Testimony on

Health Information Technology

by

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I. INTRODUCTION

Good morning, Mr. Chairman and members of the subcommittee. I am Karen Ignagni, President and CEO of America's Health Insurance Plans (AHIP), which is the national trade association representing nearly 1,300 health insurance plans providing coverage to more than 200 million Americans. Our members offer a broad range of products in the marketplace and also have demonstrated a strong commitment to participation in public programs.

We appreciate this opportunity to testify about the role health information technology can play in improving the delivery and quality of health care. We applaud Congress and the Administration for prioritizing this issue. It is encouraging to see members of Congress addressing this priority on a bipartisan basis, and we thank you for the opportunity to discuss the positive contributions our members are making in this area.

Our members are strongly committed to advancing an interconnected health care system in which health information can be exchanged electronically to empower individual consumers and clinicians to make better health care decisions and, at the same time, to improve quality, value, and efficiency throughout the U.S. health care system.

Our testimony today will focus on six areas:

- Opportunities to deploy health information technology to improve quality, value and efficiency for health care consumers;

- The role health insurance plans are playing in advancing health information technology;

- Specific health information technology initiatives implemented by AHIP member companies;

- The importance of Personal Health Records (PHRs) in an interconnected health care system;

- Keys to the successful implementation of health information technology; and

- Our concerns about certain policy issues imbedded in pending legislation to expand health information technology.

II. OPPORTUNITIES TO IMPROVE QUALITY, VALUE AND EFFICIENCY

In the U.S. health care system, the organization and management of personalized health information have not always kept pace with the advancement of modern medicine. Personal health information is often fragmented and incomplete, and can result in unnecessary and preventable medical errors, inappropriate care, and duplication of services – all contributing to rising health care costs and missed opportunities to improve patient care.

At the same time, variation in medical decision-making has led to disparities in the quality and safety of care delivered to Americans. A 1999 report[1] by the Institute of Medicine (IOM) found that medical errors could result in as many as 98,000 deaths annually, and a 2003 RAND study[2] found that patients received only 55 percent of recommended care for their medical conditions. A wide range of additional studies indicate that Americans frequently receive inappropriate care in a variety of settings and for many different medical procedures, tests, and treatments. Such inappropriate care includes the overuse, underuse or misuse of medical services. Studies also show that patterns of medical care vary widely from one location to another, even among contiguous areas and within a single metropolitan area – with no association between higher intensity care and better outcomes.

The widespread practice of defensive medicine to minimize the threat of litigation is another factor contributing to inappropriate care and higher costs. According to a study recently published in the *Journal of the American Medical Association*[3], 93 percent of specialty physicians reported that they engage in defensive medicine. When asked about their most recent

[1] "To Err is Human," Institute of Medicine, 1999
[2] "The Quality of Health Care Delivered to Adults in the United States," Elizabeth A. McGlynn, RAND, June 25, 2003
[3] "Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment," *Journal of the American Medical Association*, June 1, 2005

act of defensive medicine, 43 percent reported using imaging technology in clinically unnecessary circumstances.

To meet these challenges, it is critically important for the public and private sectors to work together to develop an interconnected health care system that provides consumers and clinicians with access, through PHRs, to a history of each individual's health information wherever and whenever it is needed. Doing so will yield benefits for consumers and other stakeholders on several levels:

- Meaningful information will be available to patients and providers in a usable form and in a timely fashion to improve the overall safety, effectiveness, and efficiency of an individual's care;

- Wasteful and duplicative care will be reduced. A well-coordinated health care system will remove the need or justification for repeating or performing unmerited interventions;

- Increased transparency in the health care system will allow for a meaningful comparison of health outcomes and resources expended;

- The latest advances in evidence-based medical practices will be disseminated broadly and rapidly;

- Consumers and purchasers will benefit from a system that deploys resources more efficiently and effectively;

- Clinicians will be able to increase their productivity when they have the complete picture of a patient's health care, including services received from other caregivers; and

- Quality performance will be rewarded.

