

STATEMENT OF
DAVID MERRITT
PROJECT DIRECTOR, CENTER FOR HEALTH TRANSFORMATION*
BEFORE THE GEORGIA STATE SENATE
HEALTH CARE TRANSFORMATION STUDY COMMITTEE
NOVEMBER 26, 2007

* The Center for Health Transformation (CHT), founded and led by former Speaker Newt Gingrich, is a collaboration of leaders dedicated to the creation of a 21st Century Intelligent Health System that saves lives and saves money for all Americans. CHT members highlighted in this testimony include Microsoft, WellPoint, UnitedHealth Group, UPS, WellStar Health System, AT&T, Southern Company, American Academy of Family Physicians, and Blue Cross Blue Shield of Georgia. For more information on the Center, please visit www.healthtransformation.net.

Chairman Hill and members of the Georgia Senate Health Care Study Committee:

Thank you for the opportunity to speak with you today about transforming health and healthcare, with a particular focus on new solutions to expand health insurance coverage to all Americans.

Let me state unequivocally: We can get to 100% insurance coverage, but it will take bold, transformational, and collaborative solutions.

That's what we at the Center for Health Transformation are devoted to creating: a 21st Century Intelligent Health System that brings more choices of greater quality at lower costs to every American. And there are things that we must do as individuals, as communities, as states, and as a country to get there.

Why We Must Be Bold

As a nation, key quality indicators continue to show little improvement or even decline. The rates of obesity and diabetes are on rapidly increasing, and the real threat of preventable medical errors remains a dangerous reality for millions of Americans. And we spend a staggering amount of money for these outcomes. Just to put the size and scope of our healthcare system in context, think of it this way: last year we spent \$2 trillion or 16% of our entire economy on healthcare—this is almost the entire gross domestic product of France, Britain, or China. Our annual healthcare spending almost doubles the entire economy of Canada. Just what we spend on healthcare is larger than the gross domestic product of 175 nations.

And healthcare costs continue to rise. According to the Centers for Medicare and Medicaid Services, last year was a good year, when healthcare costs rose “only” 6.8 percent.¹ CMS projects that within the decade, by 2016, total healthcare spending will more than double to \$4.1 trillion a year and consume 19.6 percent of our GDP.² As a country, we cannot sustain our current path.

States are not immune from the burden of healthcare. Both as employers and as insurers through SCHIP and Medicaid, states pay the price of our current system. For example, the state of Florida spends about 25 percent of its budget on Medicaid. Former Florida Governor Jeb Bush told us at the Center for Health Transformation that if nothing changes, ten years from now Medicaid will consume 59 percent of all state revenue. This will crowd out every other priority, including education, transportation, law enforcement, and others. As states, we cannot sustain our current path.

¹ “Health Spending Projections Through 2016: Modest Changes Obscure Part D’s Impact.” Poisal et al. *Health Affairs*. 2007; 26: w242-w253.

² Centers for Medicare and Medicaid Services, Office of the Actuary: *National Health Expenditure Projections 2006-2016*. 2006

Individuals fare no better. According to the Institute of Medicine, individuals average one medication error every day they stay in a hospital—1.5 million medication errors every year.³ According to the Kaiser Family Foundation, between 2000 and 2007 health insurance premiums skyrocketed 87 percent. Over the same period, inflation rose by 18 percent and wages grew by only 20 percent.⁴ In addition, the number of Americans without insurance is also on the rise. According to a recent report by the Census Bureau, a record 47 million Americans lack health insurance.⁵

Not all of these folks are in this predicament for the same reason. The same Census Bureau report shows that there are 15 million Americans who are uninsured but earn more than \$50,000 a year. Many have chosen not to purchase health insurance.

There are approximately 15 million other Americans who do not have health insurance because they have moved, lost a job, or their employer does not offer coverage anymore. Most of these folks ultimately get coverage, but if you were to walk in their shoes—or anyone without health insurance—it is a sad situation. They live in fear every day. Fear that their child will get sick but cannot see a doctor. Fear that their spouse will have a serious accident that prevents them from working. And the constant fear that they are one step away from medical bankruptcy.

The same goes for people who are denied coverage or who cannot afford insurance but earn too much to qualify for a public program. As a result, they have virtually no access to a primary care doctor, will likely be sicker, and may die needlessly. The Institute of Medicine estimates that the lack of health insurance actually kills 18,000 Americans every year.⁶

Right here in Georgia, the crisis of the uninsured affects every Georgian, even those who are insured. Every citizen who has health insurance pays a hidden tax to cover the cost of delivering care to the uninsured. After all people without insurance still need and ultimately do get medical care, but it is often in an emergency department, the most expensive healthcare setting one can find. The cost of this care is passed along to those who do have insurance in the form of higher insurance premiums. Ken Thorpe of Emory University estimates that in 2010 these higher premiums for those with insurance will total \$1.8 billion in Georgia—more than \$1200 for every insured family in Georgia.⁷ As individuals and families, we cannot sustain our current path.

