

**Testimony on Health Care Reform
before**

**The Health Subcommittee of the Committee on Energy and Commerce
U.S. House of Representatives**

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This testimony is presented on behalf of the physicians and staff of Marshfield Clinic, who thank you for conducting this hearing. We commend you for advancing the national health reform debate, and in particular, your commitment to enacting comprehensive health reform legislation this year. At Marshfield Clinic we have followed President Obama's campaign proposals for health system reform very closely. In particular, we believe the President is on the right track with his orientation towards not only improving the quality and efficiency of health care, but that reform cannot build upon the tragically flawed incentives of the current Medicare program. We strongly urge you and all members of this Committee to be as bold as possible with your reform proposals in addressing the problems of affordability, quality, and disparities in payment and access that plague the program.

Marshfield Clinic is the largest medical group practice in Wisconsin, and one of the largest in the United States, with 796 physicians, 6500 additional staff, and 3.6 million annual patient encounters. The Marshfield Clinic system includes 49 regional centers located in northern, central and western Wisconsin, predominantly rural areas. As a 501(c)(3) non-profit organization, Marshfield Clinic is a public trust, and serves all who seek care, regardless of their ability to pay. Although we are a regional system of care, we do have patients who come from virtually all 50 states, as well foreign countries. The Clinic serves multiple federally-designated Health Professional Shortage Areas (HPSAs) providing primary care, dental and mental health services in partnership with our community health center known as the Family Health Center at 13 medical and 4 dental locations in Wisconsin. Recently, we have begun to address critical shortages in dental services that bear a direct relationship on the overall health of the population we serve. Marshfield Clinic has developed and acquired sophisticated tools, technology, and other resources that complement and support the population health management mission and strategy of the Clinic. These include an internally-developed CCHIT-certified electronic medical record, a data warehouse, an immunization registry, and an epidemiological database that enable enhanced definitions of disease states, diagnoses or conditions, and cost analysis of CPT level interventions. Marshfield Clinic's 49 regional centers are fully electronic, paperless, and linked by common information systems. With this infrastructure, the Clinic is presently publicly reporting clinical outcomes, and providing physicians and staff quality improvement tools to analyze their clinical and business processes, eliminate waste and unnecessary redundancies, and improve consistency while simultaneously reducing unnecessary costs.

Marshfield Clinic has long used information systems to facilitate care process redesign for patients with chronic illnesses, and the organization expanded its efforts after becoming a participant in the Center for Medicare and Medicaid Services (CMS) Physician Group Practice (PGP) Demonstration project. As a result of these expanded efforts, Marshfield Clinic reduced hospitalizations and costs, and has achieved significant savings for the Medicare program. By using and integrating EHR tools into rationally designed care and care measurement processes, the Clinic has saved CMS over \$25 million in the first two years of this demonstration, while meeting or exceeding 27 out of 27 possible quality metrics. Results of the third year of the demonstration have yet to be released by the

Agency, but leave it to say that our internalized care management processes are demonstrably effective, enhanced through HIT applications, resulting in measurably improved patient outcomes, substantially reduced hospitalizations and profound savings for the Medicare program. We believe that equivalent or better performance by other organizations such as Accountable Care Organizations is imminently achievable and likely if Congress and CMS would take the big leap to appropriately align the incentives of Medicare program reimbursement around value and efficiency. We have made administrative decisions that prioritize the better understanding of healthcare delivery. In addition to rich data-mining processes, we are investing in bioinformatics and a center for healthcare intelligence. These, along with our Personalized Medicine project, will be the cornerstones of how Marshfield Clinic will make a difference in providing high quality, cost-effective care in the future.

Marshfield Clinic also owns and operates Security Health Plan (SHP) of Wisconsin, a physician-sponsored health maintenance organization, which serves more than more than 168,000 people in a 32-county area in northern, western and central Wisconsin, with a network of 42 affiliated hospitals, more than 4,100 affiliated physicians and other providers, and over 55,000 pharmacies nationwide. SHP is the third largest health maintenance organization in Wisconsin and provides insured and self-funded plans to a variety of large and small employers, as well as to individuals and families. SHP has been named to the U.S. News & World Report/America's Best Health Plans (1) ranking for four consecutive years and is accredited by the National Committee for Quality Assurance (NCQA). In November 2008, SHP was named the nation's 19th best commercial health plan and the 5th best Medicare plan by U.S. News & World Report.

