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Getting the Facts Straight on Health Care Reform

Jonathan Gruber, Ph.D.

The United States stands on the verge of the most significant change to our health care system since the 1965 introduction of Medicare. The bill that was passed by the House and a parallel bill before the Senate would cover most uninsured Americans, saving thousands of lives each year and putting an end to our status as the only developed country that places so many of its citizens at risk for medical bankruptcy. Moreover, the bills would accomplish this aim while reducing the federal deficit over the next decade and beyond. They would reform insurance markets, lower administrative costs, increase people's insurance choices, and provide "insurance for the insured" by disallowing medical underwriting and the exclusion of preexisting conditions. And the Senate bill in particular would move us closer to taming the uncontrolled increase in health care spending that threatens to bankrupt our society.

Despite the many reasons to be excited about this legislative breakthrough, skeptics abound. Their criticism is only going to get louder as the bill is debated on the Senate floor over the next few weeks. But the primary criticisms of the bills are largely unwarranted.

One common refrain of opponents of reform is that it represents a government takeover of health care. But reformers made the key decision at the start of this process to eschew a government-driven redesign of our health care system in favor of building on the private insurance system that works for most Americans. The primary role of the government in this reform is as a financier of the tax credits that individuals will use to purchase health insurance from private companies through state-organized exchanges. In Massachusetts, which passed a similar reform in 2006, private health insurance has expanded dramatically. The public insurance alternative that is included in the Senate bill simply adds another competitor — on a level playing field — to the insurance market, and the Congressional Budget Office (CBO) projects that it will enroll only a tiny minority of Americans.[1]

A second criticism is that the bills are budget busters. This is simply incorrect. Both bills are completely paid for — indeed, both would reduce the deficit by more than $100 billion over the coming decade. And the CBO estimates that both would reduce the deficit even more in the long

run, particularly the Senate bill with its strong cost-containment measures.[1] Some argue that the bills won't reduce the deficit because Congress won't follow through on its cost-reduction plans, as it has failed to do with the sustainable-growth-rate program for Medicare's physician payments. But this one example has been ridiculously overused, given the sizable Medicare reductions that Congress has made in the past; the proposed reduction in Medicare spending is less than half of the percentage reduction enacted in 1997, for example.[2] To oppose a bill because of a misplaced fear that the government cannot keep its promises is essentially to shut down the legislative process.

In addition, some claim that the bills are an attack on Medicare and argue that it is unfair to pay for expanded coverage by reducing overpayments to hospitals and to the private insurers that offer Medicare Advantage plans. It's ironic that the people taking this position are often the same ones who make the first criticism (Medicare, after all, is a government-run insurance system) or the second (if the government will never follow through on its promises, we needn't worry about reduced payments). In any case, there is substantial evidence that reducing these overpayments will not harm the health of Medicare patients — just the pocketbooks of those who profit from them. This reform would simply use market bidding to set the reimbursement rate for Medicare Advantage plans, rather than setting administrative prices, which have traditionally been much too high; and it would reduce payments to hospitals by a small percentage, while tying them to outcome measures. Moreover, the dollars that are raised will save thousands of lives each year by increasing insurance coverage among the nonelderly.

The bills are also said to impose unaffordable mandates on individuals. Without the individual mandate, fundamental insurance-market reform is impossible and we cannot cover the majority of the uninsured. But an individual mandate without financial assistance for low-income families is unethical. Both bills contain billions of dollars in subsidies to help families pay for health insurance — and an exclusion from the mandate for families that still find coverage unaffordable. Rather than imposing an unaffordable mandate, these bills would finally guarantee that almost all Americans could find affordable insurance.

