ITUP's Summary of Key Steps on the Road Toward Universal Health Care

By Lucien Wulsin,
Adam Dougherty and
Michael Sloyan
Insure the Uninsured Project
(www.itup.org)

July 6, 2009

Insure the Uninsured Project (ITUP) prepared three reports on topics relevant to future California health reforms efforts.[1]

1) Health Information Technology-Electronic Health Records
2) Health Technology Assessment
3) The Individual Mandate

This summary presents ITUP's views on these issues in the context of potential major health reform at the state or national level. This report and the views expressed herein are those of ITUP alone.

The context for comprehensive reform

The United States is the only industrialized nation without universal health coverage, and fundamental reform is agreed by many to be long overdue; there remain deep disagreements on how, what and how fast to reform. Comprehensive health reform in the United States may be moving closer to reality due to growing public desire and increasing political will. To achieve universal coverage, health reform will need to include the right combination of increased coverage and more effective cost containment.[2]

Today over 46 million Americans are uninsured and that number is growing due to rising unemployment, stagnating employer based coverage, and the ongoing rise in health care costs that outpaces wage growth.[3] The current rate of growth in health care expenditure is widely agreed to be unsustainable both with respect to public revenues and to the capacity of many of the employers and employees that pay for health coverage. The explosion of new health care technology and the anticipated increase in Medicare beneficiaries due to the aging of the baby boomers are expected to place severe pressures on the federal budget over the coming decades.[4]

Corresponding improvements in American's health would surely justify this expenditure, but this is not the case; the United States spends nearly double the Organization for Economic Cooperation and Development (OECD) average on health care spending per capita yet our country consistently ranks lower in numerous health outcomes compared to other OECD countries.[5] Health reform must improve the value (health outcomes) for the public investments we make as a nation. Improvements include upgrading the efficiency of information systems which are still primarily paper-based, finding what health procedures work best and at what cost, integrating health systems, and fostering prevention and chronic disease management. As part of reform, the health sector may be tasked simultaneously to improve the value of health care, to expand coverage, to reduce costs, to achieve better health outcomes, and to more effectively spread risk.

The possibilities for comprehensive reform

In 2007-08, California sought to pass and finance a comprehensive reform with the support and leadership of the state's Republican Governor and Democratic Assembly Speaker. The legislation (AB X 11 Nunez) included proposals to improve coverage for California's then 6.5 million uninsured and improve quality and reduce costs for the 30 million Californians with public and private health coverage. These efforts were defeated with bi-partisan opposition by the members of the Senate Health Committee who expressed concerns whether costs would be adequately controlled such that the coverage expansion could be sustained over time. Since then, the state has been mired in a series of very large budget deficits due to the long and deep recession; the sharp decline in state revenues has elicited proposals from the Governor to roll back eligibility for public health coverage for young children and working families.

Beginning in 2009, the Obama administration and Congress have engaged in federal efforts to cover the uninsured, improve quality and reduce costs for America's publicly and privately insured. Congress has already passed and the President signed a very substantial increase in funding for uninsured children, an increase in federal match for hard pressed state Medicaid programs and important components of the infrastructure for federal health reform, including funding for Health Information Technology, comparative clinical effectiveness and budget allocations for the federal reform efforts. Overall federal reform details are still being negotiated and fleshed out in the House and Senate, but the starting points are similar in concept to the California proposals.

This spring Congress passed legislation to improve assessments of the effectiveness of new technologies and to increase the adoption of health information technology. Implementation will take some time, but will have marked impacts in California.

In both the House and Senate, committees are discussing, framing and debating comprehensive reforms, which may include an individual mandate and the accompanying subsidies to make coverage affordable and the underwriting reforms to make individual and group coverage available to all regardless of medical condition.[6]

As of the writing of this document, an individual mandate with accompanying reforms is included in the three-committee House version as well as in the outlines of the packages being developed in the Senate Finance Committee and the Senate Health, Education, Labor and Pensions (HELP) Committee.[7] The bills differ somewhat as to the income levels at which premiums are subsidized, and the details and control of the Health Insurance Exchanges. More assistance to foster the wider spread and faster adoption of Health Information Technology is in the Senate Finance Committee version. Increased support and governance for a Center for Comparative Effectiveness Research is in the three-committee House version.

