



Many of our fellow Americans are hurting. Between rising unemployment, a troubled housing market, and volatile financial markets, there is no shortage of challenges we face. But where there are challenges, there are also opportunities. For all of these problems and others, we can find bold, innovative solutions. And few issues are as important to solve as healthcare.

The American people have long demanded quality care and affordable coverage. Healthcare is too expensive. Millions of Americans cannot get health insurance. It does not promote better health. And it does not deliver the best possible care.

This does not have to be. With the right reforms, we can bring about the kind of change we all want.

We can improve individual health. Focusing on prevention, wellness, and early health will save countless lives and avoid hundreds of billions of dollars in costs every year. We can reform our healthcare system to deliver the best possible care. Doctors and providers that are constantly migrating to what works will deliver higher-quality care. We can reform Medicare and Medicaid to be vibrant, sustainable programs. Reforming public programs to root out fraud, cut waste, and reward health and quality will place them on sound financial footing for future generations. We can expand access and coverage to every American. The savings from better health and better quality care can be used to insure every American—either through a robust, competitive private market or through an effective, efficient, and sustainable public program.

Forty years of reforms have failed because they did not address what should be the foundational function of our system: the health and well-being of individuals and families. That means focusing on health; delivering better quality care that focuses on the individual, not the bureaucracy; and supporting a wide array of choices so that every American can get health insurance.

This reform plan outlines the principles, goals, metrics, and solutions that can build such a system. When the pieces are put together, we will have a system that delivers more choices of greater quality at lower cost for every American.

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Health Reform Principles

For Individuals:

1. Every American should be encouraged and incentivized to take personal responsibility for their health.
2. Every American should have genuine access to quality, cost-effective care that best meets their individual needs.
3. Every American should have health insurance coverage (private or public) that is affordable, accessible, and portable—no matter where they choose to work or live.

For the Delivery System:

4. Healthcare providers should deliver the best possible care based upon best evidence or best practice.
5. Every provider of care, from doctors and nurses to pharmacists and hospitals, should be interconnected with an electronic health record for every American.
6. Payment to providers should be based on the quality of care delivered, not the number of transactions or services provided.
7. Cost, quality, and performance information should be available and accessible to all consumers in a way that each person can understand.

For Government:

8. Government should promote and encourage competitive, market-based solutions in the private sector.
9. Government should offer effective, efficient, and sustainable public programs for those who truly need them.
10. Government should aggressively invest in targeted clinical research, laying the foundations for future breakthroughs and cures.

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Goals, Objectives, and Metrics of Success

Much like when President Kennedy boldly declared we would send a man to the moon by the end of the decade, so too should we declare what we will do to improve healthcare.

1. *Within ten years, we will cut in half the number of Americans who suffer and die from the leading chronic diseases and poor health: diabetes, obesity, and heart disease.* We can accomplish this by shifting the focus to wellness, cost-effective prevention, chronic-care management, and personal responsibility; designing insurance to reward and emphasize wellness; creating closer relationships between individuals and healthcare providers; and investing in research to combat today's deadliest and most prevalent diseases.
2. *Within ten years, we will eliminate preventable medical errors, which kill nearly 100,000 Americans every year.* We can accomplish this by improving the processes of care, using the best approaches that are based on evidence and proven to work; getting the most modern and cost-effective tools, treatments, and technologies into the hands of providers; and by paying providers not based on the number of services they provide, but based upon the quality of care they deliver.
3. *Within five years with reforms that focus on the individual; emphasize wellness, prevention, and self management; constantly migrate healthcare to better and better outcomes; and minimize fraud, healthcare spending will decline even as coverage increases.* A modernized and transparent health system should rise in cost at the general rate of inflation as competition and information reduce costs and improve outcomes.
4. *Within five years, we will place Medicare and Medicaid on stable, sustainable ground.* We can accomplish this by implementing the recommendations of the National Bipartisan Commission on the Future of Medicare; and introducing cutting-edge technology, transparent financing models, and tougher fraud prevention tools in Medicaid.
5. *Within five years, we will insure every American, either through a robust private market or through public programs that actually work for those who truly need them.* We can accomplish this by investing in innovative state-based reforms; creating a free, fair, and functional private market for individuals and associations; transforming Medicaid; and extending tax credits to low- moderate-income individuals and families.

There are many other goals that should be set, from eliminating disparities in care to reducing the wide variation in cost and quality. The goals outlined above are a start. By outlining the metrics of success, we will be able to measure progress and know when we succeed. Taken together—better health, more

efficient delivery, sound public programs, and a competitive marketplace—we can and will transform health and healthcare in America.