Cost Savings

While it is difficult to predict the cost savings that will be achieved through health information technology, a number of studies suggest that the savings will be significant. In a January 2005 study published by *Health Affairs*[4], the Center for Information Technology Leadership (CITL) estimated that implementation of an interconnected and fully standardized health care system would yield $77.8 billion in annual savings. This study focused specifically on the benefits of a system in which hospitals and medical groups can exchange information electronically, using uniform standards on a nationwide basis, with five key stakeholders: payers; pharmacies; public health departments; radiology centers; and independent laboratories.

Separately, the Government Accountability Office (GAO) issued a report[5] in October 2003 on the cost savings achieved through health information technology. The GAO found that one health insurance plan, Blue Cross and Blue Shield of Alabama, reduced its data entry costs by $20 million annually by applying health information technology to its claims processing functions. The GAO reported that health insurance plans also achieved other benefits including "increased staff productivity, improved timeliness in processing claims, improved customer satisfaction, and improved clinical care to members."

III. ROLE OF HEALTH INSURANCE PLANS

Quality-Based Programs

AHIP's member companies are on the front lines of developing information technology systems to improve health care quality and administrative efficiencies.

Health insurance plans have a strong track record of using health information technology to implement programs that reward providers for quality performance. Health insurance plans have instituted a range of provider payment arrangements – often referred to as pay-for-performance

[4] "The Value of Health Care Information Exchange and Interoperability," *Health Affairs*, January 19, 2005
[5] "Information Technology Benefits Realized for Selected Health Care Functions," Government Accountability Office, October 2003

programs – that are promoting high quality and efficiency throughout the U.S. health care system. Our members' experiences clearly indicate that paying for quality is a promising strategy for improving overall wellness and advancing evidence-based medicine, which translates into better health outcomes and greater value for employers and consumers.

Some quality-based payment programs provide financial awards to physicians in the form of increased payments, while others offer non-financial rewards in the form of public recognition, preferential marketing or streamlined administrative procedures. Additionally, some plans are offering consumers reduced co-payments, deductibles, and/or premiums in exchange for using providers deemed to be of higher quality, based on specific performance measures. In all of these programs, health information technology plays a role in collecting data to evaluate the performance of health care providers and determining the extent to which they are achieving desired goals.

Collaboration Through the AQA

A critically important step in moving forward with programs that reward quality performance is the development of a uniform, coordinated strategy for measuring, aggregating and reporting clinical performance. To address this challenge, AHIP has been working with the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), other medical specialty organizations, the Agency for Healthcare Research and Quality (AHRQ), consumers, and employers.

This collaborative effort – called the Ambulatory Care Quality Alliance (AQA) – recently reached a consensus on a common set of 26 ambulatory care performance measures that are intended to serve as a "starter set" that will provide clinicians, consumers, and purchasers with a set of quality indicators that can be used for quality improvement, public reporting, and pay-for-performance programs. This starter set will be expanded in a multi-phase process, resulting in a more complete set of measures to address a wide range of additional quality indicators addressing efficiency, patient experience, sub-specialties and other key areas.

In addition, the AQA is developing strategies for uniform data aggregation and for reporting reliable and useful quality information to consumers, providers and other stakeholders. The AQA recently developed two sets of fundamental principles for reporting. The first set of principles, which addresses reporting to consumers and purchasers, aims to facilitate more informed decision-making about health care treatments and investment. The second set of principles, which addresses reporting to physicians and hospitals, is designed to facilitate quality improvement and to inform providers of their performance.

The AQA will continue to move forward in the areas of measurement, data aggregation and reporting, and encouraging additional key stakeholders to become involved in this important effort to improve health care quality and patient safety. The dissemination of information derived from *aggregated* performance data ultimately will yield benefits on several levels. Consumers will be able to make more informed decisions about their health care treatments. Physicians, hospitals and other health care professionals will be better able to improve the quality of care they provide. Purchasers will receive greater value for their investment in health care benefits. Health insurance plans will continue to develop innovative products that meet consumer and purchaser needs.

Electronic Prescribing

Electronic prescribing – a key element of the overall strategy for interconnectivity – is another area where health insurance plans are making significant contributions.