We should not accept such failure.

³ Institute of Medicine, *Preventing Medication Errors*, 2006.

⁴ Kaiser Family Foundation and the Health Research and Educational Trust, *Employer Health Benefits: 2006 Survey*.

⁵ U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2006*. August 2007.

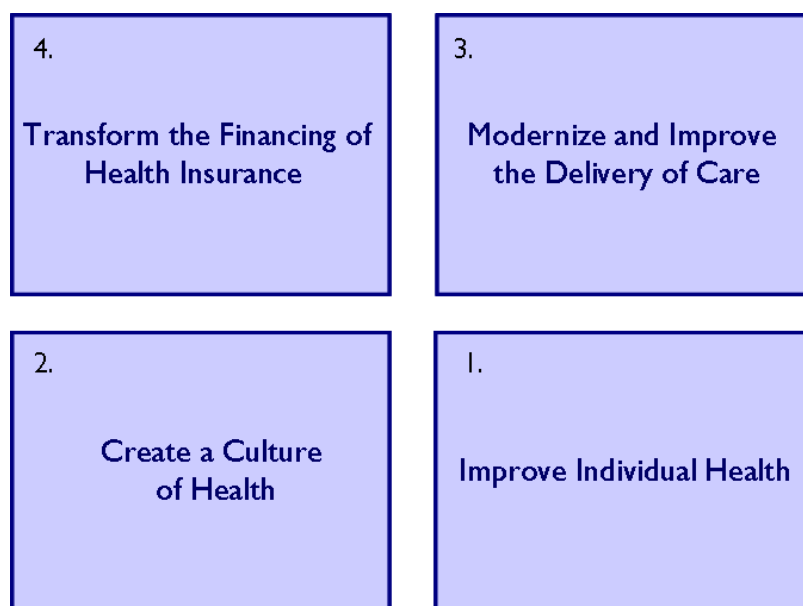
⁶ Institute of Medicine, *Insuring America's Health: Principles and Recommendations*. January, 2004.

⁷ Kenneth Thorpe, *Paying a Premium: The Added Cost of Care for the Uninsured*, Families USA Publication No. 05-101, June 2005.

We can get to 100% insurance coverage, but it will take bold, transformational solutions. This requires collaboration, consensus, and action from everyone—from employers, providers, insurers, and citizens to policymakers of both parties.

However, what has been proposed so far by presidential candidates, trade associations, think tanks, and others is typically more of the same tired financing we have seen many times before. They try to cover the uninsured within the current system, which is akin to building a house on quicksand. They have nary a word on how to make healthcare more affordable—and that is why they will all fail.

The uninsured crisis is a symptom of the larger structural problem of rising healthcare costs. As in medicine, we must cure the disease, not just alleviate its symptoms. By driving down costs and making healthcare more affordable for every American, we can achieve 100% coverage. But to get there, we must implement four transformational changes.



Improve Individual Health

First, we must focus on health first—then healthcare—and individuals must take an active role in becoming healthier. The Centers for Disease Control and Prevention report that 64 percent of adults are either overweight or obese.⁸ The CDC also reported that diabetes is a major factor in killing more than 220,000

⁸ 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>

Americans every year.⁹ 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. Individuals must be incentivized to improve their health and prevent disease by making more responsible decisions. This can be done through closer relationships with their physicians, proper education, and through wellness programs that reward healthy living.

For example, Blue Cross Blue Shield of Michigan introduced Healthy Blue Living, where individuals can save 10% or more on their premiums, co-payments, and deductibles if they work with their physician, exercise, eat right, control chronic conditions, and do not smoke. My in-laws are enrolled in this health plan, and they have saved a significant amount of money—while becoming healthier.

Under former Governor Jeb Bush, Florida Medicaid introduced a radical approach to incentivize beneficiaries to focus on their health. Medicaid members could earn credits, up to \$125 in value, if they met certain goals, such as preventive care maintenance, immunizations, and completing health screenings.

UnitedHealthcare has introduced a product called Vital Measures, where individuals with a Health Savings Account can earn up to \$2000 towards their annual deductible, typically \$2500, if they meet certain health benchmarks.