Solutions

Delivery Reform to Improve Individual Health

1. **Rewarding health and wellness.** The Centers for Disease Control and Prevention report that 64 percent of adults are either overweight or obese.¹ The CDC also reported that diabetes is a major factor in killing more than 220,000 Americans every year.² These two conditions alone cost our system hundreds of billions of dollars every year. But they are, for the most part, a consequence of poor individual choices. We must focus on health—then healthcare—and individuals must take an active role in becoming healthier. Tools like the Gallup-Healthways Well-Being Index can help identify and focus on communities most in need.³

Solution: Change federal law to give health plans, employers, as well as Medicare and Medicaid, more latitude to design benefits to encourage, incentivize, and reward individual healthy behaviors. Incentivize individuals to participate in worksite wellness programs, focus on prevention, and adopt healthy lifestyles. Broader incentives to purchase healthier foods in the food stamp and WIC programs. Increase federal funding to public schools that 1) have physical education five days a week for every K-12 student, and 2) provide school lunches, breakfasts, and vending machines that promote healthy foods.

2. **Migrating everyone to best practices.** We must ensure that *health* is the driving focus of the health reform debate. The best way to accomplish this is to surface what is actually working today to save lives and save money and then designing public policy to encourage their widespread adoption. For example, according to the *Dartmouth Health Atlas*, the definitive authority on healthcare quality and variation, if the 5,500 hospitals in the country provided care at the level of Intermountain Healthcare in Utah or the Mayo Clinic in Minnesota, Medicare alone would save 32 percent of total spending ever year – with better health outcomes.⁴ We need to make best practice minimum practice.

¹ Centers for Disease Control and Prevention, National Health and Nutrition Examination Survey, “Healthy weight, overweight, and obesity among U.S. Adults.” July 2003.

<http://www.cdc.gov/nchs/data/nhanes/databriefs/adultweight.pdf>

² Centers for Disease Control and Prevention, National Diabetes Fact Sheet, 2003.

<http://www.cdc.gov/diabetes/pubs/factsheet.htm>

³ America’s Health Insurance Plans leads the State and Congressional District profile tool. More information is available at <http://www.well-beingindex.com>.

⁴ Jack Wennberg, Dartmouth Atlas Project, *The Dartmouth Atlas of Healthcare 2006*, Available online at: <http://www.dartmouthatlas.org>

Solution: Support a private-sector led best-practice initiative that educates the industry on documented, evidence-based best practices that work. This initiative should support the development and diffusion of knowledge for the purposes of expanding care, improving outcomes, and lowering costs—and explicitly not used by government to ration care. Government health programs should reward organizations that adopt these best practices through higher reimbursements. Two examples:

- The Veterans' Affairs Pittsburgh Healthcare System (VAPHS) created a best practice to combat *staphylococcus aureus* (MRSA), one of the nation's most alarming public health threats, infecting more than 94,000 Americans every year, leading to more than 18,000 deaths. VAPHS has reduced MRSA infection rates by as much as 82%, saving the hospital nearly \$1.3 million a year in costs. This best practice has now migrated to all 153 VA facilities, delivering a system-wide savings of nearly \$200 million a year. If the nation's 5,500 hospitals implemented this one best practice alone, it could save more than \$7 billion a year, and most importantly it would save approximately 15,000 lives every year.
 - More than 20 percent of all Medicare spending occurs in the last two months of life. Gundersen Lutheran Health System in La Crosse, Wisconsin has developed a successful end-of-life best practice that combines: 1) community-wide advance care planning, where 90 percent of patients have advance directives; 2) hospice and palliative care; and 3) coordination of services through an electronic medical record. The Gundersen approach empowers patients and their families to control their lives and direct their care. Over the last two years of life, this model has been documented by the Dartmouth Health Atlas to deliver care 30 percent lower than the national average (\$18,359 versus \$25,860). If this best practice were used to care for the approximately 4.5 million Medicare beneficiaries who die every year, Medicare could save more than \$33 billion a year.
3. **Paying for quality care.** Building on migrating to best practices, we must develop a policy roadmap to replace current physician reimbursement models, including the Resource-Based Relative Value Scale (RBRVS) and the Sustainable Growth Rate, with a model rewards the use of best practices, chronic care management tools, information technology and emphasizes patient wellness. We need to eliminate the vast geographical differences in reimbursement. We need to promote the development and use of primary care and its providers. The delivery reform proposal released in November 2008 by Kaiser, Intermountain Healthcare, and the Mayo Clinic provide a range of options that would be vast improvements over the status quo,

including bundled or episode-based payments, Accountable Care Organizations, and chronic care coordination payments.⁵

- 4. Moving from paper-based care to modern, electronic tools.** The stimulus law made a substantial and badly needed investment to incentivize providers to use modern tools, like electronic prescribing and electronic health records. Technology undoubtedly saves lives and saves money. We must now ensure that the new systems that doctors and providers adopt can talk with each other.