Public Health Insurance Option

In the current Tri-Committee mark, unveiled last week, you have proposed the establishment of a Public Health Insurance Option available through a Health Insurance Exchange that would be capitalized by the US Treasury. Providers who voluntarily participate in Medicare would be required to participate in the public option, and would be paid at Medicare rates, and in some circumstances, Medicare plus 5% for the first three years of operation of the Public Plan. Under these circumstances the public plan would have a significant competitive advantage over private plans in localities where commercial rates are greater than Medicare rates. This raises substantial serious financial and ethical questions around how the federal government could ever compel physicians to see those patients. For instance, would this mean that patients must be seen when they present, or would providers be compelled to see the patient within a certain time frame?

If the public plan pays its providers for services at Medicare rates it could operate more efficiently than Security Health Plan (SHP) Marshfield Clinic's insurance subsidiary. As patients migrated from our plan to the lower cost public plan, the combined reductions in commercial service revenue, and premiums would compel restructuring of both Marshfield Clinic and Security Health Plan. As such, Marshfield Clinic and SHP strongly oppose this public plan alternative, based on the belief that a level playing field could never exist between public and private providers/insurers. In localities where Medicare rates are higher than commercial rates, the commercial plans would have a competitive advantage. In Wisconsin, however, where commercial rates vary between 180% and 280% of Medicare rates the public plan would have such a profound competitive advantage that providers would uniformly abandon the Medicare program to survive in the practice of medicine.

Further, there is a significant problem with Medicare payment rates in Wisconsin, as well as the entire Midwestern US. By our calculations the Medicare program currently reimburses the Clinic at 51.6% of its Medicare allowable costs, and other providers within Wisconsin and other Midwestern states report a similar inequity in Medicare reimbursements. If all services provided by the Clinic were provided at Medicare payment rates we calculate that the Clinic's current \$900 million revenue stream would collapse by more than \$ 400 million.

As a not-for-profit 501 (c) 3 institution Marshfield Clinic accepts and treats all patients regardless of their ability to pay. As one might expect, other providers in our Wisconsin service areas are reluctant to see Medicare patients or

accept referrals unless the patients require services that are more highly compensated under Medicare's flawed and regionally variable reimbursement systems. As a result, Clinic encounters for the publicly financed health care population have risen dramatically. While Marshfield Clinic physicians and practitioners make up about one-third of the provider population in our service area, we treat 60 - 70% of the Medicare population. In the same counties we also presently treat 60- 90% of the Medicaid population. Medicaid in Wisconsin reimburses the Clinic at about 48% of our costs. If the public plan could compel other providers to participate in the Medicare program some of our expected losses would be attenuated as other providers in our area us opened their doors to more Medicare patients. If a public plan were created and paid providers based on Medicare rates, or even Medicare plus 10%, Marshfield Clinic would be at risk in terms of its long-term viability. Specifically, as revenues decline we would be compelled to furlough physicians and staff, and close facilities – reducing patient access to care.

We believe that this problem is attributable to the inaccuracy of Medicare's formulas for reimbursing for physician work and practice expense, and Medicare's geographic adjustment of these portions of Medicare payment. At current Medicare rates even a 20 percent increase in Medicare reimbursement yields a payment that would only cover 61.9 percent of our costs. To address these systemic problems we believe that Congress and CMS must refine Medicare payment systems to address the systemic access problems and encourage appropriate clinical care by proving incentives that focus on quality and efficiency.

We also have a number of concerns related to the practice expense (PE) Geographic Practice Cost Index (GPCI) that have direct implications for equitable compensation of physicians under the Medicare fee schedule. We are concerned that the data used to estimate non-physician wages in the current PE GPCI do not properly reflect prevailing relative wage rates for the index occupational groups. We are also concerned that the composition of the PE GPCI, especially the non-physician wage component, is outdated and does not adequately reflect prevailing practice organization realities. Both of these have the potential to distort practice-related expense payments across localities, resulting in the Medicare program paying too much in some localities and too little in others.