Many of AHIP's members use web portals to give individual members access to their pharmacy-related personal information, including pharmacy claims, benefits information, up-to-date formulary listings, and online search tools to find participating pharmacies. Some health insurance plans also allow members to fill or refill prescriptions online, send questions electronically to a pharmacist about their medications, and purchase over-the-counter medications online at discounted prices. Others are working with health care providers to incorporate health information technology into practice settings – in some cases through personal computers and handheld devices for patient order entry and electronic prescribing.

These programs demonstrate our members' strong commitment to the development of electronic prescribing technologies at the point of patient care.

Public Health Surveillance

The unique capabilities of health insurance plans also are evidenced by their active involvement in the development of early warning health surveillance systems. Following the events of September 11, 2001, a number of AHIP member companies collaborated with the Centers for Disease Control and Prevention (CDC) to develop a demonstration program to identify illness patterns that might represent the initial warnings of a bioterrorism event.

This demonstration program includes a rapid response capability to identify unusual clusters of symptoms or illness from daily encounters, to alert public health officials about these clusters, and to facilitate the ability of public health officials to obtain detailed clinical information about specific cases when needed. Health insurance plans report only aggregate de-identified data to the surveillance system, thus providing maximum protection of patient confidentiality. In cases where unusual clusters are identified, the state or local public health team will work with clinicians to decide if additional information is needed.

By arming public health officials with real-time data on clusters of emerging symptoms and illnesses, health insurance plans have established themselves as an important part of an advanced disease surveillance system to help protect our nation from emerging infectious diseases and potential bioterrorism agents. This is possible because our members have a unique set of skills and competencies based on their integrated care coordination systems, large defined populations, and comprehensive data sets. These same assets will enable health insurance plans to play a central role in helping the nation transition to an interconnected health care system.

Initiatives By AHIP Member Companies

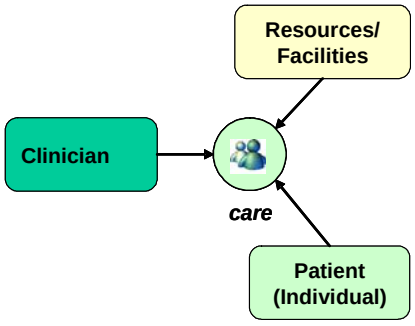
To provide a better understanding of health information technology initiatives developed by our members, we are attaching an appendix that provides brief examples of some of the programs being implemented across the country. We are providing these summaries to give the committee a better understanding of the depth and breadth of initiatives that are being adopted.

IV. PERSONAL HEALTH RECORDS (PHRs) AS THE CORNERSTONE OF AN INTERCONNECTED HEALTH CARE SYSTEM

Our members' vision for an interconnected health care system involves the creation of a PHR that contains information key to the safety, effectiveness, and efficiency of an individual's care, and will be linked to and fully compatible with Electronic Health Records (EHRs) initiated by health care institutions or clinicians.

The delivery of health care requires three basic inputs as illustrated by the diagram below:

- the individual, with his or her personal history, needs, and preferences;
- the clinician with the knowledge, skills, and experience necessary for the evaluation and treatment;
- facilities and other resources necessary for care to be conducted, such as a radiology department or an ER.



As the committee is aware, an individual's encounters with the health care system may consist of a family practitioner, a specialist who deals with heart disease, a physiotherapy service at a local clinic, and a local pharmacist. Some relationships between an individual and the health care system may be episodic, such as a visit to the emergency room; others may endure for many

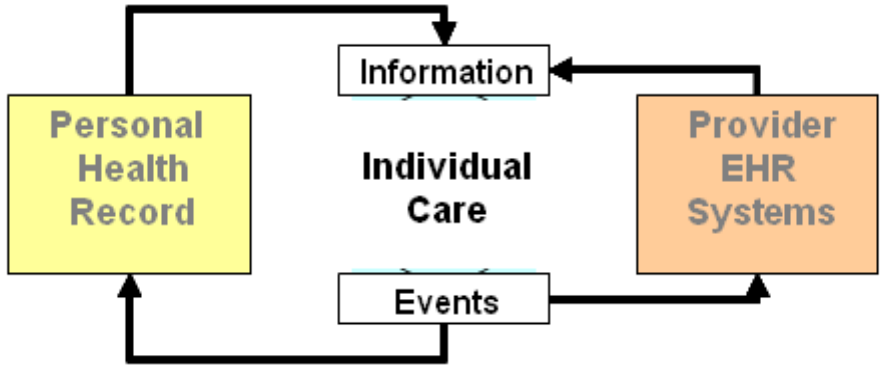
years. A healthy individual will have only infrequent health encounters. By contrast, a person with multiple chronic diseases will have numerous complex relationships and encounters with the health care system that span multiple institutions and physicians. Some relationships will arise as part of a prescribed treatment, while others will be *ad hoc* or consumer-initiated.

