

To Your Health!

Aetna's Proposal for Health Care System Transformation

Introduction

The U.S. health care system remains the world's pioneer in research and medical technology, leading treatment breakthroughs that benefit Americans and people across the globe. The presence of first-rate physicians, hospitals, drugs and treatments are due, in large measure, to the competition inherent in our market-based system. While an impressive 85 percent of people in America — over 250 million people — have some form of health insurance, there are also real and severe deficiencies within the U.S. health care system:

The crisis of the uninsured: There are now nearly 46 million uninsured in the United States, which represents a staggering one in six adults under the age of 65. Over 8 million of these uninsured are children. The uninsured come from a variety of ages, household incomes and work statuses — but they share a common plight. A robust body of research concludes that the uninsured obtain less care, receive fewer preventive services and fail to adhere to recommended treatments. Additionally, tens of billions of dollars are spent each year treating those without health insurance, often in expensive emergency room settings for illnesses or chronic conditions that could have been prevented or treated earlier had they been part of a course of care associated with having health insurance.

Escalating health care costs and affordability problems: There are many reasons why people are uninsured, but rising health care costs and their attendant effects on affordability of coverage are widely viewed as the fundamental problems. Indeed, the price the nation pays for these problems comes in the form of 46 million uninsured. Health care is expensive — and costs continue to rise at a rapid pace, which is reflected in the form of higher premiums for health insurance. Premium increases are driven primarily by three factors: general inflation, health care price increases in excess of inflation (for example, cost shifting and higher priced technologies) and increased utilization (for example, aging population, lifestyle changes and new treatments).¹ These rising premiums, in turn, have made it increasingly difficult for employers to offer coverage to their workers. Today, approximately 60 percent of firms offer health benefits — down from 69 percent as recently as 2000 — which is of concern given the vital role employers play in the health care system. Rising premiums also have made it increasingly difficult for people to purchase coverage. With the average premium for employer-sponsored family coverage now exceeding \$12,000, participating in the health insurance marketplace is a financial strain for a growing number of Americans.² At the national level, health care now represents more than 16 percent of the gross domestic product, and the traditional funding sources and mechanisms used to support health care cannot keep pace with costs accelerating at approximately twice the rate of inflation.

Pervasive quality problems: Quality problems in the U.S. health care system came into focus in the late 1990s when the Institute of Medicine documented persistent, systemic shortcomings in quality, including preventable medical errors and widespread overuse, underuse and misuse. Huge gaps exist between the levels of care delivered by health care organizations in different regions and settings. These quality gaps result in 35,000 to 75,000 avoidable deaths each year and between \$2.7 billion and \$3.7 billion in avoidable medical costs.³ Numerous studies have found that, overall, American adults receive only about half of recommended care.⁴

What Aetna believes

As one of the oldest and largest insurers in America, we believe Aetna has both an opportunity and an obligation to be a key part of the solution. Our commitment to advancing public good is ingrained in the company's 155-year heritage and is reflected in Aetna's core values of integrity, quality service and value, excellence and accountability, and employee engagement. We believe that being a leader in health care means not only meeting business expectations, but also exercising ethical business principles and social responsibility in everything we do. We also believe that our considerable intellectual resources and experience can be leveraged to build a stronger and more effective health care system — a stance that is embodied by Aetna's leadership on a variety of public policy issues, including racial and ethnic disparities, genetic testing, price transparency and health and benefits literacy.

Aetna has been active in both developing and supporting proposals for change. For example, the company played an integral role in creating the comprehensive health care access proposal put forward by America's Health Insurance Plans (AHIP) in November 2006. Titled *A Vision for Reform*, the AHIP proposal articulates a set of policy recommendations aimed at achieving near-universal coverage for all children within three years and adults within ten years. In addition to endorsing this comprehensive access proposal, Aetna was the first national health insurer to publicly announce its support of President Bush's Executive Order on health care transparency and was one of the first Fortune 100 employers to sign the Statement of Support for the Four Cornerstones of Value-Driven Health Care.

Aetna's proposal for health care system transformation

Described in the following pages is Aetna's proposal to transform the U.S. health care system. It is intended to serve as a framework for sensible policy action, and reflects Aetna's commitment to being part of the solution and our willingness to serve as a resource in the health care discourse.