Reform of Physician Payment and the Sustainable Growth Rate (SGR) Formula

In Section 1121 of the current Tri-Committee mark, the authors propose to revise the SGR formula via updates in reimbursement for physician services in a manner that will promote primary care and care coordination. The proposal would rebase the SGR using 2009 as the cumulative adjustment period. This would in effect wipe the physician slate clean and repeal the 20% cut expected in 2010. The proposal would divide physician services into two categories: 1) Evaluation and Management services, including primary care and preventive services identified by codes which will be annually subject an expenditure target and growth rate update of GDP + 2%; and 2) All other services identified by codes which will be annually subject an expenditure target and growth rate update of GDP + 1%. In addition the proposal establishes new Accountable Care Organizations (ACOs) similar to the Physician Group Practice Demonstration model that will be separate from the general physician pool and updating categories. This will allow groups of physicians who qualify as an ACO to be measured for their quality and performance on their own merits separate from the larger pool of all other physicians.

Marshfield Clinic commends you for this innovative proposal. We appreciate it for a number of reasons. Rebasings the SGR updating period will eliminate some of the budgeting uncertainty that we have been subject to since physician payment reforms were initiated in 1992. In addition, the segregation of evaluation and management services into a separate bucket will favor primary care over specialty services – reversing the trend that has reduced primary care payment since 1992.

Members such as Chairman Waxman and Rep. Dingell who were on the Commerce Committee that enacted Physician Payment Reform as section 6102 of the Omnibus Budget Reconciliation Act of 1989 will recall that under the Medicare Volume Performance Standard provisions of the Resource-based Relative Value Scale (RBRVS) there were then two buckets of services: 1) Primary Care, which included diagnostics and other ancillary services and 2) Specialty Services. While the congressional intent of RBRVS was to promote primary care and

cognitive service over specialty services, the exact opposite happened, and primary care has suffered ever since. The change that you are recommending today was needed 20 years ago.

Chairman Waxman and Rep. Dingell may also recall that former HHS Secretary Louis Sullivan who was in possession of longstanding research data that demonstrated the greater efficacy and efficiency of multi-specialty physician group practices recommended that they be considered separately for annual payment updates. This provision was opposed by the American Medical Association so Secretary Sullivan's recommendation was amended to become a "Study of Volume Performance Standard Rates of Increase by Geography, Specialty and Type of Service." In the study, the Secretary of HHS was required to "report to Congress on the development of criteria to allow qualified physician groups to opt-out of the national aggregate performance rates of increase and to have separate performance standards." A subsequent study was performed by Stan Wallack, Ph.D, and Christopher Tompkins, Ph.D. of the Institute for Health Policy at Brandeis University and led to the establishment of the Physician Group Practice (PGP) Demonstration in the Benefits, Improvement and Protection Act of 2000 (BIPA), and now 20 years later, we have come full circle to Secretary Sullivan's original proposal. It is a shame that we have wasted 20 years demonstrating the wisdom of Garrett Hardin's understanding of the Tragedy of the Commons. The beauty of this proposal, however, is that physicians will quickly realize that it is disadvantageous to be in the common pool. Consequently, the proposal has the potential to steer physicians towards efficient, integrated multi-specialty practice arrangements that would otherwise be incentivized to behave in the public interest. We believe that if Congress couples this proposal with more aggressive reforms that we suggest below, dramatic score-able reductions in the rate of increase in the cost of Medicare services might be achieved.

Marshfield Clinic believes that, as a part of an American commitment to greater value in health care, there is a role for greater accountability among providers. Our experience as a participant in the Medicare Physician Practice Group demonstration project has shown that physician group practices, utilizing population-based care management strategies, and tools like HIT, can achieve better coordination of care at lower costs. However, we have concerns that the criteria for participation in Accountable Care Organizations may be too restrictive to incentivize provider enrollment. Spending targets based upon expected national growth rates will favor the creation of ACOs in high payment localities, but will discourage participation in localities where the culture of medical practice is already conservative. Eligibility thresholds should be structured to maximize physician interest and capitalize participation in delivery reform, and incentive payments should be actuarially sound and risk adjusted based upon complete and accurate coding. These principles will sustain progress toward delivery system reform. Anything less will discourage providers and thwart your laudable objectives.