Solution: Expedite the development, completion and promulgation of key interoperability data standards by setting aggressive deadlines for completion. Invest in promising state and local health information exchanges that are replicable and self-sustaining.

- 5. Delivering a consumers' right to know.** Information on performance, cost, and quality allows consumers to make informed decisions, but the reality today is that healthcare consumers are blind.

Solution: Release all price and de-identified patient quality information from all government health programs—Medicare, Medicaid, Veterans Affairs, and FEHBP—for all providers, suppliers, and health insurers that do business with the federal government. Taxpayer-funded data like this will give consumers the information to see which organizations provide the best and most efficient care. Genuine public access to this kind of data will push providers, health plans, public programs, and all other stakeholders to improve.

Cost Reduction and Transforming Medicare and Medicaid

- 1. Cutting waste.** The [U.S. Healthcare Efficiency Index](#), which measures the administrative processes in healthcare, estimates that if the U.S. healthcare system moved from manual paper and phone processes to electronic administration, we could save \$30 billion a year (\$150 billion over five years). For example, today 90 percent of all medical claims are paid by printing a paper check and mailing it through the U.S. Postal Service. It is reported that electronic payment through direct deposit—think PayPal for health—could alone save an estimated \$11 billion every year.⁶

Solution: Migrate all payers and providers to fully electronic processes for administration, including claims submission, insurance eligibility verification, claims status inquiry, claims remittance, and electronic payment. All payers—CMS, state Medicaid programs, and private plans—must lead by making a real

⁵ To access the paper, please visit <http://intermountainhealthcare.org/About/News/Documents/deliveryreform.pdf>

⁶ This is an estimate based from Emdeon, the largest commercial claims processor in the country.

investment in their own electronic processes building on claims submission, followed by rewarding and then requiring their use.

2. **Reforming medical liability so that providers can deliver evidence-based medicine—not defensive medicine.** The elimination of procedures, tests, and treatments done solely out of fear of being sued would save an estimated \$124 billion a year.⁷

Solution: Extend federal liability protection to providers who follow established clinical guidelines or use certified best practices. Limited liability protection should also be extended to those who report medical errors and participate in quality improvement programs. Create uniform expert witness criteria to require that they have a current, valid, and unrestricted license to practice medicine; be board certified in the appropriate nationally recognized specialty or subspecialty; and have been actively involved in the clinical practice of his/her specialty at the time of the event. Establish federal guidelines that create appropriate limits on non-economic damages not to exceed \$500,000, though states may establish more restrictive standards.

3. **Attacking healthcare fraud.** Outright fraud – criminal activity – accounts for as much as 10% of all healthcare spending. That is more than \$200 billion every year. Medicare alone could account for as much as \$40 billion a year. As it stands now, it is simply impossible to keep up with fraud in a paper-based system, but this level of theft and crime can be detected, eliminated, and then prevented with the right kind of electronic resources. An electronic system would free tens of billions of dollars to be invested in the right priorities to transform healthcare and expand coverage.

- *Posting all Medicare and Medicaid claims data online for public access as close to real time as possible.* Currently, the financial accounting and health outcomes of Medicaid are incredibly opaque. Posting patient-protected, de-identified claims would reveal billing and practice patterns for all participating providers in both programs, laying bare for all Americans, particularly academic institutions and researchers, the extreme outliers who are likely engaged in fraudulent behavior.
- *Stop using Social Security numbers as each senior's Medicare Beneficiary Identifier.* The Federal Trade Commission tells Americans, “Protect your Social Security Number – do not carry it in your wallet or write it on checks.” But on the back of every Medicare card, which includes seniors’ Social Security number it says, “Carry this card with you when you are away from home.” Having this vital information so prominent makes fraud and identity theft much easier for criminals.

⁷ Daniel Kessler and Mark McClellan, “Do Doctors Practice Defensive Medicine?” *Quarterly Journal of Economics* 111, No. 2 (1996), pp. 353–90. PriceWaterhouseCoopers, *The Factors Fueling Rising Health Care Costs 2006*; Washington, D.C.: America’s Health Insurance Plans, 2006.

