

**Statement As Prepared For Delivery**

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**“Health System Reform: The Vital Need for Transparency,  
Finance and Payment Reform, and Improved Care Coordination”**

Senator Wyden, I thank you, Chairman Baucus, and Senator Grassley for the opportunity to participate in today’s summit that will serve to inform congressional action on health reform in the 111<sup>th</sup> Congress.

The high and rising cost of *ill*-health care has again placed health reform center stage in the American political debate. As we prepare to launch a new bipartisan approach to health care reform in 2009, there is an urgent need to focus on sharply rising rates of chronic disease, lifestyle behaviors that negatively affect health and well-being, and how the care delivery system must modernize to address these challenges. Building a modern, efficient, and high-quality health care delivery system designed to care for the chronic medical needs of patients is not a partisan issue. Common sense dictates we cannot go on the way we have been, and that’s why today’s summit, along with other events the Finance Committee has sponsored over the course of this year, is so important.

The U.S. health care system was built to deliver services to acutely ill patients requiring episodic care, not to patients who are chronically, persistently in need of medical care. And as a result of that structural deficiency, today’s chronically ill patients receive only 56 percent of clinically recommended preventive and

maintenance care they need. It is this systematic discrepancy between what is and what should be that must be addressed in any health care reform. The clinical protocols for preventing and treating diabetes, hypertension, and other chronic conditions, and preventing costly secondary complications, are well established in the provider community – our system just does not deliver the services, since physicians and hospitals are not paid to provide them (or paid poorly), and we do not have either a care delivery model or modern health information technology that facilitate doing so. And so we find ourselves facing six unhealthy truths about America's health and health care:

- 1. Chronic diseases are the number one cause of death and disability in the United States.** 133 million Americans, representing *45 percent* of the total population, have at least one chronic disease. Chronic diseases kill more than 1.7 million Americans each year, and are responsible for 7 of 10 deaths in the United States.
- 2. Chronic diseases account for 75 percent of the nation's health care spending.** During 2007, the U.S. spent over \$2.2 trillion on health care, and 75 cents of every dollar went towards treating patients with one or more chronic diseases. In public programs, treatment for chronic diseases constitutes an even higher portion of spending: 83 cents of every dollar in Medicaid and more than 95 cents in Medicare. Even among our elders, the distribution of spending is highly skewed: More than *three quarters* of total spending is associated with patients with *five or more* chronic health care conditions.
- 3. About two-thirds of the rise in health care spending is due to the rise in the prevalence of treated (primarily) chronic disease.** From 1987 to 2000, health spending for non-institutionalized populations *doubled* from \$314 billion to \$628 billion per year – and fully \$211 billion of that increase was attributable to the increase in treated disease.
- 4. The doubling of obesity between 1987 and today accounts for 20 to 30 percent of the rise in health care spending.** The percent of children and youth who are overweight has tripled since 1980. If the prevalence of obesity was the same today as in 1987, health care spending in America would nearly be 10 percent lower per person – about *\$200 billion less*.
- 5. The vast majority of cases of chronic disease could be better prevented or managed.** The Centers for Disease Control and Prevention estimates that 80 percent of heart disease and stroke, 80 percent of type 2 diabetes, and 40 percent of cancer could be prevented if only Americans were to do three things: *stop smoking, start eating healthy, and get in shape*. Unfortunately, our “health” care payment and delivery systems don't facilitate these common sense actions.

**6. Most Americans (five in six) are unaware of the extent to which chronic disease harms their health – and their wallets.** Only a small fraction of Americans, less than one in six, comprehend the magnitude of the problem that chronic diseases account for more than 70 percent of the deaths in the U.S. and more than 70 percent of health care costs. Even fewer are aware of the toll chronic disease takes on U.S. productivity, further adding to the costs. Direct health care costs represent *only a quarter of the total cost* of chronic diseases. Indirect costs such as absenteeism and presenteeism, or lost productivity that occurs when employees come to work but perform below par due to any kind of illness, cost America's businesses *over \$1 trillion a year*.