Reform Must Reward Value

As one of several organizations recognized in recent press accounts in the *New Yorker*, the *New York Times*, and the *Washington Post*, and in research published by Dartmouth School of Medicine as a center of high quality and efficient health care, we believe that health reform must reward value. Marshfield Clinic has addressed multiple challenges regarding quality and variations in care, demonstrating that proposals that shift payment for outcomes can be successful while providing a high level of care to Medicare recipients. The success of health reform rests on providing incentives that emulate this proven performance.

Research has demonstrated that throughout the U.S. there is costly and unjustified variation in the utilization and provision of health care services. In a number of recent addresses, President Obama has called attention to the huge geographic variations in Medicare spending per beneficiary. In the President's own words, "This is what we've got to fix."

Wisconsin Senator Russ Feingold and eleven of his colleagues have called attention to the same problem, asking Senate Finance Committee Chairman Max Baucus and Ranking Member Charles Grassley to provide incentives to healthcare systems that coordinate care and utilize aggressive quality controls to provide Medicare beneficiaries better care for lower cost, and to protect "high efficiency" providers from payment cuts. Chairman David Obey,

who represents Marshfield and central Wisconsin recently told HHS Secretary Sebelius that Medicare “reimbursement disparities are outrageous in my view and I would just hope that the people putting this bill together will understand that they would make a big mistake if they take for granted the support of people from states like Wisconsin or Minnesota if this outrageous disparity in reimbursements isn't corrected to a significant degree. Our states feel like we've been taken for suckers for years. Those outrageous disparities are just going to have to shrink significantly if we're going to get a product that everybody can support.”

As the country's single largest purchaser of health care, Medicare can have a profound influence on the entire health care system. Yet, Medicare's fee-for-service (FFS) payment systems continue to reward inefficiency and poor quality, paying many health care providers much more than what it pays the most efficient and effective providers to treat the chronically-ill – individuals that represent less than a quarter of the Medicare population (20%) but account for a growing and disproportionate share of Medicare spending (75%). *If the US health care system mirrored the practice patterns of the most efficient and effective health care providers, Medicare could save billions of dollars annually.*

Problem: Misaligned Financial Incentives – More Care Does Not Equal Better Care

Research has long-documented glaring variations in the distribution and utilization of U.S. medical resources. The Dartmouth Atlas of Health Care depicts wide variation in the cost of care. Center researchers who produce the Atlas have documented how Medicare and other payers encourage the over-use of acute-care hospital services and the proliferation of medical specialists through misaligned financial incentives, especially for treating chronically-ill people. A recent report by the Congressional Budget Office (CBO) further supports this notion generally, indicating that spending in high-spending regions could be reduced without producing worse outcomes, on average, or reductions in the quality of care (CBO - February 2008). The extent of variation in Medicare spending, and the evidence that more care does not necessarily result in better outcomes, leads us to ask if some chronically-ill Americans are receiving more care than they actually want or need.

Recommendation: Paying for Value in Medicare – Physician Fee Schedule and Hospital Payment Reforms
Medicare currently reimburses physicians under the Physician Fee Schedule (PFS) on the basis of: (1) the amount of work required to provide a service; (2) practice expenses related to maintaining a practice; and (3) medical liability insurance costs. Under such system, Medicare rewards physicians based on the volume of services provided without any regard to quality. In addition, the formulas by which Medicare's payments are calculated are widely variable throughout Medicare localities and are based upon outdated data assumptions regarding the cost and organization of medical practice. Mis-measurement of the cost of providing services by the Medicare program leads to systemic inequities in reimbursement that have created access problems throughout the country but especially in rural areas.

A crucial first step to addressing these problems begins with modest changes to Medicare's current payment methodologies:

- **Rewarding Value in the Reimbursement System** – Congress must introduce a “value index” into Medicare Parts A and B, to reward physicians and hospitals who provide safe, high quality care with excellent service to Medicare patients at a reasonable cost. The value index can be constructed for many types of payment models, including hospital DRG payments, physician fees, payment updates, and other payment formulas. We recommend that the geographic adjustment of physician work should be eliminated as recommended in legislation introduced by Senator Feingold (S 712) and Senator Grassley (S 318), and replaced with a quality/efficiency based coefficient for physician work as soon as possible. Legislation that we strongly support and would accomplish this objective, has been introduced by Iowa Rep. Bruce Braley and Wisconsin Rep. Ron Kind in the House and by Minnesota Senator Amy Klobuchar and Wisconsin Senators Feingold and Kohl in the Senate. The Medicare Payment Improvement Act (HR 2844, S 1249) seeks to reform the Medicare system to one that rewards the value of care over quantity of procedures, improving quality and lowering the

total cost of care over time. The bill's outcome-based approach creates the incentive for physicians and hospitals to work together to improve quality and use resources efficiently. According to a study by the McKinsey Institute, fee-for-service reimbursement, the predominant method in outpatient treatment, actually gives providers strong financial incentives to provide more, and more costly, care, not more value. Under the Act, medical professionals who produce more volume will need to take steps to also improve care, or the increased volume will negatively impact reimbursements they receive from Medicare.

