Health Care Reform for Workers and Working Families

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PILMA
Pharmaceutical Industry Labor-Management Association

www.pilma.org

Introduction

Each day, hundreds of thousands of workers in the United States start their day researching, developing and manufacturing biopharmaceutical products, and building the facilities where those medicines are discovered or produced. The resulting health care innovations are vital to the American people and the nation.

The global leader in scientific research, innovation and manufacturing, the U.S. biopharmaceutical industry provides hundreds of thousands of high-paying jobs, and contributes more than $200 billion to the gross domestic product.

The unions and companies of the Pharmaceutical Industry Labor-Management Association recognize that a strong domestic biopharmaceutical industry that provides innovative medicines is vital to the American people and to the nation as a whole. At the same time, the association recognizes the need to address issues of mutual interest and concern to the industry, its workers and all Americans, including: accessibility and affordability of health care; funding of innovative research and future cures; and, maintaining a strong biopharmaceutical industry in the United States. As an association of labor and industry, we recognize fully that not only do our employees research, discover and produce the medicines that enhance and sustain lives, they are also patients.

To that end, the trustees of PILMA tasked a working group to study and discuss thoroughly the issues surrounding health care reform so that they could answer this question: How can we, as a nation, make health care reform work for workers and their families?

What follows is a consensus-driven document that embraces our founding principles. We believe by working together, industry and labor can forge common-sense approaches and provide solutions to some of the biggest problems facing workers who are dealing with their health care and that of their loved ones.

As an organization deeply involved in health care, we wanted to do more than just state the problems — we wanted to come together and suggest solutions. We recognize that, despite achieving our goal of reaching consensus among ourselves, not everyone else will agree with our suggestions. And while we know that our solutions don't address all of the challenges facing the American health care system, this document represents our best efforts to address key reform issues and join a dialogue about solutions.

With an economy facing challenges of historic proportions, we understand we must work even harder to find real solutions. We believe fully that significant reform of the health care system today is a requirement of economic recovery, not something we can afford to put off until another day. Today's economic crisis compels us to come together now and help forge health care solutions that expand coverage, improve quality and provide value. By acting now, we can make meaningful change that will benefit America's workers and their families at the time when they need help most.

We welcome the opportunity to participate in this important dialogue.

Chairman Michael J. Sullivan
General President, Sheet Metal Workers' International Association

Vice Chairman Richard H. Bagger
Senior Vice President, Pfizer Inc.

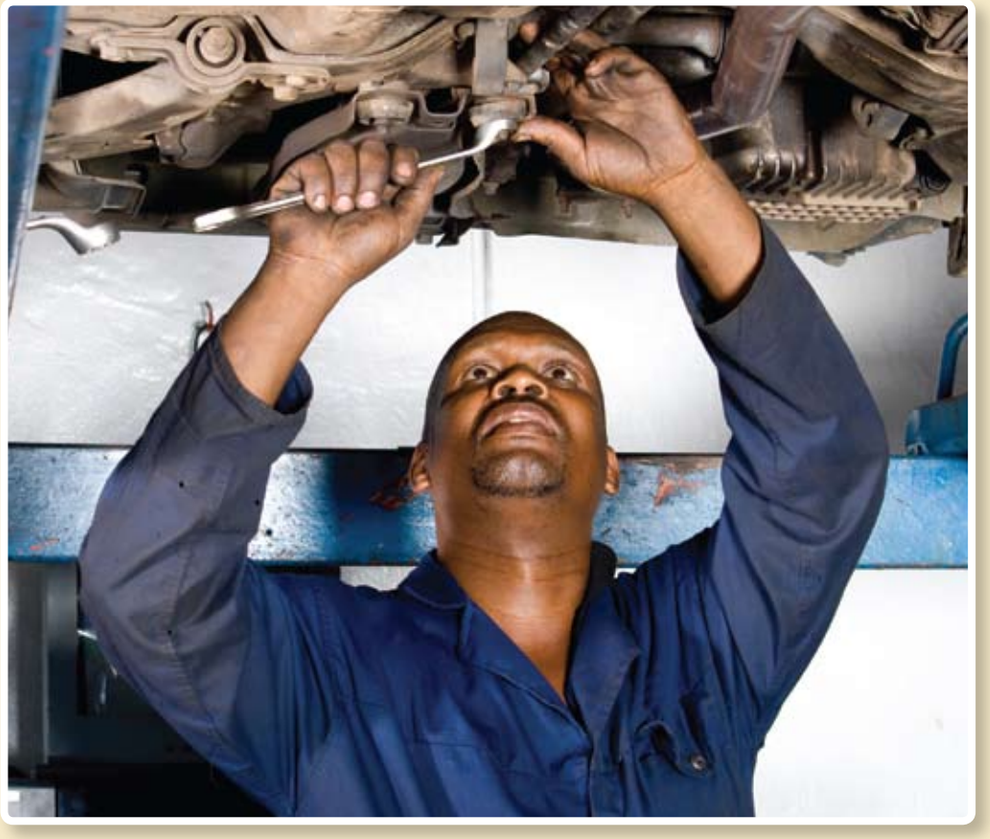
Health Care Reform for Workers and Working Families

