

## Remarks to the Illinois Chamber of Commerce, Chicago, April 29<sup>th</sup> 2009

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### **“Modernizing health care while containing costs – can it be done?”**

Thank you for the invitation to join you today, at what is a critical time in the national discussion about a better health system. It's good to be here, too, because over a million people living here in Chicago and in Illinois entrust us at UnitedHealth Group with funding and arranging your health care. That's a great responsibility; we take it very seriously.

So today I've been asked to talk about how the healthcare system *needs* to change – and how it *can* change. I'm going to start with what should be an uncontroversial statement. For the \$2.6 trillion the nation will spend on health care this year, we should be able to do a lot better.

That's not to deny there are some excellent hospitals and health professionals, who devote their lives to serving patients. Many of them are here in this State and in this City – where ten of your hospitals were ranked as amongst the best in America. But the fact is: health care is now 18% of the US economy – that's over 6 percentage points higher than most other industrialized countries. And our results don't reflect that investment – either in terms of population health, or universal access to good quality healthcare.

In many ways this isn't news. As my colleague Steve Hemsley, CEO of UnitedHealth Group, pointed out in a recent speech in Detroit, *Fortune* magazine declared the US health system to be in crisis - forty years ago. But the rising cost of health care is increasingly squeezing middle class incomes. Between 1999 and 2008, workers' earnings increased 34%, but health care costs – reflected in premiums – shot up by 119%.

So it's no surprise that one in four Americans report problems paying medical bills. That's somewhere between 45 and 50 million people lack coverage. And that 6 out of 10 believe it's now more important than ever to reform and modernize the health care system: not despite - but precisely because of - the wider economic crisis.

And as I'll discuss a bit later on, employers are feeling the pressure too. That's clearly true here in Illinois, as health care costs add increasing burdens at a time when the State has shed jobs at a faster pace than at any time since World War Two. All these problems are, I think, quite widely understood. The real question is: what do we do about it?

### **The current national health reform debate**

That's the question that the Congress and the White House are wrestling with as we speak. Yesterday we saw another step along the way with Congressional budget proposals being hammered out. Legislative proposals are now being worked up, and costed out. Ideas are being floated. Negotiating stances refined. Endgames assessed. May, June, July are going to be critical months.

But can meaningful reform and modernization pass? Can this President succeed where both Roosevelts, Truman, Eisenhower, Kennedy, Nixon, Carter and Clinton all couldn't? We at UnitedHealth Group certainly hope so – as we see it, the need for change is too great, the opportunity for modernization too obvious, and the chance now on offer too precious for the nation to squander.

But we're under no illusions as to the enormity of the task. We see the scale of challenge firsthand, as we help look after the health of 70 million Americans each year - funding and arranging \$115 billion of care for them, in partnership with over 5000 hospitals and 650,000 doctors across the nation.

Our core capabilities are in care management, health information, and technology, which we adapt for many different clients, markets and geographies. We're one of America's largest providers of employer-sponsored health benefits – taking as much pride in serving small entrepreneurial family-run businesses as we do in working with the nation's most respected Fortune 100 household names. But we're also the Federal Government's largest Medicare partner – serving one in five seniors nationwide in both traditional Medicare and Medicare Advantage – as well as the nation's largest Medicaid managed care plan, supporting underserved communities in 21 states and the District of Columbia. It's this diversity of experience that directly informs how we think about health reform.

It means we strongly support the goal of universal coverage.

To help reach that goal we've suggested six key building blocks:

- given where the country starts from in the design of its health care system, we expect the pragmatic route to expanded coverage will partly involve strengthening employer coverage that already supports 160 million people
- while reforming individual insurance markets, and
- targeting expanded public funding for low income individuals and families.
- We also believe that coverage expansions and cost containment are two sides of the same coin and must be pursued in tandem,
- together with modernizing Medicare and
- making better use technology.

Now you sometimes hear it said that the United States is somehow unique in having an employer based health insurance system. Of course that's not true – half the G7 industrialised countries do the same. The difference is that in those countries everyone is required to have health insurance whereas here it's voluntary. One of the problems that causes is that average family health insurance premiums in this country are estimated to be about \$1,100 a year higher because people with insurance are indirectly paying the medical costs of people without insurance.

That's why we and others in our industry have proposed that reforms to the insurance 'rules' should comprise a new system of shared responsibility, in which once coverage is available to all at an affordable prices, everyone should be required to be covered. But the devil really will be in the details here, and we have detailed and constructive thoughts on how to get it right. Health reform is littered with the risks of unintended consequences. In the individual market, for example, if you introduce 'guaranteed issue' of insurance but without requiring that everyone be in the risk pool by taking out affordable coverage, then the number of people with health insurance actually tends to go down, as rates spiral and many existing healthy participants are priced out of the risk pool.

