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American Hospital Association
Comments
to
the Senate Finance Committee
on
Financing Comprehensive Health Care Reform:
Proposed Health System Savings
And Revenue Options

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on your May 18 policy options paper on financing comprehensive health care reform.

Hospitals support the enactment of comprehensive, meaningful health care reform legislation this year. Over the past several years, the AHA Board of Trustees has worked to develop a framework for health reform. The board spoke with hundreds of hospital leaders, held public listening sessions and convened more than 100 organizations representing consumers, health advocacy groups, business, insurers, providers, unions and others to identify those changes in law and regulation necessary to improve health and health care in America. The result – *Health for Life: Better Health. Better Health Care.* – identifies five essential elements of reform:

1) Health coverage for all, paid for by all;
2) A focus on wellness;
3) The most efficient, affordable care;
4) The highest quality care; and
5) The best information.

Rising health care costs top the concerns of Americans and dominate the news. America's health system is at a crossroads, and we commend the Senate Finance Committee (SFC) for its efforts to put forth proposals to transform our health care delivery system, provide coverage to all Americans, and find fiscally responsible options for financing reform. Keeping health care affordable will involve every segment of the health care system – insurers, hospitals, business, physicians, nurses, employers and individuals. It also will involve personal responsibility, better stewardship of health resources and innovative ways to transform care for an aging and increasingly diverse population. Many opportunities exist to reduce costs without compromising care.

Unfortunately, discussions of health care spending too often focus simply on cutting costs and overlook other important parts of the equation. Advances in medicine bring enormous benefits to daily lives – benefits that need to be weighed against the costs. Also, health care is a huge part of the U.S. economy, accounting for millions of jobs, trillions of dollars of economic activity and providing continued growth even in these troubled economic times. Efforts to address affordability must consider the value of the economic, social and medical contributions of health care alongside the costs.

The SFC's financing options paper highlights many options to both lower health spending and raise new revenues to fund health reform. The AHA commends the committee for evaluating the options for financing health reform and supports the SFC's proposals that would look to new revenue streams, such as new lifestyle-related revenues and the tax exclusion for employer-provided health coverage, to fund needed investments in coverage and other health reforms. We also support the SFC's proposals to expand the Medicaid drug rebate program and would encourage the SFC to extend that program to more hospitals, and to inpatient services to help lower the fast-growing pharmaceutical costs in hospitals.

The paper also cites, by reference, several of the policy options in the SFC 's first paper on delivery system reforms that would reduce health care costs in addition to changing incentives for care delivery. The AHA supports efforts to improve the delivery system, as detailed in our May 15 comments to the SFC.

The AHA has concerns about several of the provisions that generate health system savings. Proposals to reduce Medicare hospital payments, such as reductions in the annual update, are misguided and ignore that the Medicare program already underfunds hospitals. The Medicare Payment Advisory Commission (MedPAC) projects that hospitals will have a *negative* 6.9 percent Medicare margin in 2009 – down from a *positive* 6.2 percent Medicare margin in 1999 – the lowest level in more than a decade. According to AHA annual survey data, a staggering 58 percent, or 2,840 hospitals, lost money serving Medicare patients in 2007. The federal fiscal year (FY) 2010 inpatient prospective payment system (IPPS) proposed rule would further reduce hospital payment by $22 billion over the next 10 years. Hospitals can not withstand additional reductions to Medicare rates.

We look forward to working with the SFC and other policymakers to make the best changes possible to achieve better health and health care in America. Following are our detailed comments on key provisions affecting hospitals. We also have included recommendations related to Congressional Budget Office scoring methods, administrative simplification and liability reform, as we believe that these issues are critical in the debate over how to finance health reform initiatives.