Considering the U.S. economy is experiencing the worst recession since World War II, federal lawmakers maintain that health reform is paramount to the economic recovery effort. President Barack Obama's message is clear: health reform is an essential element to economic recovery.

In a June 15, 2009 speech at the Annual Conference of the American Medical Association (AMA), the President outlined systematic problems in the health care system and the elements of policy that would need to be changed for effective health reform.[8] Not surprisingly, Health Information Technology, Health Technology Assessment, and the individual mandate were addressed among other components of proposed federal legislation. On Health Information Technology and Electronic Medical Records, President Obama commented that the U.S. does a better job tracking FedEx packages than tracking health records. On Health Technology Assessment, he emphasized the fact that less than one penny of every health dollar spent goes to examining what treatments are most effective. On the individual mandate, the President indicated a preference for

promoting individual responsibility and using incentives to increase coverage without a mandate—at least for adults.

In a June 3, 2009 letter to U.S. Senators Ted Kennedy and Max Baucus, President Obama indicated his full commitment to passage of a comprehensive reform to replace our unsustainable system and the need to pair coverage expansion with reductions in growing public and private health expenditures.[9] That letter reflects the severity of the growing cost problem and the absolute necessity to reform the payment system as part of the immediate economic recovery effort and as part of a long-term effort to stem the rise in health costs contribution to the spiraling federal budget deficit. In his June 13, 2009 radio address to the nation, the President put forward an additional $300 billion in Medicare and Medicaid savings over the next ten years, including reductions in hospital, drug and physician payments.[10]

Improving the value of health care, assessing the clinical effectiveness of technologies

Up to half of the increase in health care spending has been attributed to the ever-increasing development, use, and pricing of new medical technologies.[11] New clinical products and services are being introduced and heavily marketed to patients and doctors at an increasing rate. It is becoming ever more difficult for patients, providers and payers to navigate competing claims of breakthrough treatments and new medical successes. Though the United States is a recognized leader in biotechnology and medical research, these advances have not translated into better health outcomes for our citizens as compared to other nations.[12] There is mounting demand for better information to improve health care decision making, to maximize effective practice of medicine, to improve health outcomes and to improve the value of health care expenditures. Health "value" can be increased through better information on the clinical effectiveness of new and existing medical technologies.

In general, health technology assessment (HTA) is the evaluation of the properties and impacts of medical technology, which in this sense is a broad term including devices, pharmaceuticals, procedures, therapies, and systems.[13] HTA tools, such as comparative clinical effectiveness, provide stakeholders with reliable clinical information in order to make knowledgeable and evidence-based decisions. HTA is an informational tool that can organize and stratify new and old technologies at specific stages of diffusion: future, experimental, investigational, established and obsolete, and that can compile information on safety, quality and clinical efficacy. If applied well, the effectiveness comparisons can limit the use of unnecessary, excessively expensive, or outdated procedures while improving health outcomes. This is not a straightforward formula, as hard evidence can be costly to develop, the results may be inconsistent, the conclusions of cost effectiveness studies can be disputed, and the effectiveness of new technologies can improve over time.[14]

Clinical effectiveness compares the patient outcomes of one treatment to an alternative irrespective of cost, whereas cost effectiveness compares a therapy's cost using outcome measures such as quality-adjusted life years (QALYs) per $1000.[15] Subjective responses to concepts such as cost-effectiveness and the expected responses of those technologies found by researchers to be less effective than their competitors can politicize and derail progress. Many experts who recognize the importance of comparative cost analyses argue that clinical effectiveness measurements should be separated from cost comparisons.[16]

A Lewin study projects savings from a National Center for Medical Effectiveness of $368 billion over 10 years.[17] The extent of realized savings depends quite specifically on what payers and providers do with the new information. In other words, do doctors change their prescribing and treatment practices; do payers such as Medicare, Medi-Cal and private insurance change their reimbursement methodologies? Information without application will save very little.