- *Fully fund the HHS Office of the Inspector General.* Current temporary funding streams under the Medicaid Integrity Program end at the conclusion of FY 2010 so staff reductions via attrition are already underway. HHS must be given the means necessary to be impactful in combating fraud and abuse.
- *Follow MedPAC's recommendation and move Medicare to a program where there is risk adjustment and payment for sticking with best practices and professionally recognized standards of care.* This incentivizes identification of overpayment and recovery.
- *Require enhance coordination of benefits and third-party liability identification.* There are huge savings to be found by simply being more accurate with identifying patients' primary source of insurance. A sizable minority is actually already covered by private insurance, though Medicaid is footing the bill. One insurer recently analyzed Medi-Cal claims coming through its company and found \$250 million in claims to Medicaid when other insurance had been *volunteered* by both the patient and the provider. This is a 1 percent savings, just on volunteered information. Further attention would undoubtedly yield even greater abuse.
- *Require enhanced use of electronic remittances/Electronic Fund Transfers to and from providers.* The U.S. Healthcare Efficiency Index estimates an \$11 billion a year savings just from EFT. This saves on paper postage and increases the accuracy and timeliness of payments.
- *Aggressively utilize predictive modeling for payments.* These technologies catch outlier billing practices before payments are made.
- *Require biometric identification for Medicaid patients to access provider treatment.* Texas is currently expanding a pilot program that gives Medicaid recipients a plastic card, encoded with eligibility and identity information required by providers. Beneficiaries scan the card and his/her fingerprint at the doctor's office. The system compares readers and verifies the person's identity in seconds. This "smart card" reduces costs, particularly the reduction in mailing paper cards, and protects client information.
- *Ensure that providers and suppliers meet government standards, and enforce removal from the system of those who do not.* This is particularly a problem in Medicare, as fraudulent durable medical equipment suppliers claimed more than \$1 billion in improper payments in just over a year. In addition, it should be ensured that doctors who lose Medicare/Medicaid billing privileges in one particular state must be unable to bill in another.
- *Emulate best practices in billing and anti-fraud efforts from the credit card industry.* Fraud programs are most effective when they are composed of measures for prevention, detection, and mitigation, which requires a number of efforts in each phase of the point of interaction and the payment lifecycle: from participant participation (e.g. account opening) through authentication and authorization for a transaction to application of back office analysis and customer service.

4. **Saving Medicare for future generations.** The upcoming Medicare Trustees Report will undoubtedly show a continued financial disintegration. The worst-case scenario for the Hospital Insurance Trust Fund will likely show insolvency beginning in 2011. A sound roadmap to reverse this spiral was released by the National Bipartisan Commission on the Future of Medicare. Central pieces of that report have been implemented, most notably the prescription drug benefit, but others, particularly those that address long-term financing and solvency, have been ignored. Reviving many of these recommendations, along with new proposals, can save Medicare and ensure a vibrant, sustainable program for future generations. Solutions include:

- Combine Medicare Parts A and B into a single Medicare Trust Fund to more easily and openly estimate solvency and future accounting.
- Introduce premium support to stimulate competition among providers and private insurers, increase beneficiary choice, and place the program on sound financial footing.
- Limit general revenue to a fixed contribution to the program, indexed to economic growth, inflation, or another established factor.
- Introduce the same competitive features of the prescription drug benefit and the Medicare Advantage program to other areas, such as durable medical equipment and Part B drug pricing.
- Target assistance to lower- and moderate-income seniors.
- Incentivize beneficiaries to seek out Centers of Excellence that deliver the highest quality, lowest-cost care. Consumer demand will help address the egregious geographic variance in cost and quality.
- Allow Medicare private contracting so that beneficiaries and their doctors—not federal bureaucrats—can decide what care they should receive. Current law restricts beneficiaries from using their own money to pay for services that Medicare already covers.⁸ Medicare should be a floor, above which doctors, patients, and their families can decide what is best.

5. **Transforming Medicaid.**

- Eliminate the current open-ended federal match financing mechanism and replace it with a model that pays states a transparent amount of dollars based on the actual number of people in poverty. This focuses Medicaid dollars on people who are poor. If by everyone under 125% of FPL, for example, over 40 states would actually receive more money initially. You could also take Medicaid off autopilot by making in appropriated spending rather than mandatory spending. The benefits of this change include:

⁸ Robert E. Moffit, Ph.D., *Congress Should End the Confusion Over Medicare Private Contracting*, Heritage Foundation, Executive Summary #1347, 2000.