HEALTH SYSTEM SAVINGS

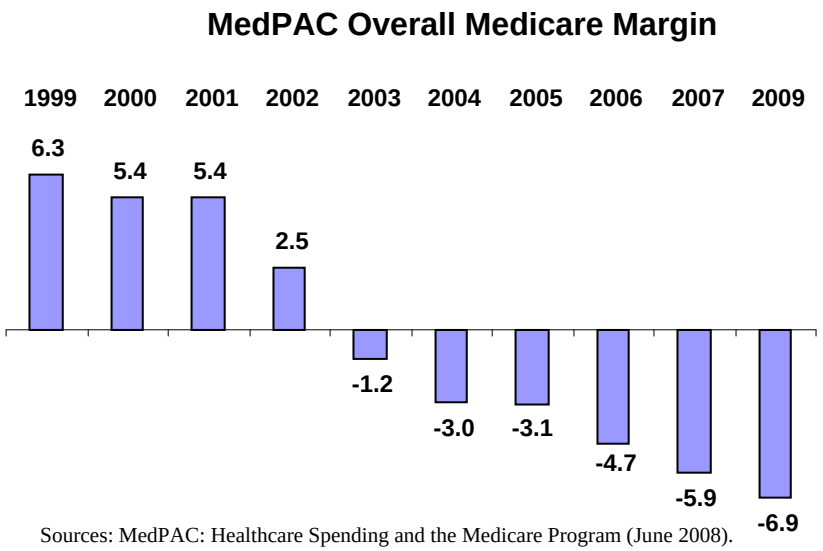
Ensuring Appropriate Payment

The SFC's proposals rely heavily on MedPAC's recommendations to reduce or eliminate market basket updates for Medicare fee-for-service providers for fiscal year FY 2010, as described in the commission's March report to Congress. These recommendations include eliminating the 2010 update for skilled nursing facilities and inpatient rehabilitation facilities; eliminating the update for home health agencies, along with a further reduction of 2.71 percent to account for changes in coding; and updating long-term care hospitals by the market basket rate minus an adjustment for productivity growth. For inpatient hospitals, MedPAC recommended a full market basket inflation update concurrent with implementation of a value-based purchasing program and a reduction in indirect medical education (IME) payments.

While the market basket update is intended to reflect cost increases, it has taken on more complex functions. In recent years, receipt of a full market basket update for hospitals has not simply related to increased costs for the provision of care. Per legislated changes, receipt of a full update now also functions as a financial incentive related to quality reporting and will soon be linked to hospital adoption and use of health information technology (IT). Hospitals that fail to successfully submit quality data to the Centers for Medicare & Medicaid Services (CMS) are subject to a 2 percentage point reduction in their market basket updates. In 2015, hospitals that have not yet achieved the status of a "meaningful user" of health IT will have their market basket reduced. The market basket update no longer functions as an independent variable that can be altered to achieve budget savings – it also is a financial incentive to achieve quality and health IT goals.

The AHA believes that the market basket update is necessary and should fulfill its original function: providing an increase in payment to account for inflation in the costs associated with delivering care. However, since its purpose has evolved to become a tool to incentivize the adoption of valuable policy goals, the AHA believes that this new purpose makes cutting or eliminating the market basket update even more counter-productive for providers, patients and health care reform goals.

<u>Improving Payment Accuracy through Adjusting Annual Market Basket Updates Hospitals</u>. According to MedPAC estimates, overall Medicare margins – including the costs of inpatient, outpatient and post-acute care services – will reach a 10-year low in 2009 at negative 6.9 percent (see chart on overall Medicare margin below). AHA annual survey data show that a staggering 58 percent, or 2,840 hospitals, lost money in 2007 serving Medicare patients. This clearly indicates that Medicare payments are woefully inadequate. The MedPAC recommendations for 2010 recognize that a full market basket increase for inpatient and outpatient hospital services is necessary, and the AHA urges the SFC to support the MedPAC recommendation of a full market basket update.



Sources: MedPAC: Healthcare Spending and the Medicare Program (June 2008). December 2008 MedPAC meeting.