When considering this proposal, it is important to recognize the considerable interplay between various policy interventions. Aetna believes that health care reform should identify and take advantage of companion solutions. Companion solutions refer to the pairing of complementary public policies. When implemented together, companion solutions result in an outcome that greatly exceeds the impact of any isolated reform component. A good example of a companion solution is the pairing of an individual coverage requirement with both strong enforcement mechanisms and broadly funded subsidies to increase the affordability of coverage for lower-income Americans. Another is coupling reasonable public program expansion with efforts to enroll individuals who are currently eligible but not participating in these programs, as well as implementing targeted tax credits for low- to moderate-income households, which controls against the risk of crowd-out (that is, individuals who would have purchased private coverage choosing to utilize public coverage instead).

Get and keep everyone covered

Point 1: Transform health insurance into a civic responsibility

- Require all Americans to possess health insurance coverage — an individual coverage requirement — as a common-sense approach for achieving universal coverage through universal participation.
- Pair an individual coverage requirement with government assistance for low-income Americans who are ineligible for public programs to enter the health insurance marketplace.
- Create or improve broadly funded safety net programs, such as reinsurance mechanisms or state high-risk pools, to ensure that the most vulnerable Americans have health insurance. Public-private collaboration is critical to the success of these safety nets.

Point 2: Strengthen public programs and the safety net for those most in need

- Strengthen public programs to ensure certain populations have access to quality health care. The federal government should expand SCHIP funding to ensure all states can, at a minimum, fully cover children from low-income households. Medicaid eligibility should be expanded to cover all adults up to 100 percent of the Federal Poverty Level, including single adults. Public programs should not, however, displace those who would otherwise participate in the private health insurance marketplace.
- Health insurers, the federal and state governments, and employers should come together to explore new ways of working together to ensure no American lacks affordable health insurance options.

Maintain the employer-based system and export its strengths to make the individual market function better

Point 3: Leverage the strengths of the current health care system, which already covers 85 percent of the U.S. population, to advance the goal of achieving universal coverage

- Encourage public-private coordination and collaboration. It is imperative that government and the private sector work together to expand access, increase affordability and improve quality. A competitive marketplace and a strong public health system are not mutually exclusive.
- Continue to support the existing employer-based system, which is responsible for covering over 60 percent of the non-elderly population in the United States (177 million people). At the same time, support policies that promote affordable health insurance options for individuals and small employers not participating in the employer-based system.

Point 4: Use the tax system to expand access and increase affordability

- Equalize the tax treatment of health insurance for those who obtain coverage through their employer and those who purchase it directly in the individual market by extending favorable tax treatment to both sets of individuals, without changing the favorable tax treatment employers currently receive for offering benefits.
- Create tax-based incentives for employers — especially small firms — to offer or continue offering health benefits to their employees in order to preserve and strengthen the employer-based system. Employers should be encouraged to offer, at a minimum, Section 125 cafeteria plans.
- Use tax credits as a tool to encourage and enable target populations (e.g., lower-income adults and children) to enter the health insurance marketplace. Tax credits should be administered on a sliding scale according to income and should be broadly financed.

Point 5: Promote greater portability of health insurance

- Facilitate the growth of consumer-directed health plans with health savings accounts, which allow people to save for future medical needs by investing in tax favored accounts that are portable. Consumer-directed health plans should include first-dollar coverage for the most common chronic conditions to ensure people benefit from disease management and care coordination.
- Permit the purchase of health insurance across state borders (that is, rather than having to purchase in one's home state) so consumers can use phone, mail and internet facilities to purchase coverage in states with legislative and regulatory environments that facilitate the existence of affordable health insurance options.
- Explore new mechanisms for portability, such as developing new pooling arrangements, reforming COBRA and creating new products designed for people in transition.