Thus, we cannot and should not delve into discussions regarding viable health care reform without first understanding the role that chronic disease plays in driving preventable ill-health, increasing costs for care, and decreasing American competitiveness. We must change how we pay for health services and we must modernize our health IT and care delivery systems. This won't happen absent major changes in how payers like Medicare pay providers to treat the chronically ill.

Restructuring our systems of financing and delivering care to better meet the needs of people with chronic conditions will require a renewed focus on preventing disease when possible, identifying it early when it occurs, and implementing secondary and tertiary prevention strategies that slow disease progression and the onset of activity limitations.

Chronically ill patients receive a little more than half of clinically recommended preventive health care services. If you went to a mechanic about four problems with your car and he fixed just two of them, would you go back, time and time again? Not likely. Especially not if that mechanic then charged you to fix the problems he should have fixed to begin with. That's the result our health care system produces. And this systemic failure is not attributable to lack of clinical understanding about the efficacy of the procedures but is instead a function of how we pay for and deliver health care services, resulting in ever-rising health care costs.

What really accounts for the rise in health care spending over time? Most people assume the culprits are the usual demand-side drivers of care: the rising share of spending flowing through insurance, medical malpractice, rising real income, and demographics. Collectively these factors account for approximately 40 percent of the rise in spending over time. The residual has commonly been attributed to medical advances. Innovations in health care clearly assume a major role in driving the rise in spending, but other factors are clearly in play. Technology plays an important role in expanding the share of patients with a disease we can treat, as well as replacing older treatment modalities with newer, often more expensive, and sometimes more effective interventions. However, the missing component in this technology explanation is the increase in disease prevalence.

In fact, about 27 percent of the rise in health care spending is associated with the doubling of obesity over time and two-thirds is associated with the rise in the prevalence of treated disease, much of it obesity-related, like hypertension, hyperlipidemia, and diabetes. The rise in obesity is by itself responsible for virtually all of the 53 percent increase in the clinical prevalence of diabetes since 1980.

The implication for health care reform is that attacking the affordability issue along these dimensions – better care management (including information technology tools that enable effective management) and disease prevention – is essential, and it is not inherently partisan. Developing more rational health policies for balancing the trade-offs of innovation, higher attendant spending, and potentially better outcomes has to be part of the equation as well.

Starting the health care reform debate around the affordability agenda, with a clear understanding of the forces driving the rise in spending, seems a more attractive approach than limiting the debate to how best to pay for including the uninsured in an under-performing health care system. Integrating the uninsured into a more efficient, better-performing system, while still contentious, may prove an easier next step with this approach. Health services research, particularly focused on Medicare beneficiaries' care, can inform our restructuring efforts.

The traditional Medicare program is ill-equipped and not designed to address the care needs of chronically ill, older populations. Most clinically recommended care should (but all too often doesn't) occur outside physicians' offices at patients' homes, including better nutrition, exercise, prescription adherence, and so on. During office visits, we know that routine eye, blood sugar, hypertension and other exams do not occur as clinically recommended. Overall, Medicare beneficiaries receive a lower percent of clinically recommended clinically recommended services than similar patients in the VA, private insurance, or even the Medicaid program. Efforts to reduce the level and growth in Medicare spending are not likely to meet success unless we can provide a different style of care for chronically ill patients in the program.

There have been key lessons from seven major demonstration projects in the Medicare program designed to test various models for treating and managing chronically ill patients. An eighth demonstration will occur as outlined in the Tax Relief and Health Care Act of 2006 (section 204 directs CMS to conduct a three-year demonstration project of the medical home concept of patient care). Ideally, these reforms would be adopted and used by all payers for managing chronically ill patients. While the results of the seven demonstrations were, overall, disappointing, at least four key lessons have emerged:

**1. The need for primary care physicians to assume responsibility for coordinating care and recruiting patients into care coordination.**

Most of the demonstrations relied on care management firms, health plans, and other entities to enroll Medicare beneficiaries into a form of chronic care management. Enrollment rates were often low, particularly among more severely ill patients, largely since enrollment was not motivated by and coordinated by the patient's trusted primary care physician. However, once enrolled, much of the on-going care could be provided by nurses and nurse practitioners.