The issues of the rising costs of health care and benefits, the lack of coverage, variations in health care quality, and the increase of chronic disease have dominated the health care debate in the United States for the past decade. Yet, despite attention to these issues, our country still faces an ever-intensifying health care crisis.

Too often, workers and working families are lost in the conversation, and they are the people for whom coverage is becoming increasingly burdensome. Fewer employers are offering workers health coverage, and those who do offer coverage are forcing workers to shoulder a larger share of the cost, just to maintain existing coverage.

The Pharmaceutical Industry Labor-Management Association (PILMA) is an association of workers and employers who are working together on legislative and regulatory matters, as well as other key national issues affecting organized labor and the pharmaceutical industry. PILMA is focused on maintaining strong employment and leadership in the United States for the research-based pharmaceutical industry.

PILMA members have worked to develop a practical and solution-oriented health platform to help meet the current and future needs of workers and their families, many of which were underscored in a 2008 report issued by the Center for Studying Health System Change, *Trade-Offs Getting Tougher: Problems Paying Medical Bills Increase for U.S. Families, 2003-2007*:



> As health care costs continue to increase faster than incomes, many families are paying higher out-of-pocket expenses for both health insurance premiums and health care services. As a result, paying for medical care has become more difficult than ever, leading many families to make difficult financial trade-offs and increasingly forgo needed medical care.[1]

According to a survey by the Kaiser Family Foundation and the Health Research and Education Trust, yearly premiums for family coverage in 2008 rose to $12,260 — a 119 percent increase since 1999.[2] Over the same nine-year period, the national consumer price index, the general measure of national inflation, rose 22.1 percent.[3]

PILMA's platform addresses these issues and offers a number of specific proposals that will serve to help working families in both the short and long terms. Our positions are categorized in four main areas: Health Coverage and Benefit Design, Financing and Cost-Containment, Access to Quality Health Services, and Reduction of Health Disparities.

Health Care Coverage and Benefit Design

PILMA supports health coverage that provides a baseline level of high-quality, comprehensive, portable and affordable health benefits, built upon the existing employer- and union-based multipayer system with flexible benefit designs that can be tailored to better meet the needs of American families and workers in every stage of life.

Often called coverage for "sick care" instead of "health care," health insurance in its current form has historically served to respond and pay for actual medical events, and not to prevent illness and manage chronic disease. The current system also frequently imposes financial barriers that prevent beneficiaries from accessing needed medical services. And most employer-based health insurance is not portable, so when workers leave (or lose) a job, they lose health coverage for their families, unless they elect to pay for COBRA continuing coverage, which is offered for a relatively short time at a cost that is much higher than they were paying previously.

Before looking at ways to reform the health care system, it is important to note that employers and unions have spent significant time, effort and money developing health programs and sponsoring coverage. When we say "employer-and union-based plans," we mean all employer plans, as well as those provided by employers and unions together. Meaningful national health reform should not undermine those efforts, but build on and enhance those efforts. Further, any reform should represent a floor, not a ceiling; it should represent the basics of what is provided, with coverage providers competing to improve it.

Redesign benefits

One of the first parts of the current system that needs to be reformed is the problem-laden area of health benefit design. As it is, state health insurance mandates require coverage for a guaranteed set of services, which vary by state. However, this ignores the disparate needs of workers and working families.

Not only do people's needs change throughout life, but the health needs of a family of five (pediatrics, vaccinations, pre- and post-natal care) differ greatly from the needs of a couple whose children are no longer at home (mammography, cancer screening), and from the needs of young people without children, who will likely have limited health care needs. Another growing population whose burdens are too often ignored is that of the "sandwich generation" family caregiver, who cares for children at home, as well as parents or other elderly relatives from the baby boomer generation.

Also, needs vary geographically — as does the availability of care — adding another wrinkle to instituting a national program.