What is certain is that individual relationships and encounters with the health care system are becoming more complex and diverse with growing rates of chronic disease, an aging population, and greater consumer choice. Each health care event may result in a diagnosis or treatment that has widespread and enduring significance for an individual's future care and overall health. The information that populates a Personal Health Record (PHR) comes from these events. AHIP's Board of Directors has launched an effort that is designed to result in each consumer having a PHR containing information about their health and their care, based on key information from health plan-based claims management systems, other health plan administrative data, and in some cases data from health care provider-based EHR systems. The goal is to integrate information from all sources to create a coherent and useful understanding of the individual's overall care. The information in a PHR should be owned by the individual and maintained securely and confidentially on their behalf.

The PHR will be complemented by EHRs, which are more than a record of care. An EHR focuses on the details of care 'processes' within a hospital, a doctor's office, or other care setting. It is required to manage information that is as much about the professionals, the organization, and medicine in general, as it is about the individual patient. These two characteristics – the comprehensive support for tasks and the recording of information about the provision of care – mean that an EHR is a strong reflection of the particular institutional context and the clinical services it supports. The EHR represents not only patient information, but information for medical and/or legal uses by the institution – the EHR is designed to someday become the legal and permanent institutional health record regarding the care of a patient.

It is vital to understand that PHR and EHR systems are not alternatives. They are complementary, work together, and together achieve the goal of both managing the overall care of the individual and managing the delivery of health care services that are required to have an

interconnected and electronic health care system. The diagram below illustrates the separate roles of PHRs and EHRs:



Core information for safe, effective, and efficient care across providers and time

Detailed clinical and process information about care given by a single provider

The PHR has the potential to influence both the resourcing side of the health care system and the delivery of individual care. The prime purpose of the PHR is to ensure that the information most valuable for the overall quality and efficiency of the individual's care is available wherever and whenever it is needed. The PHR links together and coordinates an individual's many health encounters.

V. KEYS TO SUCCESSFUL IMPLEMENTATION OF HEALTH INFORMATION TECHNOLOGY

To accomplish the successful development of an interconnected health care system, it is important for the public and private sectors to work together to address a number of priority issues. These include creating national, uniform interoperability standards; assuring the privacy and security of health information; and financing the adoption of health information technology.

Uniform Standards and a National Framework

AHIP supports the creation of voluntary, national, uniform interoperability standards that facilitate the interconnectivity of health information systems. It is widely recognized that the development of an interconnected health care system that improves health care quality and efficiency is dependent on the creation and adoption of such standards. We believe that the federal government and the private sector, working together, can implement uniform standards and operating rules to facilitate the exchange of information and make the process transparent, without stifling innovation.

AHIP and our members are looking forward to being active participants in this process. We intend to launch an effort to involve a diverse group of key stakeholders in developing common standards and core content areas for PHRs that take into account issues of importance to consumers, providers, and purchasers. At the same time, we encourage HHS to pursue a similar process for EHRs.

Uniform, consensus-driven standards will bring together different health information technology systems into a national health information network by specifying common data formats, communication protocols, and operating rules. Government and private stakeholders need to work cooperatively through the existing standards development organization process to create and maintain standards and push them into the marketplace. Such standards should be designed through an open model that allows sufficient flexibility to be adopted by various organizations in diverse and changing environments. The AQA's work on a strategy for measuring and reporting clinical performance, which we discussed earlier, could serve as a model for stakeholders to move forward in developing interoperability standards.

