills to help, Congress must act. And I hope we can do so this year.

In the short-term, action must help the victims of the Katrina tragedy. I have outlined a package of proposals to do that: temporary coverage under Medicaid; relief for states treating evacuees; and help to providers incurring the costs of uncompensated care. I applaud the efforts of America's health professionals, including some of your colleagues, to help Katrina victims. And I hope Congress can provide quick assistance in turn.

In the long-term, we must continue to advance the twin goals of rewarding high-quality care and making the most of health IT.

In a recent editorial for the Journal of the American Medical Association, Andrew Grove, the former chairman of the board of Intel Corporation, discussed the importance of bringing

efficiency to American health care. He noted that the health care industry represents 15 percent of the United States' GDP. And he argued that there is ample opportunity to improve health care's efficiency, through the use of appropriate technology.

We have no more excuses. Whether the issues are microchips, automobiles, health care, or disaster response, our country has a mandate to push the envelope, to take care of its people, to act decisively in the face of challenge. Dr. Grove leaves us with a challenge that I would like to share with you today. He asks, "If not here, where? If not now, when?"

I would like to tell Dr. Grove that we are ready. If we begin investing in health IT and start paying for health care quality, we can make the most of our limited resources. We can improve accountability in our health-care system. And we can improve America's health in the process.

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