Long-term Care Hospitals. Long-term care hospitals (LTCHs) provide care to beneficiaries who have clinically complex problems and need hospital care for extended periods of time. The number of LTCHs has remained steady, but Medicare spending for LTCHs declined in 2007. In addition, Medicare margins have been on a downward trajectory since 2005 and are projected to reach 0.5 percent in 2009, meaning that Medicare payments will only just cover the costs of providing care to Medicare beneficiaries. In order to halt the decline in margins and preserve beneficiary access during the current economic volatility that threatens LTCHs and other hospitals, a full market basket increase to account for inflation is needed**.** The AHA is concerned that the SFC paper proposes to adopt the MedPAC 2010 recommendation that would update long-term care hospitals by the market basket rate minus an adjustment for productivity growth. We urge the SFC to reject this proposal as it would further jeopardize LTCHs.

Inpatient Rehabilitation Facilities. Inpatient rehabilitation facilities (IRFs) have specially trained doctors and staff who treat both their patients' *rehabilitation* and *medical* needs. The field has experienced significant change since 2007 and payment adequacy is on a steep downward trend. Specifically, strict enforcement of the "60% Rule" has reduced patient volume and increased the severity of IRF case mix. In addition, IRFs have been subject to an 18-month payment cut that runs through FY 2009. Many IRFs also are facing the pressure of aggressive medical necessity audits that require them to undertake costly appeals to recover funding – appeals which are being decided in favor of IRFs at a high rate. A full market basket increase is needed to maintain payment adequacy. The AHA is concerned that the SFC paper proposes to adopt the MedPAC 2010 recommendation to eliminate the IRF payment update. We urge the committee to eliminate these proposed payments cuts.

Hospital-based Skilled Nursing Facilities. Hospital-based skilled nursing facilities (SNFs) provide a fundamentally different model of care than freestanding SNFs. They treat sicker patients who require more extensive services and they have higher nurse staffing ratios per bed than freestanding SNFs. The complexity of these patients is not well accounted for in the SNF payment system; as a result, at its December meeting, MedPAC reported that these medically complex patients are experiencing delays in being placed into a SNF. We support the Commission's prior recommendations for redesigning the SNF prospective payment system, as these changes would greatly improve access for medically complex patients. However, aggregate Medicare margins for hospital-based SNFs were *negative* 84 percent in FY 2007, compared to positive 15 percent margins for freestanding facilities. With deplorably low margins and hospital-based SNFs continuing to retreat from the market**,** a full market basket update for those hospital-based SNFs is critical to preserve the high level of care provided. The AHA is concerned that the SFC paper proposes to adopt the MedPAC 2010 recommendations that eliminates the SNF payment update for hospital-based SNFs. We urge the committee to carefully revisit these payments cuts and consider reforms that more appropriately cover the cost of caring for sicker and more complex SNF patients.

Updating Payment Rates for Inpatient Services – GME and DSH Programs
Both Medicare and Medicaid provide additional payments to hospitals that train medical residents or serve a high proportion of low-income patients. Medicare pays teaching hospitals for a portion of the costs associated with graduate medical education (GME) through an indirect medical education (IME) adjustment within the inpatient prospective payment system (IPPS) and direct graduate medical education (DGME) payments made outside of the IPPS. Most state Medicaid programs also make special medical education payments to teaching hospitals.

The Medicare and Medicaid programs also make special disproportionate share hospital (DSH) payments to certain hospitals that treat high proportions of low-income patients. The Medicare program uses measures related to low-income Medicare and Medicaid beneficiaries as proxies for services provided to low-income patients. State Medicaid programs have broad discretion in defining which hospitals qualify for Medicaid DSH programs.

The SFC options paper offers several options to reform hospital GME and DSH payments. These options range from block granting these programs to targeting payments based on the costs of treating uninsured patients and training medical residents.