Another promising example is the Council for Affordable Quality Healthcare's CORE program. CAQH is an alliance of health plans – which includes AHIP and many of our member organizations – that promotes collaborative efforts to streamline health care administration. Its CORE program has brought together multiple industry stakeholders to create and, ultimately,

disseminate and maintain operating rules to facilitate real-time, comprehensive, secure transfer of patient eligibility and benefits information.

The initiative was launched because the private sector recognized the need for an interoperable solution for communicating member data to physician practices. Currently, practices do not have easy access to consistent information on plan coverage, co-pays, deductibles and other benefits information. CORE will change that by creating a variety of standards, including clear definitions and interpretations of data elements, technical transmission standards and formats, and standards for data transactions.

The CAQH program is modeled on the strict information-exchange rules that make possible direct deposits and ATMs in banking. If the initiative's rules can be as successful in unifying the health care industry, the projected administrative savings for physician practices would be significant.

Uniform standards will spur the development of a national framework that facilitates the creation, maintenance, and sharing of electronic health information. It is critically important for this framework to be national, rather than regional, to ensure that health information can be exchanged electronically whenever and wherever it is needed to improve patient care.

Privacy and Security

AHIP supports efforts to assure privacy and security for health information. Consumers must have confidence that portable and internet-enabled health information systems are maintained in a secure and confidential manner.

We believe that significant protections for health information already are provided through HIPAA and corresponding regulations. HIPAA governs the use, disclosure, and security of health information by health care providers, health care clearinghouses, and health plans. As a result, these HIPAA-covered entities should encounter few, if any, issues that would compromise privacy or security when participating in a national health information network.

Two issues, however, merit additional consideration. One question is the extent to which entities that may use or disclose electronic health information should be required to institute privacy and security safeguards if they do not meet the definition of a "covered entity" for purposes of the HIPAA rules. The Department of Health and Human Services should develop a regulatory strategy to ensure that these entities (e.g., banks and financial institutions that administer credit card transactions when patients pay co-payments in a doctor's office) provide privacy and security protections as appropriate.

Another issue involves the interaction of other federal and state privacy laws and the electronic exchange of health information. Some federal and state laws may serve as a barrier to interconnectivity by unduly restricting the types of information that can be shared and the methods used to exchange information. For example, state laws that restrict the disclosure of information related to specific diseases or medical conditions may limit the ability of clinicians to participate in a national health information network.

State laws may provide other barriers, including impediments to the use of electronic prescribing devices. Additionally, inconsistent state laws may prevent the electronic exchange of certain health information across state lines; such laws may be particularly burdensome for providers that treat consumers who reside in areas near the border of one or more states. HHS should work with Congress and other stakeholders to identify potential conflicts and consider whether such laws should be preempted. Policymakers should consider the importance of clear rules for the exchange of health information, while at the same time recognizing the impact that privacy rules have on health care quality.

Financing

AHIP supports public and private efforts to finance the adoption of health information technology with the goal of improving the quality and delivery of health care.

The health care community is investing significant resources in health information technology. For example, many health insurance plans and health care providers are using equity, loans, and venture capital to fund the adoption of health information technology and electronic record systems. This trend will continue as more members of the health care community recognize a return on these investments through improved health care and greater administrative and business efficiencies. In addition, health insurance plans and the Medicare program are developing incentives to compensate providers for using health information technology and evidence-based outcomes measures to promote better quality care.

The federal government can also play an important role by assisting solo practice physicians and others who may not have the financial resources to develop and adopt the necessary infrastructure to participate in the national health information network. This assistance can be provided in the form of incentives, low-interest loans, grants, and tax credits that reward quality through the adoption and integration of technology solutions. Tax credits would be a particularly effective approach to stimulating improvements in productivity through the use of information technology. This assistance should be directed toward achieving the overall objective of improving the quality and delivery of health care.

VI. CONCERNS ABOUT PENDING LEGISLATION

AHIP and our members appreciate the strong congressional interest in health information technology. We believe it is particularly helpful that this issue is being addressed on a bipartisan basis in both the Senate and the House. At the same time, we do respectfully suggest that legislative efforts in Congress should avoid prescriptive rules (e.g., regulating the design and operation of PHRs) that could hinder ongoing collaborative efforts. Instead, we hope that any legislation considered by Congress will allow a public-private process to move forward to develop and implement uniform standards and operating rules for interconnectivity.