## **The central importance of cost containment**

But underpinning all these considerations is a fundamental issue that simply cannot be sidestepped – that's the question of how to slow the rate of health care cost growth. Why is this arguably the central question of the current debate?

It's partly a *policy* reality - simply adjusting the coverage rules, or moving dollars around an un-modernized health care system, isn't going to do the trick. History teaches that coverage expansions won't be sustainable unless they're matched by effective mechanisms to get a grip on cost growth. That's the kind of debate we're now beginning to see bubbling up in Massachusetts following their bold experiment to expand coverage. Without a proper cost containment strategy that really addresses the underlying causes of health care cost growth in that State, their progress is unlikely to be sustainable. That's because coverage will become ever less affordable - and absent politically difficult annual tax increases to grow the public subsidies every year, they'll simply see more people drop out of coverage.

Cost containment is also partly a *fiscal* reality – given the huge sums that are now being spent on Stimulus, TARP and the like, the future prosperity of the nation increasingly depends on getting future entitlement spending in Medicare under control.

It's a *political* reality too – rightly or wrongly, the polling suggests that voters' number one concern is the affordability of health care, ahead of dealing with the uninsured or raising quality. And for all these reasons cost containment is therefore likely a *legislative* reality too – a bipartisan agreement would likely require use the 'PayGo' Congressional rules by which new spending has to be offset by new savings – rules that the President said at the weekend he too believed should be used.

## **The hunt for savings**

So the hunt is on for savings – specifically, savings in future federal health expenditure, which can be scored as such by the Congressional Budget Office. It's not yet clear how well that hunt is going. On the assumption that the desired coverage expansions come with a price tag of somewhere well north of \$100 billion a year in new spending, over \$1 trillion of savings over a 10 year budget window are going to be needed – and probably nearer to \$1.5 trillion. And even that could be an underestimate of eventual costs. The President's initial budget proposal got part of the way there - \$634 billion of the way there – but half came from a proposed change in the tax code that Congress seems unlikely to support.

Faced with the size of the challenge – and the economic reality that every dollar of health spending saved is a dollar of someone's income forgone – it would be easy to feel despondent about the likelihood of success. But our experience at UnitedHealth Group suggests that this goal is eminently attainable. In fact, our real world data suggest the possibilities for savings are in some categories even larger, and opportunities to get at them even more extensive, than are currently being discussed in Washington DC.

So over the coming few months we are determined to support policy makers in Congress and the Administration in their quest for thoughtful and pragmatic 'scorable' savings. To help in this, we have established a new UnitedHealth Center for Health Reform & Modernization, whose job it is - amongst other roles – to distill our practical insights into how these savings can be accomplished drawing on our data, research and experience. Since the Congressional Budget Office estimates that 93 cents on the dollar of national health care costs are incurred in care delivery and other programs as against on the financing side of the system (so-called

'administration and net cost of private insurance'), clearly that's where attention has to be focused.

And just so I'm not misunderstood on this point. That's not to say that there aren't also savings from reducing transaction costs and from administrative simplification – there are – and we are modernising payment systems to do just that. But the fact is, that's not where most health costs are incurred, so by itself they can't produce the level of savings that will be needed.

### **Opportunities for action**

Where, then, are some major opportunities? It's quite a long list, and here are just a few of the items where we will be bringing forward our data and our detailed savings proposals in the coming weeks and months:

- First, achieve greater transparency around variations in performance and quality, linked to payment incentives for provider improvement, and benefit designs that support patients in making good choices. Employers who have deployed the full tool kit of these UnitedHealth Group programs over the past couple of years have seen a health care cost trend averaging 4% versus 6-8%+ for Medicare and the rest of the healthcare system.
- Develop 'centers of excellence' inside Medicare where patients are treated at the best performing hospitals for more specialised conditions – we've been running these programs for two decades in the commercial sector; there's no reason why the same techniques can't benefit Medicare beneficiaries too.
- Introduce transitions-of-care programs to help seniors transfer from hospital to home – partly as a result, our Medicare readmissions are 25% lower than in traditional Fee For Service Medicare.
- Deploy more intensive support for Medicare beneficiaries with multiple chronic conditions – this has been shown to reduce hospitalization by 29% compared with traditional Medicare.
- Ensure better value from prescription drugs - as we do in our commercial and Medicare Part D programs.
- Expand oversight of evidence-based uptake of radiology services – whose Medicare costs exploded from \$7 billion to \$14 billion a year between 2000 and 2006.
- Emphasise payment accuracy and fraud reduction – applying these programs more widely to Medicare and Medicaid could save several billion dollars annually.
- Administrative simplification to take out some of the red tape and paper shuffling from a system where only an estimated 9% of hospitals have proper electronic health record systems.
- An end to the waste induced by a malpractice system in which it's estimated that only 46 cents on the dollar ever reaches the injured patient.
- And since obesity is estimated to be causing 12% of healthcare cost growth in recent years – partly because of it's a precursor to diabetes - we need junk food out of schools, and sports and physical activity back in our children's lives. We should follow New York's lead on making transparent the calorie, fat and salt content of fast food. And what about adjusting the taxes on food to change the relative costs of healthy versus unhealthy eating? It's time to call a halt to the obesity epidemic that now affects one-in-five of our children.