These examples are the exception, not the rule. State and federal law often stands in the way of making these types of plans the norm. We must reform state and federal rules, HIPAA most notably, to give private health plans, including those that participate in Medicaid and Medicare, more latitude to design insurance products to encourage and reward individual healthy behaviors.

We must establish new models of care and payment that make health and wellness a priority. The American Academy of Family Physicians and others have advocated the “medical home” model. This approach strengthens the doctor-patient relationship by focusing both the consumer and the physician on improving individual health. Primary care physicians deliver care that focuses on wellness, early intervention, and the prevention of chronic illness, in addition to acute illness as necessary. In addition to this focus on wellness, another hallmark of the medical home concept is for physicians to help coordinate the services that consumers receive in other sectors of the health system.

North Carolina’s Medicaid program spent \$20 million in payments to 3,500 primary care physicians who transformed their practices to participate in a medical home pilot. Through reduced hospitalizations, better control of chronic disease, and the reduction of complications, this investment saved Medicaid more than \$231 million in 2005 and 2006.

We must also give consumers the tools with which to better manage their health. The use of personal health records can be portals to health education, cost and

⁹ Centers for Disease Control and Prevention, National Diabetes Fact Sheet, 2003.
<http://www.cdc.gov/diabetes/pubs/factsheet.htm>

quality data, and personal health histories, and these kinds of online tools can bring to healthcare the kind of technology that we know in every other aspect of our lives. Personal health records can deliver:

- Wellness and education content
- Better understanding of treatment options
- Connectivity with doctors
- 24/7 online access to personal health information
- Cost and performance data on physicians, hospitals, and insurers
- Emergency information, such as family contacts, allergies, current medications, medical history

The Wall Street Journal released a survey last year that asked, “Which of the following technologies would you like to have access to when seeking care from a doctor or hospital?” 74% of respondents said they would like to use email to communicate directly with their doctor; 75% said they would like the ability to schedule a doctor's visit online; 67% said they would like to receive the results of diagnostic tests via email; and 77% said they would like to receive email reminders from their doctors.¹⁰

But when asked if they had access to these services, the vast majority of consumers said they do not. 92% of the public cannot email their doctor; 93% cannot schedule an appointment online; 95% of consumers cannot get their lab results online; 93% do not receive email reminders from their doctors.

When it comes to information technology, consumers are ready, but the system is not. That is why we welcome any and all innovations to engage consumers with information technology. From Microsoft to health insurers to physician-driven portals, public and private institutions must find effective ways to engage consumers to improve their health—and technology can play an important role.

Create a Culture of Health

Second, we must create a culture of health that encourages more responsible individual choices. We can do this by redesigning how public and private institutions influence individual behavior, and nowhere is this needed more than in public education.

The CDC reports that nearly 80% of students—40 million of them—do not eat the recommended five servings of fruits and vegetables a day, and only one in three high school students participate in daily physical education.¹¹ As a result, the number of obese children has tripled since 1980.¹² We can correct this course

¹⁰ Wall Street Journal Online-Harris Interactive Poll, September 2006.

¹¹ Centers for Disease Control and Prevention, *Healthy Youth: An Investment in Our Nation's Future* 2007

¹² Centers for Disease Control and Prevention, National Center for Health Statistics, *Prevalence of Overweight Among Children and Adolescents: United States, 1999-2002*. 2004.

with smart policies that give children an encouraging environment to be healthier and active.

For instance, physical education five days a week should be required for every student in grades K through 12. Individual student health reports, including weight and body mass index, should be collected and sent home to parents, along with relevant educational material. School lunches, breakfasts, and vending machines should promote healthy foods, so that unhealthy alternatives are penalized or prohibited. The University of Virginia Health System has an innovative program that prices and color codes snacks according to their health value in all vending machines and cafeterias.¹³

Another example is Somerville, Massachusetts. This community should be a model for all others to follow to promote individual health, particularly that of children. In 2002, 46% of Somerville's first through third graders were either at-risk of becoming overweight or already were overweight.¹⁴ With the specter of serious health implications down the road, the community came together—from teachers, school officials, and parents to restaurant owners, city government, nurses, and physicians. They created the “Shape Up Somerville” program, which was a three-year initiative that sought to prevent obesity in first, second, and third grader students. Specific changes included: improving school cafeteria menus; food education at both school and at home; before-, during-, and after-school curriculum that was modified to promote health, activity, and nutrition; restaurants modified their menus to be “Shape Up Approved”; new bike and walking paths were constructed within a half-mile of schools; and education and training toolkits for community nurses and physicians were created to educate providers on the best approaches to treat childhood obesity. In just one year, the rate of overweight students starting coming down.