**2. Targeting**

Medicare spending is highly concentrated among a few expensive patients with multiple chronic conditions. Among Medicare beneficiaries with chronic illness, the top 10 percent account for about half of all (non-institutionalized) Medicare spending. Previous demonstrations have cast a wide net on targeting beneficiaries, and with that broad targeting have included many lower cost patients. While a medical home model seems a good idea for all patients, the potential for the most savings could be among those most severely ill (e.g. home bound patients).

The first steps should be to identify and enroll the most expensive 5 to 10 percent of beneficiaries (based on their combination of conditions, recent hospitalization, ) and structure the evaluation based on the management impact of enrolled high-cost beneficiaries compared to a control group that mirrors them.

**3. The need for continuous health care availability 24/7.**

Patients with multiple co-morbidities have medical events that occur throughout the day and night. When their primary care physician is not available, 911 becomes a substitute, with the patient often ultimately admitted to the hospital. Having after-hours care available in-person or even by phone or computer is critical to avoiding unnecessary – and costly – repeat hospitalizations.

**4. Information Systems**

Health information technology is a critical component of successfully identifying potential candidates for chronic care management, and reducing costs. Such systems, in combination with payment and delivery system reforms, have the potential synergistically to lower overall healthcare spending.

With these three learnings in mind, I'd like to turn now to possible reform options for both traditional Medicare as well as Medicare Advantage. Ideally, these reforms should be used by all payers—both public and private. Reforms could start with the traditional Medicare program, but could also be applied to

Medicaid, and the Federal Employees Health Benefits Program (FEHB). This would leverage the changes outlined below throughout the healthcare delivery system.

## **Reforming the Traditional Medicare Program: Potential Design Components**

Four fundamental design components are essential to improve care for Medicare beneficiaries, upgrade system performance, and decrease costs: the development of a medical home program that integrates wellness into care; the elimination of cost-sharing for clinically recommended preventive services; payment reform to incentivize quality care; and performance measurement for system improvement.

### **1. Voluntary Medical Home Program and Integration of Wellness**

The patient-centered medical home is a model for health care that seeks to strengthen the doctor-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship. The medical home model is predicated on the idea that the best care is provided not in episodic, illness-oriented, complaint-based care, but through patient-centered, physician-guided, cost-efficient, longitudinal care. In the advanced medical home model, patients have a personal physician working with a team of other health care professionals. In most cases, primary care physicians, with their office care team, are ideally suited to provide principal care and be a patient's care coordinator.

Primary care physicians who meet specified standards, perhaps a version of the National Committee for Quality Assurance (NCQA) definition for medical home care, would receive enhanced payments. This top tier of providers would be supplemented with a second tier requiring fewer core elements, and receiving slightly lower payments, and an entry-level tier whose practice encompasses the essential features of a medical home: providing HRA-qualified medical services, tracking patients, and obtaining mutual agreement on individual patient care plans.<sup>1</sup> Physicians who choose not to establish a home would, of course, be free to do so but would not receive these supplemental payments.

Physicians operating in smaller practices could simply contract with health care structures already at work in the system in order to meet the medical home requirements. These contract affiliates could be home health care agencies, hospitals, care management vendors, health plans, or other providers with similar technology. The keystone is that enrollment into the care plan and service coordination would be the role of the patient's primary care physician.

One of the important new benefits would be a no-cost-share health-risk appraisal for all Medicare patients in each medical home practice. An individualized risk-reduction and care plan would be developed based on this personalized assessment, with follow-up provided by either the physician's nurse or nurse practitioner or by contracted providers from a home health agency or other similar entity.