Additionally, we would like to highlight our concerns about two specific issues addressed by pending legislation.

Regional Health Information Organizations (RHIOs)

AHIP supports efforts to define an appropriate role for community-based efforts – such as Regional Health Information Organizations (RHIOs) – within the overall development of a national health information system. First, however, a national framework needs to be developed to pave the way for regional initiatives. This framework is essential to ensure interoperability across the health care system, not only in local regions, but across state lines and nationally.

We recognize that RHIOs can play a constructive role in fulfilling health information needs at the regional level, yet we also believe that an overreliance on RHIOS – in the absence of federal standards – would complicate efforts to achieve compatibility across the country. A key factor for a successful national health information network is the ability to move information *whenever* and *wherever* it is needed. This goal cannot be achieved by regional systems that are unable to exchange information outside their geographic area. Therefore, it is important for regional projects to comply with national interoperability rules. Otherwise, stand-alone regional networks will be unable to facilitate national information exchange.

We look forward to working with Congress to discuss how RHIOs can operate within a national framework to ensure that practice patterns can be compared across regions, quality monitored, and efficiency improved.

Safe Harbors

We also believe it would be a mistake to relax federal fraud and abuse laws for the purpose of allowing hospitals to support physician use of health information technology. We are concerned about the unintended consequences of tying physicians to hospitals financially through equipment subsidies or electronic record sharing. Moreover, the ability of physicians to cooperate with other providers – and deliver services in a range of hospitals – may be hindered if they become dependent on a hospital-based information sharing network.

Another serious concern is that the proposed safe harbors could unintentionally lead to information sharing programs that are isolated, and would therefore impede the development of the interconnected system that is needed to exchange information on a national basis. Instead of encouraging isolated pockets of record sharing, we should focus on promoting open and interconnected systems that assure the free flow of information.

We believe that creating new exceptions to current fraud and abuse laws is not only unnecessary, but will undermine the integrity of the existing regulatory framework.

VII. OTHER ELEMENTS OF A BROAD-BASED STRATEGY

While health information technology can go a long way toward addressing cost and quality challenges, this is only one component of the broad-based strategy that is needed for transforming the health care system. Policymakers should at the same time encourage and pursue a variety of other programs and initiatives to further advance quality and efficiency.

Invest in Cost Effectiveness and Translational Research

While the federal government invests heavily in clinical research, it makes only modest investments in research that compares the relative effectiveness of existing versus new therapies that are designed to treat the same condition. The federal government should assign a high priority to this kind of research and also direct more funding to promote the widespread adoption of best practices and reduce the overuse and misuse of health care.

A National Center for Effective Practices should be created to ensure that the results of cost effectiveness research are translated into usable information for providers and consumers. This new entity could identify and make publicly available the latest advances in evidence-based medical practices, and also shed light on procedures determined to be less effective.

Develop a Framework for Evaluating Technologies for Effectiveness and Efficiency

To address the rapid development of new procedures, devices and other technologies, a public-private framework should be established to evaluate and compare the effectiveness and efficiency of these technologies. Moreover, new post-marketing surveillance models should be developed to assess the appropriate use and long-term value of certain breakthrough drugs, devices and biologicals.

Overhaul the Medical Liability System to Ensure Effective Dispute Resolution and Promote Safety and Value

The flaws in the current medical liability system should be addressed with reforms that place reasonable limits on health care litigation. Additionally, patient safety legislation is needed to establish legal protections for medical error information reported by health care providers, and to permit the aggregation of data that can be used to determine the causes of medical errors and develop strategies for improving patient safety. Also needed is a uniform, national administrative process to resolve malpractice disputes between patients and health care providers in a fair and efficient manner, thus avoiding the need for litigation as often as possible.

Modernize and Maximize the Effectiveness of the Regulatory System.