Some argue that a National Center for Medical Effectiveness could improve practice standards, and identify high performing new technologies. Implementation costs are modest and depend on questions such as structure and funding; for example, would the Center do in-house research or act more as a clearinghouse as reviews of existing evidence, where generating new research could be left to outside organizations.[18] A noteworthy example of innovative financing is the CMS Coverage with Evidence Development (CED) program that imposes a data collection requirement on biotechnology companies to pay for an independent technology assessment of the effectiveness of the new technology being developed and deployed.[19]

A further issue is how the Center is governed and funded as several prior efforts have run afoul of strong industry and subsequent Congressional reaction to the scientific validity of their findings. For this to work, many believe that the agency must maintain accountability, be transparent, and be far enough removed from politics and special interests.[20]

Payers could potentially use the Center's information to negotiate prices or to set copayment differentials rather than apply blanket coverage exclusions. States may find it advantageous to apply clinical technology assessment to publicly funded programs to stem spending growth in the context of restricted state budgets. It will be important to maximize public awareness, assure stakeholder input, and utilize international collaboration and global networks to execute HTA research more efficiently.[21]

Recently, the American Recovery and Reinvestment Act (ARRA, H.R. 1) includes $1.1 billion for comparative effectiveness research to be administered by Agency for Healthcare Research and Quality (AHRQ), National Institute of Health (NIH), and the US Department of Health and Human Services (HHS).[22] The Act also establishes the Federal Coordinating Council for Comparative Effectiveness Research, which will advise efforts to reduce duplicative research and better coordinate resources. It does not provide an independent long-term home for the research center. Gail Wilensky

in a recent Health Affairs article expresses concern about the breakdown of heretofore apparent bi-partisan consensus on the need for public funding for this research; she proposes that the Center be an independent federal agency, partially funded by the public and private sectors and "close but not too close" to government.[23] House proposed legislation (HR 3162 of 1987) would have placed the Center within the Agency for Health Quality Research; while Senate proposed legislation (S 3408 of 2008) would have made the Center a new non-profit corporation outside of government. An interesting financing idea proposed by Senators Conrad and Baucus in S 3408 would fund the Center with contributions/assessments of $1 per covered life from public and private payers.

Health system modernization, the role of health information technology

Health information technology (HIT) and Electronic Health Records (EHR) are widely agreed to be necessary tools to improve the value and performance of our health care system.[24] It is argued that HIT-EHR will reduce costs, improve quality, and increase efficiency in health care. Investment in HIT has not been comparable to IT improvements in other industries, and rising administrative costs are contributors to the burgeoning national health expenditure. Reliable electronic transfer of patient information may allow for improved continuity of care, substantially decrease administrative costs, and reduce the need for repeated diagnostic tests.[25] Electronic decision support could also reduce medical errors and increase overall quality through better health care decision making. HIT-EHR has the potential to knit together the fragmented delivery system and deliver care and needed consultation through telemedicine in underserved and rural areas. System-wide savings have been estimated around $40 billion annually after wide scale implementation, with productivity improvements saving another $50 billion annually.[26] There is no assurance that cost savings will accrue to taxpayers or employers, and many predict they will be mostly realized by payors or be reinvested back into the system as improved quality or expanded public savings.[27]

Despite their potential to save money in the long run, HIT-EHR systems have substantial up front costs associated with the hardware, software, and training with a nationally projected price tag of $17.2 billion for physicians and $98 billion for hospitals to achieve 90% adoption over what time frame.[28] These implementation investments have stalled wide-scale adoption rates thus far, as have unresolved uncertainties about interoperability and patient privacy.[29] Moreover, the adoption of HIT inures its benefits broadly throughout the industry while the investment is provider specific, making integrated delivery systems such as Kaiser the prime prospects for early adoption while solo practitioners lag in adoption rates.[30]