Reorient the system toward prevention, value and quality of care

Point 6: Promote preventive care and wellness

- Create incentives for individuals to achieve optimal health status by making healthy choices, participating in wellness, chronic care and disease management programs and obtaining routine preventive care.
- Preventive care should receive first-dollar coverage and public and private health insurers should promote wellness vigorously in member and provider services. All Americans should have access to wellness tools, such as health risk assessments, weight management and smoking cessation programs.
- Achieve greater integration among medical, behavioral and dental health services to facilitate total wellness and improve patient outcomes.

Point 7: Improve health care quality and patient safety

- Support rigorous analysis and research about clinical best practices, including analysis of cost-effectiveness data to determine which medical technologies, protocols and drugs are most effective.
- Reward health care providers who efficiently deliver evidence-based care through pay-for-performance (P4P) programs. Quality measures employed in P4P programs should be clinically important, credible to physicians, transparent to all stakeholders, consistent across health plans and other payers, understandable to consumers and useful to them in making choices. P4P programs should also equip providers with the information and tools necessary for improving practice outcomes and efficiencies.
- Transform the medical liability system into one that focuses on the fair and timely resolution of medical disputes and promotes health care quality improvements. The medical liability system should encourage — not discourage — physicians to discuss and learn from mistakes and preventable errors. Patients experiencing medical injuries should be fairly compensated through an administrative system that draws upon independent medical expertise in the decision-making process.
- Invest in initiatives to reduce racial and ethnic disparities in health care, including the analysis of treatment and outcomes data to ensure sustained progress in eliminating disparities.
- Create public-private partnerships to ensure the availability of end-of-life care products that empower people facing end-of-life care decisions by offering access to curative care whether in a hospital, hospice or home.

Use market incentives to improve coverage, drive down costs and make the system more consumer-oriented

Point 8: Create a legislative and regulatory environment conducive to the development and availability of affordable insurance options

- Create new pooling mechanisms that facilitate affordable access to health insurance for individuals and small employers.
- Permit private health insurers to use transparent and fairly devised medical underwriting techniques, while preserving a strong safety net for all Americans.
- Improve the affordability of prescription drugs by removing barriers to generic competition and creating a regulatory pathway for generic biopharmaceutical medicines.
- Promote the development and availability of mandate-lite and mandate-free products. Control the proliferation of costly benefit mandates by establishing independent review commissions.
- Encourage uniformity of state laws and regulations. Explore the development of an optional federal charter.

Point 9: Make the health care system more transparent and consumer-friendly

- Provide consumers with meaningful information to allow them to make value-based health care decisions. Advance transparency in health care quality and pricing, giving consumers easy access to health care information, including cost and price information, and the ability to seek out hospitals and other health care providers that have a proven track record of high-quality care. Investments in transparency should be accompanied by rewards and other incentives for providers that efficiently deliver evidence-based care.
- Invest in efforts to improve health and benefits literacy, especially for the nearly half of adults in the nation who have difficulty locating, matching and integrating written information. Government and industry should partner with providers to improve health literacy and ensure that health information is easy to understand.

Point 10: Harness the power of health information technology to reduce costs and improve quality

- Advance public-private partnerships to develop and implement health information technology (HIT), including personal health records and the development of an interoperable health record system that allows for the seamless and secure transmission of health information.
- Create incentives for consumers, providers, employers and payers to adopt health information technology — accelerating the goal of replacing the outdated and costly paper-based medical records and billing systems.

¹Price Waterhouse Coopers, "The Factors Fueling Rising Healthcare Costs 2006," Prepared for America's Health Insurance Plans, January 2006.

²Of this total premium cost, workers pay an average \$3,281 from their paychecks, with employers covering the remaining premium costs. Gary Claxton, Samantha Hawkins, Jeremy Pickreign, et al. "Employer Health Benefits: 2007 Annual Survey," Kaiser Family Foundation and Health Research and Education Trust, September 2007. Accessed online: www.kff.org/insurance/7672/upload/76723.pdf.

³National Committee on Quality Assurance, "The State of Health Care Quality 2007." Accessed online: www.ncqa.org/Portals/0/Publications/Resource%20Library/SOHC/SOHC_07.pdf.

⁴Rand Health, "The First National Report Card on Quality of Health Care in America," *Research Highlights*, 2006. Accessed online: www.rand.org/pubs/research_briefs/2006/RAND_RB9053-2.pdf.