- Encourage choice with uniform rules in the small group market: A common set of rules would encourage competition, enhance consumer choice, and provide greater predictability for employers. The solution is not to waive all requirements for particular groups, but to establish an appropriate and consistent framework for all participants to ensure that small employers have maximum options to meet their needs. This means that the federal and state governments need to work together to encourage "best practice" regulation. This process has begun with the development of draft legislation – known as the State Modernization and Regulatory Transparency (SMART) Act – that would promote uniformity in plan processes, particularly internal and external review of coverage disputes, speed-to-market and market

conduct standards.

- Encourage prompt product approval and consistency in regulatory processes. Steps should be taken to ensure that states adopt a mechanism by which health insurance plans can bring innovative products to the market in a timely manner. Ideally, the federal government should encourage states to be forthcoming regarding their standards for policy rate and form filing requirements and to abandon unwritten "desk-drawer rules." This ultimately will create oversight mechanisms that allow companies to provide consumers with the products they need in a timely manner.

- Establish an independent advisory commission to evaluate the impact of mandates on health care costs and quality. Such a commission could advise policymakers on the safety and effectiveness of proposed and existing mandated health benefits, and assess whether proposed mandates result in improved care and value. The commission's findings also could inform public program coverage and decision-making to ensure that evidence-based standards are applied consistently in Medicare, Medicaid, and other public programs.

Provide Funding for High-Risk Pools

AHIP's Board of Directors approved a statement in June 2004 indicating support for federal funding for state high-risk pools to cover individuals who have unusually high health care costs. This legislation fits within the parameters of what Congress is able to accomplish from a budgetary standpoint at this time. This initiative is one of the next steps Congress should take as part of a long-term strategy for strengthening our nation's health care safety net.

Expand Tax Credits to Encourage the Purchase of Health Care Coverage

To address the needs of working Americans who are uninsured and ineligible for public programs, Congress can help make health coverage more affordable by expanding tax credits for low-income persons. This approach will be particularly helpful to Americans who do not have access to employer-sponsored coverage and to those who decline such coverage because of the

high cost. Moreover, tax credits could prompt more small businesses to offer employee health benefits. The Employee Benefits Research Institute (EBRI)[6] has reported that among small employers that do not offer employee health benefits, 71 percent would be more likely to seriously consider offering health benefits if the government provided assistance with premiums.

Provide Adequate Funding for Public Programs

More than 75 million Americans rely on government health programs – including Medicare, Medicaid and SCHIP – to meet their health care needs. It is important for policymakers to recognize that funding shortfalls in these programs can lead to cost shifting, which translates into higher costs for employers, individuals, and other purchasers of private sector health coverage. This underscores the importance of ensuring that Medicaid and other government health programs are adequately funded.

VIII. CONCLUSION

We appreciate this opportunity to testify on this crucial priority. AHIP and our members are committed to playing a leadership role in developing an interconnected health care system – based on national, uniform standards – in which consumers and providers have access to patient-owned PHRs that provide integrated health information, from all clinicians and all settings of care, in a usable form and in a timely manner.

As Congress addresses issues surrounding health information technology and quality, we are eager to continue working with you to support the transition to a modernized health care system that is effective for patients and valuable for all stakeholders.

[6] "Small Employers and Health Benefits: Findings from the 2002 Small Employer Health Benefits Survey," Employee Benefits Research Institute, January 2003

Appendix: Health Information Technology Initiatives by Health Insurance Plans

Aetna is applying innovative health information technology to provide its members and providers evidence-based decision support tools to improve quality of care and patient safety. Aetna's MedQuery program applies evidence-based clinical rules to data derived from members' medical claims and pharmacy and laboratory data to uncover opportunities to improve care and avoid potential medical errors. The MedQuery program generates patient-specific diagnostic or therapeutic suggestions called Care Considerations that are communicated to the treating physician.

In addition, Aetna Navigator™, a member self-service website, is a Web-based portal that allows members to access a wide range of tools and information. These resources are focused on giving members the information and guidance they need to navigate the health care system and to make the most informed decisions. Aetna Navigator is secure, private, and accessible anywhere a member has an Internet connection.