Outside of public education, there are other community-based changes that could create a culture of health. Grocery stores should receive tax incentives to open in urban areas if they provide a wide selection of fresh fruits and vegetables. (The city of Detroit does not have a single national grocery chain operating within city limits.) The federal government should redesign the food stamp and WIC programs to incentivize the purchase of healthier foods. State and local governments should dramatically invest in bike paths, sidewalks, public parks, and active recreation programs to encourage physical activity. And consumers need tools to be better educated on their choices, as Safeway has done by creating an online portal called FoodFlex. This site allows consumers to view a personalized history of the foods that they purchased, with tips and recommendations on nutrition and healthier alternatives.

Employers can use the workplace to create a culture of health and influence better individual decisions. Not only do healthier employees enjoy a better

¹³ Arthur Garson, Jr., and Carolyn L. Engelhard, “Attacking Obesity: Lessons From Smoking,” *Journal of American College of Cardiology*, 2007; 49:1673-1675.

¹⁴ Program statistics and overview can be found at the website of the Tufts University School of Nutrition Science and Policy, <http://nutrition.tufts.edu/>.

quality of life, but they are very good business. IBM has more than 40 wellness programs that address health promotion, industrial hygiene and safety, medical management and benefit design. These programs have reduced emergency room visits by as much as 24 percent and reduced hospital admissions by as much as 37 percent.¹⁵ Researchers in the American Journal of Health Promotion reviewed 73 studies of similar work-site health promotion programs and concluded that employers had an average return of nearly \$4-to-\$1.¹⁶

These kinds of changes can play an important role in encouraging individuals to make better decisions about their health.

Improve and Modernize the Delivery of Care

Third, once someone enters the healthcare system, we must dramatically improve and modernize the way they receive care. This must start with rooting out waste and inefficiencies. We should eliminate any financial incentive to do any test, treatment, or therapy that does not directly benefit the patient or add value to the care process. The surest way to accomplish this is to change the physician or hospital payments from a transaction-based to an outcomes-based model.

Our current payment system is simply based on the number of transactions or services that are provided, regardless of their necessity, value, or quality of care. This approach has an inherent incentive for the over-utilization of resources. And for those hospitals and physicians that do in fact deliver better care, they are for the most part reimbursed at the exact same rate as those who provide poorer care.

We need a new model. Reimbursement drives adoption, be it a new test, device, or treatment, and we need a reimbursement model that takes into account the quality of the care that is delivered, not simply that it was delivered.

Right here in Georgia the Center for Health Transformation is leading the nation's largest Bridges to Excellence diabetes program. Led by UPS, AT&T, and Southern Company, all members of the Center for Health Transformation, there are currently fourteen major employers, including the state of Georgia, participating in the program. The state medical society and hospital association are actively participating as well. Serving in the role of administrators are Blue Cross Blue Shield of Georgia, Humana, Aetna, CIGNA, Kaiser Permanente, and UnitedHealthcare. Physician recruitment efforts are ongoing, with WellStar Health System and the Morehouse Community Physician Network leading the way.

¹⁵ Jane F. Barlow, MD, MPH, MBA, Director, Global Well-Being Services and Health Benefits, IBM Corporation, Testimony before the House Government Reform Committee, Subcommittee on Federal Workforce and Agency Organization, March 15, 2006.

¹⁶ Aldana, S.G. Financial Impact of health promotion programs: A comprehensive review of the literature. American Journal of Health Promotion, 2001; 15:5, 296-320.

The program, like other pay-for-performance initiatives, pays incentives to physicians who practice best standards of diabetes care. The program encourages individuals with diabetes to see these physicians to improve their quality of life and avoid the long-term complications of the disease. In the process, physicians are rewarded for providing high-quality care, individuals with diabetes are healthier, and employers save money. A recent actuarial analysis of the program by Towers Perrin reports an estimated savings of \$1,059 per individual if blood pressure, Hemoglobin A1C, and LDL control measures are met. By saving lives and saving money, this Bridges to Excellence module should be the minimum standard of diabetic care throughout the country.

Other examples of new reimbursement approaches include health insurers Aetna and CIGNA Healthcare. They announced last year that in select markets they will reimburse physicians for conducting electronic or web-based consultations with their patients. Studies have shown that utilizing technology this way decreases administrative time for providers and their staffs, increases patient satisfaction, and decreases office visits and utilization. Every other insurer, including Medicare and Medicaid, should follow their lead.

Physicians in Ohio are working with WellPoint, the nation's largest insurer, to implement electronic prescribing. WellPoint is covering part of the hardware and service costs, as well as reimbursing doctors using e-prescribing at a higher rate than those still writing paper prescriptions.