- **Practice Expense Payment Floor** – Congress must require the Centers for Medicare & Medicaid Services (CMS) to administratively revise its measurement of the cost of practice to assure the validity and fairness of payment. However, in the interim, a payment floor must be established for practice expense to stem the inequities of the current methodology as proposed by Reps. Braley and Kind in HR 2201, the Medicare Equity and Accessibility Act of 2009. Extreme variation induced by errors in the payment methodology may also be reduced without compromising the relativity of payment by establishing a geographic practice expense index that limits to ½ the difference between relative wages and rents between fee schedule areas and the national average as proposed by Senator Grassley in S 318.

We believe that Congress must refine Medicare payment systems to address the systemic access problems that plague rural areas and encourage appropriate clinical care nationwide by proving incentives that focus on quality and efficiency. If doctors and hospitals have incentives to provide the best care instead of more care, we can help Americans avoid the unnecessary hospital stays, treatments, and tests that drive up costs.

Payments for Efficient Areas and Primary Care Bonuses

In Section 1123 of the current Tri-Committee mark, it is proposed that there would be established an Incentive Payment(s) for Efficient Areas. Specifically, this proposal recommends a 5 percent bonus payment for suppliers of physician services in the 5 digit postal ZIP codes where the Secretary of HHS has determined that the per capita spending for services provided falls within the lowest fifth percentile for utilization. We believe that this proposal will modestly improve the circumstances of physicians in those localities. We do not believe that this will be an adequate stimulus to recruit new providers to these areas, even when they are coupled with the additional 5 percent Primary Care bonuses for Family Physicians, Internists, Pediatricians, and Geriatricians and the additional 5 percent if these specialties are practicing in Health Professional Shortage Areas.

Similar provisions were included in the Omnibus Budget Reconciliation Act of 1989 and did not reverse or improve the problems of access in rural and underserved areas. The problem that we urge you to address is that Medicare payment does not cover the cost of providing services. This is especially critical in rural areas, where Medicare and Medicaid patient encounters are a significantly larger proportion of physician practices than in more demographically homogenous areas. Rural physicians have more Medicare patient visits per week than their urban counterparts. In addition, the greater volume of Medicare patient visits among rural county physicians is largely true across all non-surgery service settings (such as office and hospital). Rural county physicians are more dependent on public insurers for revenue. This data, compiled by Mark Miller and Stephen Zuckerman of the Urban Institute in Health Affairs, (Winter 1991) also showed **“no significant difference in average total practice expenses between urban and rural locations, again even after controlling for specialty.”** At that time policy makers presumed that the physician payment reform would lead to improved reimbursement for rural and primary care physicians. As we have seen, this never occurred. Miller and Zuckerman (and others quoted in the article) observed that **“Rural physicians now have lower fees but a higher volume of Medicare services, as measured by patient visits, than urban physicians have. This higher volume could be composed of either more patients or more visits per patient. Dor and Holahan found that volume per beneficiary was lower in rural areas. Thus we believe that the higher Medicare volume per rural physician is the result of each physician’s seeing more patients, not providing more services per patient.”** Medicare payments between rural and urban localities vary by more than 30%. If the underlying cost of providing the services is the same, what is the policy justification for the variation in payment?

Adjustment to Medicare Payment Localities for California

In section 1125 of the current Tri-Committee mark, we note that the authors propose addressing the problem of geographic disparities in reimbursement via a proposal authored by your colleague, Rep. Sam Farr of California. We support this request which smooths reimbursement between localities that share identical cost burdens. We believe that this concept should only be applied if it can be applied nationwide to smooth the disparities in reimbursement between urban and rural localities that experience identical practice costs. This simplification might eliminate the complexities of administering 89 separate payment localities across the nation.