While it may not seem that one program could provide for all of these variables, it's not impossible.

For example, under the Federal Employee Health Benefits Program (FEHBP) system, federal employees can choose their coverage options from a range of plan designs. It preserves standardized choices, allowing for geographic variations in access to health care. FEHBP should be used as a basic model for the way that a program can standardize services, while protecting and providing for individual needs.

Promote innovation

Reform should also encourage innovative approaches to coverage, such as:

- Eliminating patient cost-sharing for primary and secondary preventive services;
- Creating patient-centered programs that focus on prevention of chronic disease and clinically-effective patient care; and,
- Developing medical evidence-based health benefit design concepts.

These ideas are bolstered by several studies, including one by Brown University and Harvard Medical School, which showed that, when faced with a copayment, significantly fewer women sought potentially life-saving mammograms.[4] In another study, RAND researchers found that doubling medication copays for chronic conditions reduced use 25 to 45 percent, while increasing emergency room visits by 17 percent and hospitalization by 10 percent.[5]

Encourage benefit flexibility

Flexible benefit designs that have a guaranteed level of actuarial equivalence (adjusted for age) should be allowed by state laws, and targeted to meet changing health needs. This does not mean the blanket elimination of coverage mandates. Essentially, the age-adjusted value of health services in a family policy for a couple in their 30s should be equal to that of a couple in their late 50s, with different focuses on the health services covered. In addition, all state insurance regulations should permit lifestyle incentives to encourage healthy behaviors.

Keep coverage consistent

Health benefits portability should also be a high priority. Maintaining consistent coverage helps patients avoid the many preventable, expensive illnesses and health situations that result when cost and lack of coverage prevent people from seeking needed medical care.

Maintaining continuous health benefits would also have the effect of decreasing overall administrative costs, which would — in turn — help reduce costs both for families and plan sponsors.

Financing and Cost-Containment

PILMA believes that successful health reform for currently covered workers will support expansion of coverage to the uninsured. Elements of this reform must include: establishing systemwide programs to prevent and manage chronic disease; requiring employers to offer health benefits (with recognition that small businesses may be exempt); and, treating health benefits more equitably under the tax system.

U.S. health expenditures are significant, reaching an estimated $2.1 trillion in 2006 alone.[6] Some argue that covering the uninsured would add an untenable amount to that cost, but Americans without adequate health coverage already cost others (including people with insurance) considerably, through cost-shifting of uncompensated and undercompensated care.

Any additional funds needed to cover the uninsured can likely be found within the system itself. For example, addressing the problems of underuse, overuse and abuse within American health care, all of which have been documented for years, would substantially reduce costs. And at the same time, addressing these issues of misuse within a continuous quality-improvement process would provide the opportunity to improve personal clinical outcomes and patient safety.

Of course, there would likely be a measured increase in health costs in the first few years of any major reform, due to pent-up demand and the "insurance effect," which is the term for the rise in insurance use that comes after

previously uninsured people, who have not seen a doctor for years, go for some form of medical treatment.

However, these overdue visits will enable doctors to identify earlier those patients who need to be treated and enrolled in programs to begin addressing existing illnesses. Getting those patients into disease management programs sooner rather than later, when treatment costs are higher, will result in lower costs overall.

Currently, an estimated 75 percent of all health spending goes to treat patients with one or more chronic illnesses; chronic disease is among the primary cost-drivers in health care today.[7] Only through effective prevention, diagnosis and long-term maintenance of chronic disease will the cost of this epidemic begin to stabilize.

Further, the lack of both adequate coverage and a regular treating physician means that the opportunity to prevent chronic diseases is missed, leading to increased use of emergency rooms — the highest-cost setting for non-emergent care. These costs are borne by all of us through taxes, bonds, insurance premiums and copays, and a myriad of other sources.

Expansion of community-based clinics and primary care providers, coupled with expanded health benefit coverage, would further help this issue.

The tax implications of health insurance have also led to an uneven playing field for those trying to obtain affordable health insurance because they do not have coverage through their employers. Families without sponsored health insurance are forced to pay their family health insurance premiums

with after-tax dollars, while those workers with employer- and union-sponsored insurance are able to use pre-tax dollars. In many cases, this can be the deciding factor in a family's ability to afford coverage.

This inequality should be addressed.

Tax deductibility should be expanded to include those insuring themselves, but the deductibility of employer contributions for workers and working families must be preserved.