National adoption rates in hospitals and physician practices are 9% and 17% respectively, with slightly higher rates found in California (primarily due to Kaiser's system-wide implementation), as compared to other countries with nearly 100% implementation.[31] There appears to be widespread agreement from opinion leaders as diverse as Newt Gingrich and Secretary of State Hilary Clinton, that there must be focused government involvement to foster adoption of HIT-EHR. Though adoption rates are increasing, it will be important to stimulate implementation in low-income

communities and underserved areas and among solo practitioners where providers may find adoption difficult because of cost.

Nearly half of all health care dollars are spent in public programs such as Medicare and Medicaid.[32] Since most preventable adverse drug interactions occur in the 65+ populations, Medicare has a particular interest in increasing adoption rates. This does not mean government would need to fully finance their electronic systems; proponents believe governments should reduce implementation costs through targeted financial incentives, information, guidance, and training. It will be important to establish national standards for interoperability and security of patient information between HIT-EHR systems in order for HIT-EHRs to gain broad and widespread acceptance. Microsoft and Google are currently pioneering new technology to build interoperable compatibility into patient-managed health records in a user-friendly way.[33]

HIT-EHR is not a panacea, but rather is a vehicle to improve health care if used effectively. Providers must be able to access clinical data reliably, and this necessitates a secure and interoperable pathway across systems. HIT by itself doesn't do anything, but it is the electronic process that enables change in business and practice models.[34]

As part of ARRA, the Health Information Technology for Economic and Clinical Health Act (HITECH) makes a significant investment for the wide scale adoption of electronic health records.[35] HITECH provides $17 billion for health information exchange infrastructure and physician adoption incentive payments, and provides $2 billion to the Office of the National Coordinator for HIT to establish physician and hospital technical support systems. Incentive payments through the federal government will be available up to $65,000 per physician and $11 million for hospitals that demonstrate "meaningful use" of a certified electronic system; payments are targeted to providers in the Medicare and Medicaid programs. Reductions in Medicare reimbursement rates for non-adopting providers will go into effect after 2015 as further incentives to speed adoption.

The Act also creates two new entities to guide development, the HIT Policy Committee and the HIT Standards Committee, and strengthens the Heath Insurance Portability and Accountability Act (HIPAA) privacy rules on the sales of patient information. It appears that these investments aim to swiftly increase adoption and implementation rates, while simultaneously creating standards for interoperability and security. Dr. David Blumenthal, the new National Coordinator for Health Information Technology, expects to issue guidance on what constitutes "meaningful use" by July 2009.[36]

The draft health reform proposals from the Senate Finance Committee, Senate Health, Education, Labor and Pensions Committee and the three-Committee House proposals contain additional proposals to assure interoperability, increase incentives for broader use of HIT and increase the exchange of administrative, billing and clinical data.[37]

Coverage for the uninsured, the role of the individual mandate

The health consequences of being uninsured contribute to rising expenditures and poor health outcomes: more advanced health problems, avoidable hospitalizations, lost productivity, and premature mortality due to lack of timely medical treatment.[38] In California, we have 6.5 million uninsured over the course of a year, a number that has now likely risen to 7 million.[39] In the United States, over 46 million are uninsured, and this number rises to one in three Americans who have a spell of uninsurance over the course of two years.[40]

The individual mandate and the single payor system have emerged as two policy options that would significantly reduce the number of uninsured in the United States. Individual mandates are in place in Massachusetts, Switzerland and The Netherlands, and the leading example of single payer systems is Canada. The individual mandate would require every citizen to obtain health insurance, be it through an employer or purchasing pool, in the individual market, or through public coverage. There are other forms of individual mandate, including an interesting proposal by Senators Wyden and Bennett[41] that would eliminate all forms of public coverage and private employer insurance and cover all citizens with individual private insurance and vouchers to assure affordability; that proposal was not examined. The individual mandate we examined preserves the nation's existing hybrid of public and private coverage

The individual mandate standing alone would not make coverage affordable or available for the uninsured. Most agree that there are certain essential components in order for an individual mandate to be successful: guaranteed issuance and renewal of coverage to assure availability, properly targeted subsidies to assure affordability, a new purchasing pool or insurance exchange to help assure availability and affordability, and a basic minimum level of covered benefits.

