Testimony to the Georgia Healthcare Transformation Senate Study Committee

By
James Frogue, State Project Director
Center for Health Transformation

October 19, 2006

Chairman Hill and Members of the Committee, thank you for the opportunity to be here this afternoon. My name is James Frogue and I am the state project director at the Center for Health Transformation, a four-year-old organization founded by Newt Gingrich. In my role at the Center, I work with state legislators, governors' staffs, health department officials, and people serving in the policy community from upwards of 35 states in an effort to exchange ideas on the latest successful advances in healthcare policy. My focus here today will be on the private health insurance market. I will begin by sharing these brief written remarks and look forward to time for questions and discussion. (I also direct our Medicaid Transformation project, and would be happy to answer questions about that and/or work with you on issues surrounding Medicaid going forward.)

Are Georgians getting measurably healthier? Is this progress being made in a manner that is fiscally sustainable? These are the first- and second-tier questions that we must continually ask ourselves. Any policy that is achieving these goals must be supported and/or expanded. Any policy failing to offer measurable results must be immediately discarded.

The purpose of my testimony today is to suggest ways to utilize consumerism and transparency to make Georgians healthier. Healthier people are happier, more productive, and cost less.

A key challenge is to improve the quality of care in a manner that is fiscally realistic. Healthcare cost inflation that is three or four times the Consumer Price Index, year in and year out, clearly cannot be sustained.

There are two broad schools of thought regarding how to achieve better care at lower cost – twin objectives that are *not* mutually exclusive, it must be emphasized. On the one hand are those who believe that more government regulation and price controls are the answer. This group cannot explain how that approach would improve quality and customer satisfaction in the automobile, housing, computer, or restaurant industries.

The other school of thought sees consumerism as the answer. Consumerism utilizes incentives that encourage individuals to educate themselves about all of their available options and then to shop around for the best value. Consumerism is not some radical notion. It is at play in every other sector of our economy, in addition to healthcare services, such as laser eye surgery, which are not covered by insurance. Consumerism results in higher quality goods and services at lower cost.

Can consumerism work in healthcare? The answer is yes. If people have the right incentives and accurate, reliable information, then consumerism can work anywhere.

Some will argue that consumerism cannot work in healthcare because people are not able to make rational decisions when they are unconscious or suffering from some kind of severe health emergency. It is true that consumerism has a limited role in these extremely rare situations. But the fact is that the overwhelming majority of our interfaces with the healthcare system allow us time plenty of time to consider variables such as price, location, quality, and even the personalities of providers.

Think of your most recent contact with a healthcare professional, be it a physician, nurse, pharmacist, therapist, or home healthcare worker. Was it the kind of emergency in which you had absolutely zero ability to take into account quality and price considerations? How about your visit before that? And the visit before that? What about the visits of your loved ones? The fact is that a very tiny percentage of each person's contacts with the medical system are the kind of emergencies where there is no chance for that person or any family, friends, or colleagues in the immediate vicinity to offer input on where to go for treatment and what kind of services to receive.

Healthcare Consumerism Works in the Real World

The most comprehensive study of patient behavior was the RAND Health Insurance Experiment that lasted from 1974 until 1982. It is detailed in the book, *Free for All: Lessons from the RAND Health Insurance Experiment*, by Joseph P. Newhouse. Dr. Newhouse and his team of researchers followed the medical spending habits and the health status of over 7,000 people in six cities for eight years. The 7,000+ participants were of varying income levels and health status.

The group was divided up into four specific insurance arrangements. At one end of the spectrum, people had all of their healthcare expenses covered. At the other end was 95 percent coinsurance with up to $1000 maximum out-of-pocket expenses. In the middle were two groups of 25 and 50 percent coinsurance.

At the end of the experiment, the researchers concluded that the "use of medical services responds unequivocally to changes in the amount paid out of pockets." Per capita expenses on the free plan were 45 percent higher that those on the 95 percent coinsurance plan. For outpatient services, adults on the 25 percent coinsurance plans spent only 78 percent as much as those on the free plan. For children in that group the figure was 74 percent. On the 95 percent coinsurance plan adults spent 60 percent as much as those on the free plan and children 59 percent as much.

These findings are consistent with common sense – if people have financial incentives to consider in accessing the health insurance system, it will affect their behavior. But what made the RAND experiment so significant is that despite the large spending differences among people in the four plans, "the reduced service use had little or no net adverse effect on the health for the average person." In other words, people for whom care was free over-utilized healthcare services but reaped no gains in health status as a result. Those for whom there were cost-sharing requirement did indeed use fewer services, but it did not result in poorer health outcomes.

In July of this year, Definity Health released a three-year study of 50,000 people in consumer-driven health plans (CDHPs). This refers to people who are in Health Reimbursement Arrangements (HRAs) or Health Savings Accounts (HSAs). The study had the key following findings:

1. 3 to 5 percent *more* members of CDHP sought preventive care compared to those in the PPO

2. Individuals enrolled in a CDHP showed an annual reduction in the use of acute care services (22 percent fewer hospital admissions and 14 percent fewer emergency room visits).