The system should also be made equitable by requiring all employers to offer I.R.S.-sanctioned Section 125 plans that allow employees to set aside pre-tax dollars for health care and insurance premiums. This has limited cost to employers, and represents fair treatment of all workers. This should not, however, be coupled with a removal of the employer health insurance tax deduction.

Standards are needed to prevent reductions in existing employer-paid benefits, and any change should represent an effort at expansion, not just a shifting of obligation.

Furthermore, with the understanding that small businesses may be exempt, employers should be required to offer health benefits. By not offering coverage, corporations are forcing taxpayers to subsidize them. In addition, employers should provide wage levels so that their baseline workers' wages exceed the government's low-income health plan eligibility levels.

And finally, because benefits must be affordable to have any value, there should be a system of sliding scale premiums and/or subsidies that are based on income level. This could be done through direct subsidy or through changes in the tax code.

Access to Quality Health Services

PILMA believes effective coverage for all requires access to quality health services. America's working families face significant barriers to appropriate health services and opportunities for improved personal health. PILMA supports the redevelopment of health systems to: focus on front-line primary care; contain the growth of chronic illness; protect personal privacy; and, overhaul the medical education system to attract and retain medical professionals across the health spectrum.

Access to health services and providers in both a timely and appropriate manner has been deteriorating nationally for many years. Although the levels of medical technology and innovation in the United States are at the forefront of the world's health systems, there are many weaknesses, including geographic variations in access to physicians and hospitals, and geographically uneven, often declining rates of practicing physicians per capita.

The existing system for training doctors and the near-total emphasis on paying only for acute care services via our insurance benefits programs act as barriers to improving access. Historically, U.S. physician training in academic medical centers has emphasized hospital- and facility-based health care, with a more limited focus on community-based health care. This has resulted in too few primary care doctors (i.e., family practice, internists, obstetricians, gynecologists and pediatricians), and too great an emphasis on specialty care.

On top of this complication, working families have access problems that derive from both work and family situations. Wage earners have difficulty taking time off from work. They cannot afford to lose wages, and generally, their work situations do not allow for short-term absences. Medical appointments often are not available after work or school or on weekends. Child-care and transportation costs also limit access to care. These issues could be addressed through the expansion of the *Family and Medical Leave Act*; the development of family-centered, community-based clinics; and, expanded office hours. Local schools could be sites for children's basic health services. Local and regional public health departments could be used as a network of preventive, screening and acute care service providers.

Any program that seeks to improve access to health care must also address geographic barriers. Working families in rural areas lack adequate access to the advanced medical services typically available in urban settings. At the same time, inner-city workers and their families have difficulty accessing primary care doctors, who increasingly set up practice in suburban areas. These problems can be addressed through effective and improved use of information technology and telemetry, providing incentives for doctors to practice in underserved areas, and developing community-based health services.

Advancements in electronic medical records are also needed to support both medical outreach efforts and efficient continuity of care. Electronic medical records can help prevent redundant medical tests, while enabling treatment providers to access information on the full scope of a patient's health needs. Widespread adoption of electronic medical records and associated technologies can improve efficiency, resulting in lower administrative costs.

Because these are not entirely new ideas, we can learn from established programs, such as many workplace health services programs that have shown promise. For example:

- The International Association of Fire Fighters has long-established successful personal disease prevention and occupational health programs.
- Tulane University's efforts in the Gulf region after Hurricane Katrina demonstrated effective community outreach for direct medical services.
- Mobile medical units in several locations throughout the country are providing preventive services — an approach similar to that of the international physician aid group, Doctors Without Borders.

What's more, these programs have shown that this kind of outreach can be done without compromising personal privacy.

The innovative "patient-centered medical plan" emphasizes a healthy personal lifestyle, prevention efforts, and coordination of chronic care management services (e.g., addressing heart disease, cancer, diabetes, asthma and depression). The use of a team of health professionals also provides expanded access to family-oriented primary care. Family members receive an initial assessment of their health status, and can then work with their doctor-led health professional team to develop a coordinated approach to maintain or improve their health. The care is coordinated, and it addresses lifestyle change, health education, nutrition support, and other preventive services and socio-medical concerns.

The patient-centered medical plan is the repository of patient information, and serves as the coordinator of all patient services, including referrals. Services are provided in a team-based setting, headed by primary care physicians, with physician's assistants, pharmacists, advanced practice nurses, medical social workers, nutritionists and physical therapists rounding out the provider group.