And we have many other practical ideas and programs in addition to these.

As I say, we'll be bringing forward more detailed estimates and proposals in these and other areas shortly. But there are three that I want to talk about in a bit more detail today. They are:

- the importance of greater transparency about variation in the quality and efficiency of care so as to help improvement and enable patients to make good choices
- practical ways of strengthening primary care, and
- improving the dignity of end of life care.

### **Tackling performance variation**

Arguably the most profound savings opportunity will come from being able to tackle the differences in quality and efficiency of care that exist right across the healthcare delivery system – differences that are for the most part not explained by differences in patients’ needs or preferences. What have we learned from our work over many years to measure and influence these variations? First – that our real world data confirm they are real, just as reported by academic researchers at leading institutions such as Dartmouth and RAND. Second, that it is possible to use data sharing and payment incentives to do something about it, by stimulating more evidence-based care. And third, that these improvements can be reinforced with consumer information sharing and so-called value-based benefits designs.

So for example, our ‘premium’ provider networks apply evidence-based science and specialty society guidance across 20 medical specialties in 39 states covering nearly 20 million of our members. We have been able to identify nearly 100,000 physicians who consistently produce superior clinical outcomes at up to 20% lower costs, because of the quality and appropriateness of their work. We then combine clinical evidence with our data on patients’ actual care to spot gaps in care –that is treatments or preventive services that patients haven’t yet got but they need.

And then to this, we are adding our “consumer activation index” to systematically engage consumers in better care decision making. Our research suggests that 48% of the time people are making health care decisions that are not optimal for them, as measured against 53 discrete decision variables. At the moment these kinds of programs are largely missing from Fee for Service Medicare. Our data suggests they could produce significant savings. So how might this be achieved?

CMS might consider demonstration projects under which health plans could offer to use their performance data and care management programs to create virtual network ‘overlays’ on fee-for-service Medicare. Participation in these programs would be entirely voluntary for seniors, who might however benefit from lower Part B premiums and lower cost sharing when they chose to use a premium-designated provider who scored better on quality and efficiency. The bulk of the remaining savings would accrue directly to Medicare.

In any event, Medicare should begin to contribute its data to a sector-wide effort combining public and private payer data to produce valid and relevant physician and hospital performance measures. This would go far beyond the current public reporting efforts by CMS, and mirror some of the innovation that commercial payers have driven over the past few years. If commercial payers could have confidence that such a process would not block accountability, slow innovation or lead to lowest common denominator solutions, they would probably be willing to sign up to a unified industry-wide process which could be far superior to the current efforts.

### **Strengthening primary care**

But of course this is only part of the story. We also need some fundamental changes in the structure of care delivery. Which brings me to second specific area I want to touch on.

We are convinced by the data – both from this country and internationally – that strong primary care is crucial to a high quality health care system that uses resources well. In place of the current care system fragmentation, duplication and waste, we need ongoing care coordination as well as proactive and preventive support for patients with chronic conditions. Primary care is part of how we'll do that. And we have three practical suggestions for getting there.

First, primary care physicians need to be paid more, particularly relative to specialists. In the early 1970s, the average surgeon earned 30% more than a family physician. Now it's well over double. The same is true, too, for gastroenterologists and radiologists – they also earn more than twice what a family physician makes. It's therefore not surprising that 28% of Medicare beneficiaries report difficulty finding a primary care doctor, or that in Texas apparently 62% of primary care doctors aren't taking new Medicare patients. The situation is even worse for Medicaid patients. That's what happens when government attempts to manage health care costs solely by squeezing providers' unit prices, rather than by deploying more sophisticated approaches that influence appropriateness of care.

So if Congress wants to rectify this situation in a budget neutral way they now have the opportunity to do so. For example, a larger proportion of the proposed new Medicare doctor payments – the so-called 'Doc Fix' - could be dedicated to increase primary care physician payments. And the process for updating Medicare payments to physicians could be made more transparent and robust, in place of the current specialty-dominated update process.