3. The chronically ill used less acute care (8 percent fewer hospital admissions and 12 percent fewer ER visits) but continued to visit their primary doctors at the same rate as chronically ill members in the standard PPO.

4. Costs per member *decreased* 3 to 5 percent in the CDHPs over the 2004 to 2005 period off of the 2003 baseline. This compares with *increases* of 8 to 10 percent among enrollees in the PPO.

One other noteworthy piece of data from this study is the importance of employer contributions to Health Savings Accounts. In the sample surveyed, 60 percent of employers help fund the HSA. The average large employer contribution is $736. Among mid-sized companies, when the employer helps fund the HSA, 89 percent of employees open an account and 66 percent contribute their own money. When the employer does not fund the HSA, then only 27 percent of employees open an account.

Earlier this month, Aetna released the largest study to date of consumer-directed plans. The company reviewed four years of data for 1.6 million Aetna members. Of that number, 134,000 were HRA members from 99 employers and 18,000 had a Health Savings Account offered by 27 employers. Being that the accounts have been around longer, the study had 4 years of data for HRAs compared to only 2 for HSAs which became legal on January 1, 2004.

Highlights of Aetna study included the following:

1. Full replacement plans see the most significant savings. HRAs in effect since January 2003 experienced an average medical cost trend of 1 percent. This means that medical costs increased only 3 percent from 2003 to 2005.

2. CDHP plan members with chronic conditions maintained or improved the level of care they received prior to joining the plan, including a 6 percent higher usage of inhaled steroids among asthmatics.

3. Preventive care was maintained or improved. In one example, first-year HSA members received cervical cancer screenings at a 13.8 percent higher rate than PPO members.

4. CDHP plan members utilized generic drugs at 4.5 percent higher rate.

5. CDHP enrollees accessed online tools more than twice as often as those in other plans.

6. 52 percent of HSA members rolled over their entire balance in 2005. 49 percent of HRA members rolled over some or all of their funds in 2005.

The Safeway supermarket chain is an example of one company that has experienced overall cost declines as a result of its recent introduction of an HRA product to 10,300 non-union employees. The national trend in the increase in employer health care expenses has averaged 12 percent over the last five years. Safeway saw a 4 percent decline in employer costs this most recent year and a decline of more than 22 percent for employee costs.

All Georgia state employees deserve to have a consumer-driven health plan. This should be a key recommendation from this committee. Every year that passes is a missed opportunity to empower the employees of this state with the tools and resources they need to better maintain and improve their health and that of their families. It is also a major missed opportunity for the state to be the national leader in this area and save a considerable amount of money in the process. At the very least, all Georgia state employees should have an HRA to incentivize healthier behaviors. This also would be a great way for Georgia's elected officials to leaders to lead by example.

Governor Perdue's recently announced Health Information Technology and Transparency Advisory Board is the perfect forum from which to kick off this effort. It is also important to keep in mind the forthcoming efforts by Secretary Leavitt to promote transparency of price and quality by getting all federal purchasers of healthcare, the largest 100 businesses in the country, and all 50 states to coordinate their efforts. This effort is aimed at getting these large purchasers of healthcare (those representing over half of healthcare purchasing) to ask the same questions in early 2007 for their 2008 plans.

Governor Perdue's task force and this committee might also want to look at two websites that are now up and running in the state of Florida – www.FloridaCompareCare.gov and www.MyFloridaRX.com. Both are free sites that anyone can access. The Compare Care site has quality information and prices for all of Florida's hospitals. On the first day this website was up and running in 2005, it received 70,000 hits without the publicity of any marketing campaign. Hospital administrators in particular were interested to see how their facilities stacked up against competitors. There is already anecdotal evidence that hospital management teams are putting together internal teams to improve their quality ratings in areas they rate too low. A similar site is now available to residents of Minnesota at www.MinnesotaHealthInfo.org.

MyFloridaRx.com lists the prices of the 100 top-selling prescription drugs at all of Florida's pharmacies. When it kicked off last year, the site listed only the top 50 drugs but moved up to the top 100 in spring of this year. Visitors can punch in their Zip Code and medication of choice and receive a list of all of their local pharmacies along with the price of that drug. The state simply collects and publishes the usual and customary prices that pharmacies submit for Medicaid reimbursement. Governor Pawlenty in Minnesota started a similar site this spring where residents can get the prices of 200 commonly-prescribed drugs. That site can be found at www.MinnesotaRxConnect.com.

The state of Georgia could go further than simply posting the prices of drugs at pharmacies. Georgia could actively support, via the state employee health plan, a move from the standard co-payment model of drug purchasing to an after-pay model. In this model, the state would reimburse an individual 100 percent for the lowest cost generic drug in a therapeutic class. This would help ensure compliance. Above that, a person would be free to buy any FDA-approved drug in that class provided they pay the differential. This eliminates the need for formularies and instead uses market forces to move prices. We estimate that this model could eliminate as much as 40 percent from the cost of drugs.