Federal officials are considering this approach as well. My boss, former Speaker of the House Newt Gingrich, recently co-authored an opinion editorial with Senator John Kerry on using this model in Medicare. The American Health Information Community, an advisory body to HHS Secretary Mike Leavitt, may vote to recommend this model in federal programs as well.

These kinds of new payment models will encourage providers to adopt tools, technology, and techniques that will lead to higher-quality, more-efficient care.

Transform the Financing of Health Insurance

Lastly, we must radically change the way we finance health insurance. Between individuals and their doctors are mountains of burdensome regulations, hoards of middlemen, and red tape as far as the eye can see. In no other sector of society do we accept such a convoluted approach to buying a product or service. Putting consumers squarely in control is essential.

One of the most important changes we can make is to give consumers the right to purchase a health insurance policy from anywhere in the country.

Current state and federal laws permit consumers to buy only those health-insurance plans that have been approved in their own state, meaning it is illegal for a citizen of one state to buy insurance in another. These government barriers to free trade stifle competition, producing disastrous results: The absence of

robust competition artificially inflates the cost of insurance, preventing millions of citizens from purchasing affordable coverage.

To reverse this, government must allow competition to flourish. 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. More competition and consumer empowerment will go a long way toward creating a free, fair, and functional marketplace in healthcare.

A vital part of a functional market is the availability of information. Information on performance, cost, and quality allows consumers to make informed decisions, but healthcare is perhaps the only market in which consumers have virtually no access to this information. When Americans shop for a new car, home, or thousands of other items, they quickly and easily gather information on cost and quality from an endless array of resources. But in healthcare, consumers are virtually blind. Try finding out how a doctor stacks up against his colleagues. Try finding out how much a hospital charges for an elective surgery. Try finding out which surgical team has the lowest mortality rate.

Americans have a right to know this information, and the data that can best inform us is Medicare claims history. Medicare has detailed information on nearly every doctor and hospital in the country, which can be analyzed to identify the most efficient hospitals, best doctors, and most effective treatments. The federal government also has information on disciplinary action and lawsuits filed against physicians, collected for the National Practitioner Data Bank. Inexplicably and inexcusably, the federal government will not release this data. Despite growing demand from many health plans, employers, consumers, and researchers—even an ongoing lawsuit where HHS has appealed a federal judge's ruling to release the Medicare data—this information remains locked away from taxpayers. This information will save lives and save money now. Americans have a right to know this information, and taxpayers must continue to demand its release.

We should empower the individual to root out waste by creating incentives for consumers to pursue better care at lower cost so the citizen becomes the primary driver of cost reduction in healthcare. Consumers should have the right to purchase insurance policies that are tailored to their specific needs. And individuals who purchase their own insurance should receive the same tax benefits as employers who provide coverage.

Lastly, Health Savings Accounts should be available to everyone, regardless of how or whether they obtain insurance, and consumers should be able to pay health insurance premiums with HSA dollars.

Conclusion

All of these solutions are fundamental changes from today's approach to healthcare. But in order to build what we at the Center for Health Transformation call a 21st Century Intelligent Health System, embracing this level of change is an absolute necessity.

What can leaders in Georgia do to build such a system? Plenty. Following the four-box model outlined above, Georgia leaders should:

- 1) Ensure that state law gives private health plans, including those that participate in Georgia Medicaid and the state employees' health insurance program, the latitude to design insurance products to encourage and reward individual healthy behaviors.
- 2) Conduct a full-scale review of all state education law to ensure that employers and local officials have the freedom to try new approaches to promote health, wellness, and nutrition.
- 3) Introduce new provider payment models into Georgia Medicaid and the state employees' health insurance program, that move from a transaction-based reimbursement model to an outcomes-based model.
- 4) Make available all claims data, as well as performance and price information, for all providers, suppliers, and health insurers that do business with the state of Georgia.
- 5) Enact cross-state purchasing agreements with other states so that Georgians can purchase licensed health insurance policies outside of Georgia.

Speaker Gingrich put it best when he said, "These kinds of changes will break a lot of china." They represent a serious effort that can improve quality, reduce healthcare costs, and expand insurance coverage—things that the current system is incapable of doing. Today's system will always result in rising costs, too many without insurance, poor quality, and an unhealthy population. Any plan to cover the uninsured that builds upon such a dysfunctional system simply throws good money after bad.

We can do better.

With real change, through the ideas outlined here today, we will improve individual health, modernize the delivery and administration of care, and expand insurance to every American. Our country, our states, and our citizens deserve nothing less.