The minimum package would have to be affordable for most Americans and subsidized for lower income individuals. Although it has proven difficult to agree upon objective measures of affordability, subsidies will be needed for many of the uninsured with incomes less than 300% of FPL and for some older individuals and larger families with incomes up to 400% of the federal poverty level who often pay three times as much for coverage as younger persons and single individuals.[42] If subsidies are unable to make coverage affordable for individuals, there will have to be some hardship exemptions from the mandate.

Adverse selection between plans occurs when a health plan's design and/or marketing and underwriting policies attracts disproportionate enrollment of either high or low risk individuals; this disadvantages those plans and their contracted providers that do the best job of caring for very sick and costly individuals. A risk adjustment among plans must be included to correct for adverse selection and give all plans the proper incentives to improve their subscriber's health.

Enforcement measures could act as a mechanism to facilitate enrollment, including easy enrollment procedures, outreach, education, online enrollment options, and provider/employer involvement.[43] It may be advantageous for penalties to be small initially and flexibly applied as the new system's bugs are worked out. Most agree there will need to be some sanctions for those who refuse to purchase or enroll in coverage and then cannot pay for their treatments and shift the burdens of paying for their health care to the rest of the population.

The roles of the purchasing pool include: reliable information about the plans, assurance of fair competition, distribution of premium subsidies and improvements in short and long term affordability. Some suggest the purchasing pool/health insurance exchange would be the vehicle to offer managed competition incentives for subscribers to enroll in the most cost effective well-managed plans. Some suggest the pool could negotiate premiums with plans, while others prefer the plan not negotiate.[44] The public plan option, supported by some and opposed by others, could be offered through the pool. The exchange or another independent entity might reinsure and also assure risk re-adjustments to correct for adverse selection among plans. The exchange or another entity would need to be the regulatory body to enforce the insurance market reforms such as guaranteed issuance of coverage.[45]

Proponents argue that outside of a single payor system, universal coverage cannot be achieved without an individual mandate. It would reach those who are eligible but not enrolled in employment based or public coverage as well as those "young immortals", who can afford coverage, but choose not to purchase. The mandate would be less costly to government than other options as it leaves all existing public and private coverage and their financing in place.[46] It has the potential to eliminate coverage denials and medical underwriting of individuals, spread risk more effectively, contain costs through price negotiations and improve plan and provider incentives for cost-effectiveness.

Many argue that the exchange could also be the most efficient vehicle to deliver subsidies efficiently and act as a venue for consumers to access information and enroll: it could promote transparency and accountability of health plans. Transparency of information through the exchange could improve competition between health plans on price and quality.[47]

The individual mandate may be able to fill in the gaps of coverage for the uninsured while allowing all other forms of public and private coverage to remain in place.[48] This feature is particularly important as the cost of replacing current coverage and financing runs in excess of $200 billion in California alone.[49]

Skeptics believe a mandate would not achieve universal coverage due to widespread non-compliance, would increase costs to individual consumers for the mandatory benefit package and would increase costs to taxpayers for the needed premium subsidies. They contend it could make insurance less affordable for all by inflating the scope of covered benefits at the behest of medical specialty interest groups.[50]

Additionally, it is argued that a mandate essentially forces consumers to pay for a broken sector of the economy with unchecked rising costs, would require widespread hardship exemptions, and is likely to be just as unenforceable as mandatory auto insurance. An employer mandate, which may be as a 'necessary companion' of compulsory insurance law, could cause firms to expand/contract their workforce to dodge mandatory contributions, to avoid older, sicker, or low-wage workers, and to lay-off their least productive workers.[51]