Massachusetts Model

Earlier this year, the Massachusetts legislature passed (and Governor Mitt Romney signed into law) a bill that will make it mandatory for all residents of Massachusetts to have health insurance by July 1, 2007. An individual who fails to comply will lose the personal exemption for their 2007 state income tax return. In 2008, a person without

coverage will be subjected to a penalty of 50 percent of the cost of a standard policy. The fact that a liberal Democratic legislature and a conservative Republican governor could agree on such a sweeping change has piqued the interest of state officials across the country. There is much about the Massachusetts model that is innovative and perhaps worthy of duplication in Georgia.

There are four pieces of the Massachusetts model that are particularly impressive. The first is the move toward individual ownership of health insurance policies. Ultimately, we want to achieve a system where 100 percent of Americans own an individually-chosen private health insurance plan that they get to keep regardless of their employer and regardless of their employment status. The Massachusetts model is a clear step in that direction.

Second, is the creation of the "Connector," which is an elegant combination of the individual and small group markets into an administratively simple entity for health insurers to connect with small businesses and individuals in need of coverage. The insurance companies (and their plan offerings) in the Connector meet an agreed-upon set of standards.

Third, the Massachusetts law allows employers (and employees) to make pre-tax defined contributions to employees via Section 125 in the tax code, so that employees can take that money, combine it with their own and any state subsidy they may qualify for, and buy a plan of their choosing. This gets employers out of the business of buying and administering health insurance plans, a job there are generally not qualified to do anyway. It also allows employees and families to buy the coverage that best meets their needs. Finally, it accurately targets the overwhelming majority of the uninsured – people (and their dependents) who work, but for whatever reason do not participate in an employer's health insurance plan.

Fourth, the Massachusetts model converted subsides that were originally targeted for hospitals into subsidies for individuals so that they can buy health insurance coverage. This is a much better idea than what some states are doing, which is offering subsidies to businesses to provide coverage. A piece of this puzzle not always understood by outsiders is that Massachusetts was on the verge of losing $385 million in federal Medicaid payments unless the governor and legislature agreed on a plan that met with federal approval. Instead of taxpayer dollars being sent to hospitals to cover the cost of the uncompensated care they provide, those dollars were turned into direct subsidies for individuals to buy coverage. Theoretically at least, having everyone insured would eliminate the problem of uncompensated care.

However, the Massachusetts law suffers from several serious flaws that threaten its long-term sustainability:

First, the requirement to have coverage is an unprecedented and costly mandate on individuals and families. It is not the same as the requirement to have car insurance

because having a car is a choice and the minimum insurance required covers *other* injured parties, not the owner of the coverage.

Second, the Massachusetts law preserves guaranteed issue and community ratings which combine to be the biggest threats to the plans' long-term viability. The guaranteed issue requirement means that if someone in a neighboring state with an expensive condition cannot get coverage at home, they can move to Massachusetts and not be denied coverage. We could debate all day how many people might actually do this, but it would only take a small number of very expensive cases to disrupt the Massachusetts pool, thereby pushing costs onto everyone else.

Third, the Connector, while highly innovative, still limits Massachusetts residents to these plans. If they can find a more tailored, less expensive policy from a company domiciled in California, for example, they are not permitted to purchase it. Most everyone in the 21st century agrees that competition among businesses results in goods and services at a lower cost and higher quality for consumers. Competition *among regulatory regimes* is equally important to achieving maximum choice for consumers. Just as it is wrong to assume that one particular business will get it right for all customers all the time, it is also wrong to assume that one particular regulatory regime will always get it right as well. A better way is to open up more options for Georgians to buy health insurance from insurers domiciled in other states. There is a bill in Congress sponsored by Arizona Representative John Shadegg that would allow this on a national scale. But each individual state has the power to open up that option to their citizens.

Fourth, the mandate on individuals to have coverage is likely to increase the pressure to add mandated coverage items. Massachusetts already has 40 mandates on insurers offering coverage in the state. There are approximately 2,000 such state mandates across the country, according to the Council for Affordable Health Insurance, and that number keeps growing. Where health insurance is now *required* is it reasonable to expect mandate pushers to ramp up the pressure.

Taking a Comprehensive Approach

Today's hearing focuses on how consumerism and transparency can improve health outcomes. It is important to keep in mind that a substantial minority – if not a majority – of each individual's health status is determined by choices they make surrounding diet and exercise. Relationships, family status, and the physical environment play significant roles as well. We in the United States clearly have the best "sick care" system in the world. If you have cancer, for example, or if you need heart surgery, your odds of survival and recovery are far better in America than elsewhere in the world. But we must do a better job recognizing how to improve in other areas.

A comprehensive approach to improving health would involve promoting good diets and exercise among Georgia's school children. It is during a child's early years that habits are formed for a lifetime. It is critical that kids through the high school level consume a

proper diet and engage in rigorous physical activities at least several times a week. This will help stave off, for example, the explosion in adult-onset diabetes and all its related complications. It is better to strike at the root of any problem than to try and treat the symptoms later on.

Again, thank you for the opportunity to be here. I look forward to your questions.