Some argue that the bills would harm the privately insured. But although a primary focus of reform has been on helping the uninsured, the bills also deliver enormous benefits to the privately insured. Americans who previously purchased insurance in an overpriced, unpredictable nongroup insurance market will have the ease and certainty of buying through an organized marketplace where insurance loads are lower, prices do not vary according to health status, and preexisting conditions cannot be excluded from coverage. CBO data show that the average enrollee in the new exchanges will either pay substantially less or obtain more generous coverage than the average person in today's nongroup insurance market.[3] Employees of small businesses that enroll in the exchange will also benefit from the lower prices and wide variety of health plan choices available to larger groups, and their employers will benefit from a small-business tax credit. Employees in large businesses will benefit from a shifting of their employers' money from excessively expensive insurance to increased wages. Most important for the insured, this reform will start us down the road to fundamental cost control, which will reduce costs for everyone in the long run.

Some critics also argue, however, that the bills don't do enough to control costs. This argument ignores fundamental reforms in the Senate bill in particular, which includes a four-pronged attack on health care costs. First, it imposes a tax on high-cost insurance plans that will put pressure on insurers and employers to keep the cost of insurance down, while delivering $234 billion in wage income to workers over the next decade.[4] Second, it includes funds and a structure for comparative-effectiveness research that will provide the information necessary to guide our health care system toward care that works and away from care that doesn't. Third, it establishes a Medicare advisory board with the power to set rates (subject to an up-or-down vote by Congress) if costs grow too rapidly. Finally, it sets up an innovation center within the Centers for Medicare and Medicaid Services and launches pilot projects to explore alternative reimbursement and organizational structures that could transform the delivery of care.

This argument also misses the important point that universal coverage is vital for cost control. Most of the reforms that are aimed at controlling costs work through changes in the ways in which insurers reimburse and or-

ganize care. These changes can't work if an ever-growing proportion of our population lacks insurance. Moreover, as we have seen in Massachusetts, dealing with the problem of the uninsured allows policymakers to focus more single-mindedly on cost control: after our universal-coverage law passed, the state moved aggressively to set up a cost-control commission that recommended important changes in provider reimbursement.[5]

The current bills are not perfect. The Senate bill has a mandate that's too weak and doesn't provide generous enough insurance to low-income individuals, and the House bill doesn't do enough to control costs. Nevertheless, passage of a hybrid of these bills would be a major accomplishment and a turning point for our dysfunctional health care system. We should constructively support Congress's efforts to create a combined bill, rather than leveling unsubstantiated criticisms from the sidelines.

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From the Massachusetts Institute of Technology, Cambridge.

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On Mammography — More Agreement Than Disagreement

Ann H. Partridge, M.D., M.P.H., and Eric P. Winer, M.D.

Breast cancer is the most common cancer in women in the United States, with more than 190,000 women receiving a diagnosis of invasive disease annually[1] and more than 40,000 dying of breast cancer each year. Worldwide, more than 1 million women are diagnosed with breast cancer and more than 500,000 die from it each year.[2] During the past two decades, there have been modest but real decreases in breast-cancer mortality that have been attributed to improvements in early detection and treatment. It is in this context that the recent controversy surrounding the optimal approach to breast-cancer screening should be considered.

On November 16, 2009, the U.S. Preventive Services Task Force (USPSTF) released updated recommendations for breast-cancer screening,[3] informed by additional follow-up from previous studies and a new study focused on statistical modeling.[4,5] The two most substantive and controversial recommendations were that mammography be eliminated as a "standard test" for women 40 to 49 years of age and that mammography be performed biennially rather than annually in women from 50 to 74 years of age.

The rationale for the changes was clearly delineated by the task force. Although mammography decreases breast-cancer mortality among women in their 40s, the absolute benefit is smaller than among older women, because the disease is less common in the younger age group. Younger women are also more likely to have false positive results, which lead to additional testing, anxiety, and psychological distress. For women in their 40s who are not at increased risk for breast cancer, the USPSTF recommends that the benefits of mammography be carefully weighed against the potential adverse consequences.

The recommendation for biennial rather than annual screening was based on the modeling study and cross-study comparisons suggesting that more frequent screening is not associated with better outcomes. Moreover, the panel concluded that the rate of false positive results appears to be much lower with biennial mammography.

The updated recommendations sparked substantial controversy and have had a polarizing effect in the breast-cancer community. There has been confusion, fear, and anger on the part of patients with breast cancer, their families, and women's health advocates. The intensity of the controversy