- Simpler administration and new, total transparency;
 - Poverty is an easy metric to measure, and states would be more constrained in their quest for more federal dollars, lest they be asked why poverty increased in their state;
 - States would be free to cover people above 125% FPL, but would have to use their own money. So their incentive would be to focus on the truly poor; and
 - States would have a genuine incentive to fight fraud, waste, and abuse because they would earn 100 percent of the benefit from doing so successfully.
- Require states to post all patient de-identified Medicaid claims data online for public access.
 - Require enhanced coordination of benefits to ensure individuals do not already have insurance coverage.
 - Require electronic funds transfer for provider payment to cut down on administrative inefficiencies.
 - Require biometric identification of beneficiaries to eliminate the ease of losing, duplicating, and abusing paper cards.
 - Require risk-based managed care for all Medicaid beneficiaries.

Expanding Insurance Coverage

1. **Giving states the flexibility to try new approaches to expand coverage.** Governors and legislators know their constituents and understand the special needs of their local communities far better than anyone at CMS. There is no one-size-fits-all solution to the uninsured, particularly because the reasons differ so greatly why some Americans are without insurance. Some of the uninsured can afford insurance but have chosen not to purchase it; some are temporarily uninsured because they have moved, lost a job, or their employer does not offer coverage anymore; while others are chronically uninsured and are, in essence, locked out of the system. States should have the ability to test new, innovative models that best meet their population's specific needs.

Solution: Pass legislation to fund state or multi-state collaborations to achieve 100% coverage through a flexible, transparent process. The Health Partnership Act, introduced in 2007, could be the basis of a program outside of Medicare and Medicaid that sets targets for improvements in coverage, cost, and quality.

2. **Helping small businesses.** The self-employed, small businesses, and other organizations do not have the ability to band together to purchase health insurance. This legal prohibition limits not only the freedom of private citizens to collectively organize, but creates an enormous barrier to obtaining health insurance.

Solution: Allow individuals and small businesses to pool together, giving these associations greater bargaining power for more affordable coverage.

- 3. Helping individuals and families.** A strong safety net and a vibrant private market are critical. But families are often caught in the middle because they earn too much to qualify for a public program but cannot afford private insurance on their own.

Solution: Extend a refundable and advanceable tax credit of \$2,500 and \$5,000 to low- and moderate-income individuals and families toward the purchase of private health coverage.

- 4. Extending personal responsibility to insurance.** Personal responsibility for one's health also extends to the purchase of health insurance. Citizens should not be able to cheat their neighbors by not buying or obtaining insurance, and expect others to pay for their care when they need it. Individuals should either purchase insurance that meets their individual needs or post a bond to opt out. This responsibility should be coupled with an equal responsibility for private insurers to issue a policy to anyone who applies, regardless of health status. However, these requirements are only acceptable when the larger healthcare system has been fundamentally changed. It is unjust to require an individual to buy into a broken and dysfunctional system.

- 5. Creating a nationwide individual market.** Currently, consumer choice of insurance plans is restricted to only those products licensed in each individual state, which are often dominated by one insurer. The absence of robust competition artificially inflates the cost of insurance preventing millions of citizens from purchasing affordable coverage. More competition among insurers in a nationwide market will encourage more creative products, better services and lower prices—just as it always does wherever competition thrives—and every American will be able to find affordable coverage. A study by researchers at the University of Minnesota concludes that open markets would expand coverage for up to 17 million Americans.⁹

Solution: Expand access to more affordable health insurance options by allowing individual consumers to purchase health insurance products licensed in other states to expand choice and bolster competition. Empower state insurance commissioners or legislatures with the ability to veto or exclude certain policies from sale; one idea would be to allow states to reject policies sold in up to 20 states, bringing about a “rush to the middle” and help develop a national consensus on minimum benefits that respects states' authority while expanding consumer choice. Require state insurance commissioners to

⁹ Stephen Parente, Roger Feldman, Jean Abraham, Yi Xu; *Consumer Response to a National Marketplace for Individual Insurance*; University of Minnesota; June 2008.

accept from each state at least one high-deductible health plan with a Health Savings Account.