The Massachusetts Health Reform of 2006 includes an individual mandate, and appears to have already achieved nearly 98% coverage.[52] The reform began with an eligibility expansion for the MassHealth (Medicaid) program in 2006, and the following year all adults were required to have coverage. Though there is disagreement on the effectiveness of the reform, it is clear that the number and income strata of uninsured were originally underestimated, which resulted in higher state costs.[53] The program is actually under budget per newly insured individual, but skeptics believe the higher than expected initial costs are now added to baseline expenditures, and it will be hard to reduce them in the future. Massachusetts health spending grew 66% faster than national trends, and current state revenues are insufficient to keep up; this may lead to enrollment caps, or reductions in covered services.[54] The Massachusetts reform may be difficult to translate to other states with older populations or those states with less 'tax tolerance.' It is important to note that the Massachusetts reform includes an exemption clause, where a small portion of the population (about 2%) is not subject to the mandate if the cost of insurance is not affordable even with public subsidies or because of the subscribers' religious beliefs.[55]

California has double the percentage of low income/uninsured compared to Massachusetts before it implemented its reforms because Massachusetts had already expanded Medicaid financed coverage for low income adults creating a much steeper financial hill for California to climb. Today, nearly 20% of Californians remain uninsured, compared to 2% in Massachusetts.[56] Whereas the California individual market is significantly less expensive (due to underwriting) than the individual market was in Massachusetts, the Commonwealth was able to combine its overpriced and comparatively small individual market with its small employer market and the infusion of new young and healthy enrollees under the mandate to quite markedly reduce individual market premiums.[57]

The individual mandate may become an important issue for consideration by Congress this year; it is in both Senate Committee bills and the three-committee House bill, and it may be a part of future state reform efforts. The ultimate goal of reform is to make sure every citizen receives the care they need, but there is disagreement on next steps. The ongoing debate is who should be covering what share of costs; individuals, government, employers and health plans. Skeptics are concerned with the Samaritan's dilemma that the more government support provided, the less individuals will do to help themselves. Instead of federal reform efforts, based on the Massachusetts model, some are urging states to pilot creative lower cost alternatives.[58]

Effective reform entails some measure of redistribution of costs. It is important to realize everyone is affected by rising health costs and everyone will become sick and need medical care at some point. The financial burden now falls most heavily on those that become sick, those who are at that point uninsured or underinsured. Reform should spread this risk across all. There must be a federal financing role as states are not in a good position to deficit-spend and finance the needed subsidies during economic downturns.

Concluding remarks for California's health system reform

Once a mainstream priority for the Schwarzenegger administration, comprehensive state health reform has been delayed by a focus on the state's large budget deficits. This represents a 180-degree turn from the optimistic state health reform proposals of 2007 and early 2008, leaving much of the promise of reform now in the hands of the federal government.

Statewide, the lagging economy and failed solutions to fill California's budget gap have left a $24 billion deficit. This means that publicly funded health services are again on the chopping block in California. The California Legislature's joint budget conference committee voted on June 15, 2009 to deny eliminating entirely the Healthy Families program (a portion of California's State Children's Health Insurance Program) as proposed by Governor Schwarzenegger, it did approve $70 million in cuts to the program's budget. Though the California health reform prognosis seems grim, the Obama administration has constantly reaffirmed the need for a better national health system. California, like every other state drowning in the cost of health care and the impacts of the recession, stands to greatly benefit from national reforms. Health Information Technology, Health Technology Assessment, and the individual mandate will be essential topics for discussion and debate to accomplish any meaningful and sustainable reform.

[1] For an in-depth analysis of each subject refer to the individual background reports, available at the California State Library, California Research Bureau Division website: http://www.library.ca.gov/crb/CRBSearch.aspx - search keyword 'Wulsin'.