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<sup>1</sup> Three or more tiers could be developed using points from the NCQA (PPC-PCMH Content and Scoring).

2. Improve Patient Compliance and Self-Management: No Cost-Sharing for Clinically Recommended Services

The medical community has developed consensus recommendations on the clinical treatment of patients with diabetes, hypertension, and other chronic conditions. These include annual eye exams, periodic blood pressure and sugar level testing, among others. Today, patients with chronic illness receive all of these clinically indicated services. Patients choosing a medical home that avail themselves of these recommended services should receive them with no-cost sharing. This includes an initial health risk appraisal that would allow the provider to identify and appropriately stratify risk and develop a care plan for the patient.

3. Payment Reforms

Physicians would receive a PMPM payment for each patient with a diagnosed and treated chronic illness in their practice. The level would depend on the tier (with tier 3 meeting the NCQA or other definitions of a medical home). Voluntarily participating physicians meeting the medical home model would initially guarantee a 2 percent reduction in spending on chronically ill patients (using the CMS-HCC methodology for risk adjusting in Medicare Advantage as a control). Physicians would keep 75 percent of any savings that exceed 2 percent. The 2 percent savings figure would rise to 5 percent over a three year period. This means that by targeting patients appropriately within the practice, physicians who reduce spending on very high cost patients (the 50 percent of total spending) would meet this standard by simply reducing spending on this population by 5 percent.

4. Performance Measurement

To be eligible to participate in the shared savings, participating primary care physicians would have to meet certain performance standards within their panel of enrolled chronically ill patients. These would include standard HEDIS measures and focus on improvements (i.e. changes in the number of patients receiving the recommended protocols) rather than hitting specific targets.

**Reforming Medicare Advantage: Potential Interim Design Components**

Few programs have raised more political controversy than MA with proposals ranging from reducing payments to 100% of FFS to the status quo. This option provides another approach. One of the key policy changes we face in restructuring Medicare is the role Medicare Advantage will play in the future. Today, Medicare pays the plans 12 percent more than regular fee-for-service (FFS) Medicare. Some MA plans, such as private-fee-for-service (PFFS), receive even higher payment rates—17 percent above FFS.

A Private Fee-For-Service plan is an MA health plan offered by a state-licensed risk-bearing entity that has a yearly contract with CMS to provide beneficiaries with all their Medicare benefits plus any additional benefits the company decides to provide. One major difference between a PFFS MA plan and other MA plans is that, in most cases, people who join a PFFS plan are not required to use a network of providers. Beneficiaries can see any provider eligible to receive payment from Medicare and agrees to accept payment from the PFFS plan.

One option for more productively using the plans would recalibrate payments across plan types:

- First, give PFFS plans the option of establishing a tier 3 medical home (with health IT) and continue to receive payments initially above FFS (perhaps the current FFS plus 17 percent). Those PFFS plans that do not establish medical homes would be paid at 100 percent of FFS. Since there are about 3 million Medicare beneficiaries expected to be enrolled in the PFFS program in the near term, this could be a fast way to start to transform the program.
- Next, give other MA plans – including HMOs and PPOs – the same choice. The key is flexibility in design, but to incentivize those that achieve tier 3 medical homes within their plans by providing payments initially above costs, and paying those that do not at 100 percent of FFS.

### **Additional Needed Reforms**

Modernizing our health care delivery system with payment and infrastructure reforms and integrated delivery models to address both the clinical and cost issues to care for the chronically ill is paramount. The U.S. health care system lacks the overarching institutional capacity to encourage the adoption of such technologies – primarily because it isn't a system in the true sense of the word, but rather a collection of highly fragmented structures. In addition, the underlying data are not readily available to undertake comprehensive technology assessments.