Hospitals are critical sites for the education of future physicians. Both the Medicare and Medicaid programs have recognized this important need since their 1965 inception. Medicare's payments for the direct cost of GME and payments for the higher operating costs of teaching hospitals, the IME adjustment, are crucial to the ability of teaching hospitals to carry out their academic missions of education, research and high-intensity patient care. These payments fund a social good that benefit all Americans and should not be reduced. A strong clinical workforce, including the need for additional GME training

positions and additional primary care providers, must be the foundation upon which reform is built. The AHA urges the committee to maintain the current commitment to fund the Medicare and Medicaid GME programs. Proposals to increase the number of residency positions, similar to the legislative proposal introduced by Senators Nelson (D-FL) and Schumer (D-NY), should be part of the SFC's health care reform legislation.

The Medicare DSH program supports urban and rural hospitals that provide high volumes of low-income care at a projected cost of $9.8 billion in FY 2009. The Medicaid DSH program, with $9.1 billion in federal spending, supports a broad range of services for Medicaid and uninsured or underinsured children and adults, including primary and specialty outpatient care, hospital care, chronic disease management, mental health services, dental care, social work services and translation services. Medicare and Medicaid DSH funds also help support essential community services such as trauma and burn care, readiness for natural and man-made disasters, pediatric intensive care, high-risk neonatal care and emergency psychiatric services.

Medicare and Medicaid DSH payments also offset payment shortfalls for hospital-based inpatient and ambulatory care for both programs. Even with DSH payments included, the total hospital shortfall has risen from $3.8 billion in 2000 to nearly $32 billion in 2007 ($21.4 billion for Medicare and $10.4 billion for Medicaid). Including DSH payments, hospitals received, on average, payment of only 91 cents for every dollar spent caring for Medicare patients and only 88 cents for every dollar spent caring for Medicaid patients. For hospitals that provide significant levels of care to Medicare, Medicaid and uninsured patients, DSH payments are a lifeline.

Even if universal coverage is achieved through health care reform, there will be populations that will remain uncovered, and hospitals will be asked to bear the burden of their health care and essential community services. The AHA recommends that the committee reject reductions in federal support for DSH programs until coverage expansions are universal and fully implemented, and Medicare and Medicaid payment shortfalls are addressed. These views were shared with Congress in an April 27, 2009 coalition letter sent by the national hospital organizations including the AHA, Association of American Medical Colleges, Catholic Health Association of the United States, Federation of American Hospitals, National Association of Children's Hospitals and National Association of Public Hospitals and Health Systems.

Capturing Productivity Gains

Medicare payment updates are linked to projected changes in specific market basket indices that reflect the effect of inflation on providers' cost per service. The Congressional Budget Office (CBO) and MedPAC recommend that provider updates should be adjusted to account for improvements in providers' productivity that may reduce unit costs. The SFC paper proposes to require an adjustment of the annual market basket increases for certain fee-for-service providers by some or all of the expected productivity gains as a way to improve the accuracy of Medicare payments.

MedPAC's proposed productivity measure for the hospital market basket update would link the target for efficiency improvement to the gains achieved by firms and workers of private, non-farm businesses. This measure of productivity is not at all reflective of the hospital sector, and specifically excludes not-for-profits and government entities, which account for 83 percent of hospitals. There is no current comparable measure for the service sector, government or not-for-profits because the Bureau of Labor Statistics (BLS) has been unable to create an appropriate measure of output. Additionally, the measure is affected by the composition of the labor force – so if a hospital were to substitute a higher skilled worker (e.g., a Registered Nurse) for a lower skilled worker (e.g., a Licensed Practical Nurse) to produce the same "output" with better quality and patient safety, its productivity would go down.

It makes little sense to hold hospitals and other health care settings accountable for a productivity measure that is not reflective of what is happening – or potentially what is even possible – in the health care field. The AHA urges the SFC to reject this flawed approach to reduce Medicare payments to hospitals.

Reducing Geographic Variation in Spending

The SFC paper expresses concern about the geographic variation in health care spending and utilization. The committee notes a number of reasons for the variation. The SFC paper offers policy options to reduce inappropriate spending variations across and within geographic areas. The paper proposes an option to review all Medicare Parts A and B spending and to reduce spending in areas where per-beneficiary spending is above a certain threshold compared with the national average. In this option, spending per beneficiary for Medicare Parts A and B would be adjusted to reflect differences in the price of inputs and the health status of the local population.