To ensure that tomorrow's system meets the changing needs of patients, medical education programs should change to help resolve future medical system personnel needs. Today, taxpayers substantially finance graduate medical training through Medicare's direct and indirect medical education payments. Other Medicare payments help to defray the costs for hospitals that serve a high proportion of lower-income Americans. But community-based residencies also need financial support, and by building on established approaches, we could provide financial incentives to institute community-based, primary care medical residencies.

Reduction of Health Disparities

PILMA supports the focused development of culturally-sensitive health services with a language-competent workforce that accurately reflects the demographics of the overall workforce and population of the United States.

In 2006, the U.S. Agency for Healthcare Research and Quality (AHRQ) published a broad-based survey outlining the differences in health services and health status among racial and socioeconomic groups in the United States. The *National Healthcare Disparities Report* called attention to the effect race and ethnicity have on the quality of care people receive, as well as their access to care.

Among AHRQ's findings were that African-Americans and Latinos receive poorer care than whites in more than 70 percent of health quality measures.[8] Similarly, other studies have found that:

- In 2000, death rates from heart diseases were 29 percent higher among African-American adults than among white adults, and death rates from stroke were 40 percent higher.[9]
- Diabetes is at least two to four times more prevalent among African-American, Latino, Native American and Pacific Islander women than among white women.[10]
- African-American children have a higher prevalence of asthma than white children across all income levels. And even after controlling for numerous factors, research has found that African-American children are 20 percent more likely than white children to be diagnosed with asthma and to have had an attack in the previous year.[11]

Furthermore, in a 2006 Institute of Medicine brief, former U.S. Surgeon General David Satcher estimated that nearly 84,000 deaths per year could be prevented if gaps in mortality between African-Americans and whites were eliminated.[12]

Working families within minority populations have long had concerns regarding gaps in access to health services, as well as their own personal health status. Variations in access to care and personal health outcomes are compounded when cultural and language differences are combined with lower socioeconomic status.

While we have not yet gotten to the root of the problem, this uneven landscape has been studied and documented thoroughly enough that we can start implementing effective solutions. One thing we have already learned is that any continuing research on health disparity must include the voices of minority researchers and minority public policy experts.

Another is that one of the most important building blocks to effective — and equal — health care is the combination of language and cultural competency among health care providers.

Providers and patients need to communicate with total understanding, which means not only that they use the same *technical* verbiage, but also that they share an understanding of the *implications of words*, as well as subtle nonverbal cues that vary culturally. The resulting mutual trust and cultural awareness would naturally improve understanding of a variety of health-related issues, including the higher prevalence of specific disease conditions among certain populations; community environmental issues; differing beliefs regarding the efficacy of medical interventions; and, inherited (genetic) illnesses.

Toward this end, there is a clear need to increase the number of minority individuals in health care. Health care professionals of various ethnic and cultural backgrounds are, by virtue of their upbringing and experience, especially well-equipped to treat and counsel members of their respective ethnic

and cultural groups. For these reasons, both university and technical school training programs should undertake significant efforts to attract and retain minorities to the health fields.

We can engage in community-based early detection initiatives using "trusted communicators" within these communities for selected diseases with high prevalence in minority populations. Diabetes, asthma and heart disease outreach programs can have immediate and strong positive effects on both the health and fiscal wellbeing of many communities.

It is only by gaining this mutual trust between patient and provider that we can begin to make treatment accessible, equal and effective for everyone, regardless of their race or ethnicity. Until that happens, any attempt at health care reform will exclude millions of people — many of whom are the ones who need care most.

The health coverage crisis with which the United States finds itself grappling today is a reminder that working families face a constant threat to their access to affordable quality health services. Throughout 2009 and beyond, PILMA and its members will continue to work together in promoting these themes of health coverage, financing, access and health disparities to ensure that all Americans have appropriate and timely health care.

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PILMA asked a diverse group of labor leaders and representatives of America's biopharmaceutical industry to come together to craft a vision of how health care reform should help workers and their families. This paper is the result. It is the product of a yearlong process of thorough research and study, respectful and often spirited deliberation and meetings, and thoughtful consideration. Uppermost in the minds of those involved — from the staff and consultants working on the project to the trustees who have adopted the document — has been the goal of agreeing on issues that have a deep impact on Americans and their health. There is no minority report; this is a consensus document.

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TRUSTEE ORGANIZATIONS OF THE PHARMACEUTICAL INDUSTRY LABOR-MANAGEMENT ASSOCIATION

- AstraZeneca International
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- International Association of Fire Fighters
- The International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmiths, Forgers, and Helpers
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