[2] The Commonwealth Fund Commission on a High Performance Health System, "The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way", February 19, 2009 at http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Feb/The-Path-to-a-High-Performance-US-Health-System.aspx

[3] Ibid

[4] Congressional Budget Office (CBO), Technological Change and the Growth in Health Care Spending, Washington, DC: Congress of the United States, Congressional Budget Office, Pub. No. 2764, January 2008

[5] The Commonwealth Fund Commission on a High Performance Health System, "The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way", February 19, 2009 at http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Feb/The-Path-to-a-High-Performance-US-Health-System.aspx

[6] Focus on Health Reform, Side by Side Comparison of Major Health Reform Proposals (Kaiser Family Foundation, 2009) at www.kff.org/healthreform/sidebyside.cfm

[7] Ibid.

[8] Obama, Barack. "Remarks by the President." Annual Conference of the American Medical Association. Chicago, IL, 15 June 2009.

[9] Obama, Barack. Letter from the President to Senator Edward M. Kennedy and Senator Max Baucus. Washington, D.C. 2 June 2009.

[10] Obama, Barack. "Weekly Radio Address of the President." Washington DC, 13 June 2009.

[11] Ibid

[12] IOM, Committee on the Assessment of the U.S. Drug Safety System, "The Future of Drug Safety: Promoting and Protecting the Health of the Public," *The National Academies Press, 2007*

[13] Goodman, C., "HTA 101", National Information Center on Health Services and Health Care Technology,
US National Library of Medicine

[14] CRB Seminar on Health Technology Assessment, Dec. 17, 2008, Sacramento, CA at http://www.library.ca.gov/crb.

[15] Wilensky, G., "Comparative Clinical Effectiveness: Leveraging Innovation to Improve Health Care Quality for All Americans", presented to the Committee on Finance of the United States Senate, July 17, 2008

[16] Holtz, A., ECRI Institute's "15th Annual Conference Report: Key Questions and Issues".

[17] ???

[18] Moon, M., et al, "Creating a Center for Evidence-based Medicine", The American Institutes for Research, July 2007

[19] CRB Seminar on Health Technology Assessment, Dec. 17, 2008, Sacramento, CA at http://www.library.ca.gov/crb.

[20] Wilensky, G., "Comparative Clinical Effectiveness: Leveraging Innovation to Improve Health Care Quality for All Americans", presented to the Committee on Finance of the United States Senate, July 17, 2008

[21] CRB Seminar on Health Technology Assessment, Dec. 17, 2008, Sacramento, CA

[22] HHS Federal Coordinating Council for Comparative Effectiveness Research Membership at http://www.hhs.gov/recovery/programs/os/cerbios.html

[23] Wilensky, Gail, The Politics and Policies of Creating a Comparative Clinical Effectiveness Research Center, Health Affairs, Web Exclusive, June 25, 2006 at www.healthaffairs.org

[24] The Commonwealth Fund Commission on a High Performance Health System, "The Path to a High

Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way", February 19, 2009 at http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Feb/The-Path-to-a-High-Performance-US-Health-System.aspx

[25] Woolhandler, S., Campbell T., Himmelstein D., "Costs of Health Care Administration in the United States and Canada." *New England Journal of Medicine*, 349, no. 8 (2003): 768-775

[26] Hillestad, Richard, et al. "Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, And Costs". *Health Affairs*, 24, no. 5 (2005): 1103-1117

[27] Goodman, Clifford. "Savings In Electronic Medical Record Systems? Do It For The Quality.". *Health Affairs*, 24, no. 5 (2005): 1124-1126

[28] Federico, Girosi, Meili, R., and Scoville, R. "Extrapolating Evidence of Health Information Technology Savings and Costs". *RAND Reports*, RAND Corporation. R864.G57 (2005)

[29] Jha, A, et al, Use of Electronic Health Records in U.S. Hospitals, *NEJM,* published at http://content.nejm.org/cgi/content/full/NEJMsa0900592, March 25, 2009

[30] CRB Seminar on Health Information Technology-Electronic Health Records, Sept. 17, 2008, Sacramento CA at http://www.library.ca.gov/crb.