Science, Investment, Jobs, and Savings

1. **Implementing science and investment-based budgeting with generation-long scoring.** Former NIH director Dr. Elias Zerhouni noted in recent testimony before the U.S. House and Senate that \$10 billion invested in basic research on HIV/AIDS between 1985 and 1995 saved the U.S. \$1.4 trillion in healthcare expenditures—a return of 140 to one. However, according to current scoring models, the \$10 billion would be scored as a cost, but the \$1.4 trillion saved would not be scored as savings. This kind of model must be replaced. Solutions include:

- Amending the 1974 Budget Act to create a science and technology based investment budget scored over a generation of return.
- Directing the National Academy of Sciences, the National Academy of Engineering, and the Institute of Medicine to develop annual, joint recommendations that include 1) an estimated level of return measured over a generation of investment; 2) an assessment of the ability of the science community to absorb additional resources in a productive manner; and 3) the benefits of such investments for the American people, the U.S. economy, and the science and technology communities.
- Requiring the annual development of this proposal to be done online in a transparent manner for continuing opportunities for citizens and experts to offer commentary and to file dissent.
- Ensuring that this annual investment budget should be scored separately from the current expenditures budget and should be passed by the budget committees based on initial submissions by the science committees and should have the effect of appropriations as passed.
- Modernizing the federal scoring covenants as outlined by OMB in *Circular No. A-11, Part 8*. These scoring principles bind all federal scorekeepers and cripple most any effort to enact real change. Section 14 states, “No increase in receipts or decrease in direct spending will be scored as a result of provisions of a law that provides direct spending for administrative or program management activities.” That means if savings are recouped by investing in technology to detect and prevent healthcare fraud, they will not be scored as savings. Federal investments in health IT that lead to administrative savings will also be seen as cost drivers—not cost savers.
- Require public transparency of all CBO and OMB scoring models.

An example of where this model can be applied is Alzheimer’s disease. The Alzheimer’s Study Group released a report in March 2009 that concluded, without a means of prevention, better treatment, or a cure, Alzheimer’s disease will afflict 10 million Americans from the Baby Boom generation and contribute

cumulative costs of almost \$20 trillion to Medicare and Medicaid by 2050.¹⁰ Changes in scoring models, such as generational scoring and investment-based bonds, will fund breakthroughs in research that will delay and ultimately prevent Alzheimer's disease. This will allow millions of Americans to live normal, high-quality lives and avoid the painful consequences of the disease, while at the same time saving taxpayers trillions of dollars.

Creating an Undersecretary of Commerce for Health to support innovation and promote job growth. A personal health system with electronic records and a process of continuous improvement will lead to more jobs and more economic growth. An Undersecretary of Commerce for Health should be created to ensure that: (1) regulations do not place unwarranted burdens on the industry; (2) foreign governments protect the intellectual property rights of U.S. companies and allow them fair access to their markets; and (3) the U.S. government enthusiastically and meaningfully promote the U.S. health sector in the international marketplace.

Conclusion

A health system that prioritizes individual health and wellness; delivers personalized, best practice care; and insures every American is possible. The changes and solutions outlined in this plan are the right reforms that can build such a future. By addressing health, quality, costs, and coverage:

We will not need to raise taxes. We can bring down healthcare costs and save billions of dollars by focusing on the right priorities.

We will not need to introduce a government-run plan into the private insurance market. Choice is more than a single government plan. Tax credits, open markets, and access to insurance for all will deliver many more choices at lower costs.

We will not need nor should we ever resort to government rationing of healthcare. More choices and higher quality will lower costs and empower consumers.

¹⁰ The Alzheimer's Study Group is a taskforce of national leaders charged with creating an Alzheimer's National Strategic Plan to overcome the mounting Alzheimer's crisis. Co-chaired by Newt Gingrich, former Speaker of the House and Founder of the Center for Health Transformation, and former Senator Bob Kerrey, the ASG released a final report on March 25, 2009, that assesses the adequacy of the country's current efforts to combat Alzheimer's and recommends strategies to accelerate progress toward defeating this terrible disease. More information, including the report, is available at www.alzstudygroup.org.

We will not need to create a National Health Insurance Exchange. More federal bureaucracy will not bring down costs or increase choice. Innovation in the states and a vibrant private market will.

We will not need to cut benefits in Medicare or cut eligibility for Medicaid. We can save future generations from crushing spending and debt by focusing on health, quality care, and efficiency.

We will not need to mandate that employers, including small businesses, provide health insurance. The right reforms that balance a robust private sector with effective public programs will give all Americans the financial resources and choices to get the coverage that is best for them and their families—without saddling small businesses.

Real change will not be easy. But with the right reforms—better health, more efficient delivery, sound public programs, and a competitive marketplace—we can and will transform health and healthcare in America.