Let us consider the lack of data first. Although CMS tries each year to estimate total health care spending by the source of funding and its use, the estimates are pieced together from dozens of data sources. The Medical Expenditure Panel Survey (MEPS) provides important national estimates on health care spending, utilization patterns, and medical conditions of people surveyed, although these estimates are not available at the state level. Thus, the first place to start is to make the appropriate investment in data systems to at least accurately report how much we spend, how this varies by state, and what clinical conditions and practices are driving the growth. MEPS could easily be expanded to provide state-level estimates on a rotating basis (say, a third of the states each year). The sample size (and with it the sample size of its donor survey, the National Health Interview Survey, or NHIS) should also be expanded. The several-hundred-

million-dollar cost of collecting these data is trivial in the context of what we spend and the potential for the data to provide immediate dividends. It seems counterintuitive that in a \$2 trillion health care system we do not even have the most rudimentary data linking spending, medical care conditions and other key markers on a timely state-by-state basis.

Perhaps the most important strategy for reducing the growth in health care spending without reducing benefits is to focus on slowing or reversing the growth in obesity prevalence. This will require interventions designed to change behavior with respect to diet and exercise. These strategies should target schools and the rise in childhood obesity, the workplace, and communities in general. Changing behavior is difficult, although we do have an important case study in reducing smoking in the population. Today, approximately 22 percent of adults age twenty-five and older are smokers, compared with 33 percent in 1979.

The behavioral science literature has outlined the process by which people change their behavior. This research has identified distinct stages that accompany behavior changes. The well-documented stages of change model applies across the board to behaviors ranging from smoking and drinking to exercise and diet. Lessons from this research will be important to include in the design of population-based behavior change programs.

But what we don't understand sufficiently – at either the population or individual level – is to how to motivate people to participate in behavior change programs and to sustain their participation. Unfortunately, there have been few successful broad-based interventions used in health care to reduce weight, modify diets, and lower stress. Some employers have adopted worksite health promotion programs, although these vary greatly in terms of design, intensity of the intervention, rates of participation, and results. For example, case studies from Citibank, Johnson & Johnson, Procter & Gamble, and Highmark all demonstrate returns on investment, but those returns varied significantly. At Citibank, a comprehensive health management program showed an ROI of \$4.70 for every \$1 in cost. A similar comprehensive program at Johnson & Johnson reduced health risks including high cholesterol levels, cigarette smoking, and high blood pressure, and saved the company up to \$8.8 million annually. Procter & Gamble saw reductions in hospital admissions and in-patient days as well as overall health care costs, but posted an ROI of just \$1.49 for every dollar invested. Highmark's ROI was \$1.65 for every dollar invested. To sum up, estimates of ROI are highly variable and research to date cannot account for that variability adequately, or explain exactly why successful programs work and for whom. There is a gap between science and practice that must be closed, and it can be with additional research.

What we do know, however, is that to be effective, options for reforming health care need to include both population-based/public health approaches and economic incentives for the cost-conscious use of services. Much of the current debate over health care spending has focused on demand-side innovations, such

as consumer-driven health care, that target overuse of health care by consumers. However, most of the rise in health care spending is traced to the rise in population risk factors and the application of new technologies to treat chronically ill patients. Even if widely adopted, these demand-side fixes would do little to reduce the rise in obesity and other key risk factors, and the corresponding increase in treated disease. Maintaining or reducing the population prevalence of disease is a strategy with large potential payoffs, without the side effects of rationing and other interventions such as managed care that have proved politically unpopular.

As Executive Director of the Partnership to Fight Chronic Disease, we have recently published information on wellness and lifestyle programs (school based, community based, workplace based) that work –either to lower costs, improve health and productivity or all the above. Moreover, the compendium also includes information on care coordination programs with demonstrated value (such as a recent randomized trial by Health Dialog showing a 5-7% net reduction in health care spending). These successful programs are presented by state and by type of intervention and may be found at <http://promisingpractices.fightchronicdisease.org/>.

With that, I'll close, and I look forward to answering any questions you may have. I'd like to again offer my thanks for your invitation, and for this Committee's long-standing commitment to health security for all Americans and for its willingness to foster informed bipartisan discussion about the health care challenges facing our nation.