The second policy option would utilize a similar analysis of Medicare Parts A and B spending, but require spending reductions only for individual providers who are above a certain threshold in spending compared to their peers in their local area. Spending per beneficiary for Medicare Parts A and B would be adjusted to reflect differences in the price of inputs and the health status of the local population.

The SFC paper states that policy options to reduce variation would need to be addressed in the context of delivery system reform options that also are under consideration. Delivery system reform options also are intended to reduce geographic variations in spending.

The AHA strongly opposes attempts to reduce variation in health care spending and utilization by altering levels of payment either across-the board or to individual providers above certain thresholds. The AHA agrees with the SFC in that delivery system reform changes, such as value-based purchasing, readmissions and bundling payments, will have the effect of reducing variation in spending by their very implementation. We are working with the SFC staff to refine these reform proposals. Additionally, a robust comparative effectiveness research program that disseminates to the provider community findings of

what works or does not work will contribute to reducing variation in spending and utilization.

OTHER HEALTH CARE RELATED REVENUE RAISERS

Modifying the FICA Tax Exception for Students

Employers and employees pay taxes for Social Security and Medicare under the FICA. FICA taxes are not applied to certain income, such as employer-provided health benefits, and are not assessed on certain services or services performed by certain employees, such as certain state and local government employees and students (sometimes including medical residents).

Current law exempts students employed by a college or university from contributing to FICA through payroll taxes. Teaching hospitals have applied this exception to medical residents receiving stipends. The Internal Revenue Service (IRS) issued regulations to narrow the definition of "school" for purposes of the exemption, and to better describe student employment.

In general, the SFC paper considers options that would codify the IRS regulations that clarify the scope of the current student exception. In addition, the proposal would amend the student exception so that it does not apply to individuals whose earnings subject to the exception exceed an annual dollar limit. The proposal also applies for purposes of determining wages for Social Security and Medicare.

The AHA strongly opposes codifying the IRS regulations on the student exception. The regulations were developed after a long and intensive period during which stakeholders had an opportunity to meet with the IRS and submit comments in response to the proposed rule. The AHA is aware that the rule has been successfully challenged in several court cases that currently are under appeal. Once the legal process has been exhausted, there may be reason to consider whether legislation is appropriate. At the current time, the regulation is fully implemented and affected entities and individuals are in compliance, so there is no need for legislation.

Modifying the Requirement for Tax-exempt Hospitals

Not-for-profit (NFP) hospitals organized under section 501(c)(3) of the tax code are generally exempt from federal, state and local income tax. They are eligible to receive tax deductible contributions and have access to tax-exempt financing through state and local governments. Since 1969, the IRS has applied a "community benefit" standard for determining whether a hospital is meeting its charitable, not-for-profit mission. That standard has been appropriately flexible to allow hospitals to respond to the needs of their unique communities. Under this standard, a community effectively decides whether a hospital is meeting its charitable obligations rather than an IRS official unfamiliar with the community or its needs. Not surprisingly, the IRS' own General Counsel staff has noted that the community benefit standard continues to work well.

The SFC paper includes a policy option that would effectively undermine the community benefit standard and replace it with a hodge-podge of requirements. Such requirements could include, among other things, that section 501(c)(3) hospitals provide a minimum (but undefined) annual level of charitable patient care, and impose an "excise tax" on tax-exempt hospitals that do not meet their yet-to-be-determined standard.

All of these proposals are either redundant or premature. Next year, in an unprecedented national effort, the IRS will begin collecting information from NFP hospitals on the benefits they provide to their communities and the policies and programs they employ to do so in a single document called "Schedule H." That form will give policymakers much more complete information on which to make important decisions about whether the current requirements for tax exempt status need to be updated. All of the areas encompassed in the SFC paper and the slide in the presentation are queried in Schedule H.