[31] Ibid

[32] Ibid

[33] Ibid

[34] Ibid

[35] Blumenthal D., Stimulating the Adoption of Health Information Technology, *NEJM*, March 2009 at: http://content.nejm.org/cgi/content/full/NEJMp0901592

[36] Ibid

[37] Focus on Health Reform, Side by Side Comparison of Major Health Reform Proposals (Kaiser Family Foundation, 2009) at www.kff.org/healthreform/sidebyside.cfm

[38] Institute of Medicine, Care Without Coverage: Too Little, Too Late (May 21, 2002) and America's Uninsured Crisis: Consequences for Health and Health Care (February 24, 2009) http://www.iom.edu/CMS/3809/54070/63118.aspx

[39] Brown, E. Richard, Lavarreda, S.A., Nearly 6.4 Million Californians Lacked Health Insurance in 2007 – Recession Likely to Reverse Small Gains in Coverage (UCLA Center for Health Policy Research, Dec. 2008) at www.healthpolicy.ucla.edu and Jacobs, K. and Graham-Squire, D. No Recovery in Sight, Health Coverage for Working Age Adults in the United States and California UC Berkeley Center for Labor Research and Education, April 2009) at http://laborcenter.berkeley.edu

[40] Ibid. Americans at Risk: One in Three Uninsured (Families USA March 2009) at www.familiesusa.org/resources/publications/reports/americans-at-risk.html

[41] S.334, Healthy Americans Act (Wyden, Bennett) at http://thomas.loc.gov/cgi-bin/bdquery/z?d110:s.00334

[42] CRB Seminar on the Individual Mandate, April 15, 2008, Sacramento, CA at http://www.library.ca.gov/crb.

[43] Blumberg, L., Holahan, J., Do Individual Mandates Matter? (Urban Institute, January 29, 2008) at http://www.urban.org/publications/411603.html

[44] Ibid

[45] Fuchs, V., Health Reform: Getting the Essentials Right, *Health Affairs* 28:w180-w183, January 16, 2009

[46] RAND Compare, Effects of Individual Mandate Policy Options, accessed from: http://www.randcompare.org/analysis/mechanism/individual_mandate#spending_anchor_1. A RAND study projects that government spending will increase $12 to $62 billion under a mandate while Gruber projects a higher annual expenditure of $124 billion. Gruber's spending estimate includes expanded public plan enrollment as well as higher administrative costs under the mandate.

[47] Nichols, L., Ask the Experts: Individual Mandate, Kaiser Network HealthCast, Washington, D.C., January 31, 2008

[48] Glied, S., Universal Coverage One Head at a Time – The Risks and Benefits of Individual Health

Insurance Mandates, NEJM, April 2008, 358:1540-1542

[49] LAO Senate Bill 810 Analysis, April 2009 at http://info.sen.ca.gov/pub/09-10/bill/sen/sb_0801-0850/sb_810_cfa_20090504_113314_sen_comm.html

[50] Cannon, M., Perspectives on an Individual Mandate, The Cato Institute, October 17, 2008 at www.cato.org/pub_display.php?pub_id=9722

[51] CRB Seminar on the Individual Mandate, April 15, 2008, Sacramento, CA at http://www.library.ca.gov/crb.

[52] Gabel, J., After the Mandates: Massachusetts Employers Continue to Support Health Reform as More Firms Offer Coverage, *Health Affairs,* 27:w566-w575, October 2008

[53] CRB Seminar on the Individual Mandate, April 15, 2008, Sacramento, CA

[54] CRB Seminar on the Individual Mandate, April 15, 2008, Sacramento, CA

[55] Massachusetts Health Connector, Facts and Figures, (March 2009) www.mahealthconnector.org/

[56] http://www.statehealthfacts.org

[57] CRB Seminar on the Individual Mandate, April 15, 2008, Sacramento, CA

[58] Ibid.