Second, primary care providers need to be paid differently. Medicare, Medicaid and private payers all need to move to more blended payments rewarding ongoing care management and appropriate use of resources, rather than only relying on the current Fee for Service system. Let's pay for quality not just quantity.

At UnitedHealth Group we've been experimenting with these approaches for some time, working with the primary care medical societies. Patient-centered medical home is one model, and there are many others, including in other countries with stronger traditions of primary care. So if primary care physicians are going to get higher pay – including from the 'Doc Fix' – it should be a 'something for something' deal, by which the physicians agree to new reimbursement structures that link more of their pay to quality and appropriateness. Medicare in turn should, as payment expert Bob Berenson has suggested, evolve the RBRVS mechanism away from compensating for input costs to increasingly paying based on the value to patients' health of the service being provided. That will help primary care too.

None of this will be easy, but all of it is do-able. In fact many other industrialised countries have already done it, and help point the way. Britain, for example, found that within three years of having put in place a new contract structure for its family physicians, head count was up by 15%. And the same could happen here.

Third, more can be done to build up the primary care infrastructure. The \$19 billion of new health IT money should help, given that only an estimated 17% of physicians have electronic health records. But it'll only produce lasting value if the government ensures that new systems meet appropriate standards for interoperability and include appropriate clinical decision support and other tools to promote evidence based care.

We also need new models to support primary care physicians who are working single-handedly or with one or two other colleagues – the dominant model in many parts of the country. While large multi-specialty groups may have advantages – indeed UnitedHealth operates physician

groups like that that work very well, such as Southwest Medical Associates in Nevada - the fact is that's not the way doctors are organized everywhere, nor are they likely to be anytime soon, so you can't have a reform model that only works in those settings.

Instead there could be alternative models in which health plans help provide the necessary technology, nursing and infrastructure support for physicians to help them integrate care 'virtually' at the level of the patient. This could perhaps be a more scalable way of becoming an 'accountable care organization' rather than requiring doctors to forgo their independence and merge organisationally with hospitals, as some are advocating. It's why for example, together with IBM, UnitedHealth Group is currently testing a new model in Arizona in which we provide primary care practices with the extra staffing and technology they need in order to be able to respond to the new payment models I just talked about.

Longer term, we need to make primary care a more attractive specialty for new doctors – raising pay and status will help, but we also support new federal loan forgiveness initiatives, additional training programs and similar measures. Public and private efforts to simplify health care administrative processes would also make primary care practice more attractive. Last but not least, more explicit support should be given to the role of nurse practitioners and other non-physician primary care professionals –starting perhaps with the 10 states that still heavily restrict nurses' scope of practice.

Now I'm not arguing that any of this constitutes a magic bullet. Much of it will take time. But there's no reason why within three years we shouldn't have better family physician pay, more sophisticated incentives, and much stronger infrastructure. The new Doc Fix money coupled with the stimulus cash provides an historic opportunity to do just that. We mustn't blow it.

### **Dignified end-of-life care**

Let me briefly mention a third area where we can do better. I'm referring to the care people receive in the last few months of their lives. It's a difficult topic that people are understandably reluctant to talk about. Most people die in hospital whereas most people say they'd rather die at home. Clearly our current system is failing to support patients in making their choices stick. If anything, the system is imposing its preferences for hi-tech hospital stays on patients –and at very considerable cost. Over a quarter of Medicare spending occurs in the last year of life, with big variations across the country that don't relate to differences in what patients say they want.

Yet we know from our own data from our own hospice programs, that for every month a patient with a terminal illness is engaged with hospice or with our advanced illness case management, there are substantial Medicare savings. But patients often don't get to hear about these programs until shortly before they die - the median time that patients are engaged with hospice programs is a mere 3 weeks.

So what can be done to give patients more information and choice earlier on? Every patient should have the opportunity and be encouraged to complete an advance directive. Palliative care consultation should be expanded to all hospitals. And Medicare should pilot expanding eligibility for hospice for people with a prognosis of a year not just six months as at present to encourage earlier enrolment so that the programs can have a bigger impact.

As well as improving the quality of end of life care, providing the appropriate care that families want rather than unwanted and unneeded care would likely save Medicare at least \$20 billion over the next 10 years, and according to estimates from experts at Dartmouth College, possibly

10 times that amount. So there's every reason to act on this now – for human reasons more than anything else.

## **Conclusion**

And there I must leave it. I hope I've been able to sketch out an argument showing that – despite the challenges facing healthcare here in Illinois and right across the country – reform and modernization are not only *needed*, they are truly *possible*.

And just as important, it can be done without breaking the bank: there are real opportunities for getting more value out of the health care dollars the nation is spending. And we at UnitedHealth Group are committed to helping unleash them.

Thank you.

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