If the committee elects to consider changes to the current body of law governing tax-exempt status absent the actual information that will be provided by Schedule H filings, it is at least important to understand the crucial role hospitals play in every community across the country. America's hospitals provide compassion, care and curing 24 hours a day, seven days a week. Last year alone, hospitals provided $34 billion in uncompensated care – vastly more than any other provider group in the health care sector. This figure, while enormous, does not include many billions more hospitals spent on valuable community service programs such as research, teaching, subsidized care, neonatal and burn care, and other activities designed to promote and protect health and well-being of the community. (See the AHA's Uncompensated Hospital Care Cost Fact Sheet at www.aha.org/aha/content/2008/pdf/08-uncompensated-care.pdf.)

NFP hospitals are distinguished by certain charitable obligations that have evolved over time to keep pace with the needs of the American people. A 2006 review by Ernst & Young of information provided to the IRS reported that 100 percent of the general/medical hospitals queried operated an emergency room that provides care to "all members of the community regardless of the patient's ability to pay." Please review Community Benefit Information from *Non-Profit Hospitals: Lessons Learned from the 2006 IRS Compliance Check Questionnaire, A Report Prepared for the AHA By Ernst & Young LLP*, Nov. 27, 2006, www.aha.org/aha/content/2006/pdf/061127-ErnstYcombenreport.pdf. This same review similarly showed that 100 percent of surveyed hospitals also offered preventive care and wellness programs designed to address unmet medical needs before patients require treatment in an emergency room. It also reported that hospitals' efforts do not end there: In addition to emergency care facilities and preventive care programs, NFP hospitals provided uncompensated care to, on average, 12 percent of their total patients in 2006, at a cost of approximately $14 million per hospital.

This committee should not act prematurely to undermine the community benefit standard or impose an excise tax on NFP hospitals that fail to meet a rigid numerical quota for financial assistance. The AHA recommends that the committee undertake a review when

the information it needs to get a full and fair picture of the ways in which NFP hospitals are meeting their community benefit obligations is available next year through Schedule H. We believe that the Schedule H information will demonstrate that hospitals more than meet their community benefit obligations and do so in a manner that outpaces any other provider group in the health care sector.

RAISING REVENUES FOR HEALTH REFORM

The AHA recognizes that additional sources of funding for health care reform will be required. While delivery system reforms, ensuring all Americans have coverage, and providing meaningful prevention, primary care and wellness services will result in eventual savings, funding these reforms will require an upfront investment using additional federal revenues. The AHA supports the SFC's review and consideration of revenue raising options, such as modifying the exclusions for employer-provided health coverage, imposing tax incentives on lifestyle-related choices, and other non-health related revenue options. Considering these options will place the nation on a path toward better financial security, better health and better productivity.

Consumers, providers, employers, payers and government all should share in the responsibility to achieve comprehensive reform that leads to coverage for all. This means fair and balanced reform that considers all funding options, including new revenues or taxes. Reform should reflect both the immediate need for change and the long-term savings reform can bring. We support a flexible approach to scoring that recognizes the need for up-front investment to set the health system on the path toward significant long-term savings and improvement in the long-term fiscal health of the nation.

SCORING THE COST/SAVINGS OF HEALTH REFORM PROPOSALS

The CBO plays an important role in health care reform through its responsibility for estimating the costs and savings of specific legislative proposals. The AHA is pleased that the budget resolution included a provision to extend the scoring windows to six- and 11-years, but many reform ideas need an even longer timeframe. We believe it is important for CBO to provide policymakers with estimates over longer scoring periods to appropriately capture the value of well-designed prevention and wellness proposals and to prevent a bias against investments in better health and health care that necessarily take time to demonstrate better health status and lower rates of cost growth. In addition, we believe that CBO's conventional approach to estimating the cost of proposals that have the potential to significantly improve the health status of the U.S. population should be modified to consider reductions in emergency room visits and hospitalizations. CBO has recognized that increasing vaccination rates would "reduce influenza-related hospitalizations and mortality" (CBO 2008 Budget Options, page 197). This also could apply to other targeted prevention-related initiatives, and we recommend that CBO take a broader view of the potential savings, both in health spending and economic productivity, from initiatives that will have similar results, such as preventive services, primary care, readmission policies, value-based purchasing and bundling payments.