Medicare Advantage Reforms

In Section 1161 of the current Tri-Committee mark, the authors propose the phase-in of Medicare Advantage payment rates based on fee-for-service costs beginning in 2011 and completed in 2012. Marshfield Clinic supports parity in reimbursement between traditional fee for service and the Medicare Advantage program. However we believe that this will only result in fair premiums for beneficiaries, equivalent benefits for patients, and fair treatment for providers when the disparities in Medicare reimbursement have been addressed nationwide. Currently the taxes of individuals in low payment areas of the country are subsidizing zero premium plans with generous benefit structures in the high payment localities. This cross-subsidization is one more example of well intended health policies that have been implemented to benefit the wealthy and powerful localities at the expense of the less powerful. We recommend that Congress take steps to correct the inequities between localities.

In addition we commend the authors for including quality bonus payments and improved quality plan adjustments for high performance health plans.

Payments for Care at the End of Life

We believe that significant patient satisfaction and cost savings may be obtained by providing appropriate end of life counseling and care. In order to properly implement such programs on a nationwide basis, providers should receive payment for the use of advanced care planning tools for the chronically ill in their last two years of life. Such a payment mechanism should account for the time and resources of physicians and mid-level practitioners to counsel patients and document an end life care plan using an advance directive, health care power of attorney, or physicians order for life sustaining treatment. This documentation should be portable and accessible to all providers involved in the patient's continuum of care. Finally, provider's compliance with the documented plan of care should be measured and appropriately incentivized. We believe that when properly implemented, end of life care plans have the potential to significantly improve the quality and cost effectiveness of the health care system.

Comparative Effectiveness Research

Marshfield Clinic commends you for your emphasis on comparative effectiveness research on drugs, devices, treatments and other medical interventions centered at the Agency for Health Research and Quality though we respectfully recommend that you increase the funding and accelerate the timetable for implementation of the research agenda. We applaud your establishment of national priorities for performance improvement that focus upon prevalent high-cost chronic diseases, improve patient-centeredness, address variations in care and health disparities across groups and areas, and have the potential for rapid improvement due to existing evidence and standards of care.

Physician Payment Sunshine Act

Marshfield Clinic strongly supports the physician payment transparency proposal. It is the policy of the Clinic and our insurance subsidiary Security Health Plan not to accept gifts or gratuities of any type or value. Individuals who accept gifts or gratuities as agents or employees of MC/SHP are subject to discipline, including termination.

Redistribution of Unused GME Slots

Marshfield Clinic is concerned about having a sufficient supply of primary care physicians in order to meet the demands of an expanding and aging population. This is doubly true for patients and health systems in a rural setting. Currently only about 10% of physicians practice in rural areas while 25% of the population resides there. While 36% allopathic residents and 50% osteopathic residents who are trained in a rural residency end up practicing in a rural area, a recent report by Chen et al [2008] identified that only 4% of the residency training [based on FTEs] actually occurs in rural areas.

An increase in graduate medical education [GME] primary care training positions [be they rural or not] is essential to maintaining high-quality, accessible, and cost efficient care. With its longstanding history of providing GME, Marshfield Clinic supports your proposed recommendations to expand primary care training. A national healthcare workforce strategy should be a part of this process. As a rural community based GME partner, Marshfield Clinic would welcome an opportunity to collaborate with Health and Human Services and other external GME partners in developing and implementing such a strategy.

Payment for Transitional Care Activities

We think payment for transitional care activities and other services that are not paid for under the fee schedule today but demonstrate value to Medicare patients is an important part of the Tri-Committee proposal. Payment for certain care coordination services for chronically ill patients would be a critical component of a policy focused upon improving the quality and efficiency of care processes, and we applaud your efforts to address this important area of concern. We also respectfully ask that the Committee consider ways in which CMS could further promote care for patients with chronic health conditions through greater use of telephonic care assessment and management, coaching, education, and self management support to patients provided by registered nurses in rural areas.

We appreciate the opportunity to share our views regarding health care and delivery system reform. We commend you and your diligent and capable staff for addressing this public challenge and shouldering this responsibility. We look forward to the opportunity to assist you with the resources of the Clinic as you pursue this legislation, moving it to a meaningful resolution.