ADMINISTRATIVE SIMPLIFICATION

In 2007, the U.S. Congressional Research Service estimated that the administrative costs of private insurance and government programs were about $465 billion a year. This figure does not include the administrative costs borne by health care providers to comply with these requirements. Most experts estimate that about a quarter of total hospital spending and a little more than a quarter of physician office revenue is spent on complying with administrative requirements. Increasingly complex administrative requirements cause great confusion for patients and their families, who often find that a service is not covered by their insurance or that their out-of-pocket liability is greater than expected. A major key to reducing administrative cost and confusion is limiting the variability and complexity of both public and private health plans by standardizing plan design and benefits, plan notifications, claims submission and adjudication, and appeals.

The AHA recommends that the SFC and Congress require the adoption of a standardized framework and terminology within which all health plans (whether subject to federal and state or just federal regulation) would be required to describe their plans, the benefits covered, the conditions for coverage and the cost-sharing required (i.e., deductibles, copayments, coinsurance, balance billing), including any differences related to the use of in-network or out-of-network providers. Such a requirement would allow plans to continue to develop customized plans for different purchasers, as long as their descriptive information adheres to the standard framework and terminology, so that consumers can more easily compare health plans and better understand their coverage and its limitations.

Hospitals also recommend expanding the scope of the administrative simplification provisions of the *Health Insurance Portability and Accountability Act* (HIPAA) statute, specifically to:

- Establish common rules for claims involving coordination of benefits to increase the timeliness and accuracy of processing those claims.
- Expand the transaction standards to require that health plans fully utilize the information codes in the uniform bill.
- Prohibit administrative denials for otherwise covered and medically necessary services unless there is a documented pattern of repeated provider abuse.
- Establish requirements to standardize Explanations of Benefits (EOBs).
- Improve remittance transaction standards to standardize and better define common terms and timeframes so that providers will have accurate and timely information about the disposition of individual claims and specific adjustments made to plan payments for billed services.
- Make modifications to ensure that claims are paid on a timely basis.
- Establish a more standardized and equitable process for auditing and resolving claims.

Finally, the AHA recommends that the SFC standardize the collection and reporting of clinical information for quality measures. The ever-increasing burden to collect, analyze

and submit vast amounts of patient care data associated with quality and patient safety, along with the lack of consistency in public and private payer requirements, has made it more difficult for providers to spend their time treating patients. All payers should adhere to common definitions for data elements and standard practices around data collection, submission, and frequency of reporting.

CREATE A BETTER ALTERNATIVE TO TODAY'S LIABILITY SYSTEM

Hospitals and physicians face skyrocketing costs for professional liability insurance. Unaffordable insurance is affecting access to care as physicians leave states with high insurance costs or stop providing services that expose them to higher risks of lawsuits. Particular areas of concern include obstetrics, neurosurgery and emergency services. In addition to the rising costs of insurance, physicians also practice "defensive medicine" – the practice of providing extra care to minimize the risk of lawsuits. Estimates place the national cost of defensive medicine at between $50 billion and $100 billion per year.

The AHA recommends that the SFC consider including liability system reforms in the context of health care reform. Specific approaches to reforming today's liability system could include: using administrative compensation systems and health courts to determine when an avoidable, preventable event has occurred; providing prompt compensation to injured patients and families based on agreed-upon payment schedules when an error takes place; and adjusting provider's liability insurance premiums based on the occurrence of preventable errors.

The AHA will continue to work with the SFC and its staff to strengthen the ideas presented in its series of options papers. We are steadfast in our support of health system reform and look forward to working with the committee and its staff as Congress moves forward with reform legislation.