Blue Cross Blue Shield of Massachusetts, Neighborhood Health Plan, and Tufts Health Plan are working with providers and employers to provide access to affordable, quality health care for all Massachusetts citizens through their e-prescribing initiative. The e-prescribing initiative was established in October 2003 and represents a collaboration among the health plans, DrFirst, and Zix Corporation. The program subsidizes handheld devices for providers, a one-year e-prescribing application license, installation, training and support, and six months of internet connectivity where applicable.

At the end of the first quarter of 2005, over 2,600 providers had joined the program; over 2,000 prescribers had the technology incorporated into their offices; and over 40,000 electronic prescriptions were sent during the final reporting period in March 2005 – a 41 percent increase from the highest weekly prescription count of the previous quarter.

BlueCross BlueShield of Tennessee formed a new company, Shared Health, with the goal of improving the delivery of health care for patients, doctors, hospitals and health care payers. Shared Health has developed Community Connection, a patient-centered community health record (CHR) that securely connects medical professionals to a database that merges individual patient health care information, including claims data, lab results, prescription drug information, and immunization history. Shared Health Community Connection effectively removes a key obstacle in the health care delivery system – a lack of information that impedes health care decisions and drives up costs.

Shared Health's CHR is currently serving Tennessee's TennCare population. Next year, BlueCross BlueShield of Tennessee will make Community Connection available to its commercial and private health plan clients. Other private health insurers will then be invited to participate. Ultimately, Shared Health's Community Connection will be accessible to consumers to review their own personal community health record. Based on an extensive cost-benefit analysis, Shared Health Community Connection will ultimately provide an estimated return on investment to the State of Tennessee of more than $4 saved for every $1 spent, within four years of implementation.

CIGNA HealthCare, in 2004, launched myCIGNAplans.com, a national award-winning Web site for consumers who are considering a CIGNA consumer-directed health plan. The site offers an unbiased, side-by-side comparison of the medical and pharmacy costs of CIGNA health plans and helps consumers choose the one best suited for their needs. The Web site is customized to include information specific to the individual's plan options and is highly interactive, allowing consumers to model various health scenarios to determine how health events may impact their benefits and costs. The site was introduced with the launch of CIGNA's new suite of consumer-directed health plans; in a three-month period, 100,000 consumers enrolled for these new health plans.

In addition, in April, CIGNA launched an integrated online Hospital Value Tool to help consumers choose a hospital. The online tool provides "star-based" health care patient outcome

and cost efficiency ratings for hospital-based treatments of 19 medical conditions using both CIGNA and third-party hospital data. The new tool is available to the general public at no charge and rates Patient Outcomes (a combination of quality measures – risk-adjusted, complication and mortality rates, and The Leapfrog Group Patient Safety Index) and Cost Efficiency (based on the hospital's risk-adjusted total costs) for a particular medical procedure or condition. CIGNA HealthCare members may also access more extensive and detailed quality information for more than 150 hospital-based procedures and conditions through the CIGNA member Web portal, myCIGNA.com.

Group Health Cooperative in Seattle, Washington utilizes a clinical information system (CIS), created by Epic Systems and called EpicCare, that facilitates the rapid, accurate, and secure sharing of patient medical records among providers involved in a patient's care. EpicCare continually stores and updates a patient's entire medical record, providing doctors with instant access to a far more encompassing knowledge base than was previously available.

This system enables e-prescribing, provides information on recommended and appropriate drug prescriptions, generates warnings for potential safety conflicts between multiple drugs, and allows patients direct access to information including lab results and prescription refill reminders. Patients can access their own online medical records through secure access to the MyGroupHealth Web site. In addition, the MyGroupHealth Web site provides a host of online services for patients including secure messaging between patients and their health care team, online appointment scheduling, online access to immunization records, access to Healthwise® Knowledgebase, and condition centers and moderated discussion groups.

Harvard Pilgrim HealthCare, in 2003, launched an updated version of its member Web portal, HPHConnect. Through this Web portal, Harvard Pilgrim members can view their prescription drug history; check the status of doctor and hospital bills; check the status of referrals and authorizations for care; compare hospitals using information about quality and patient safety; understand and compare treatment options for health care they may need; and securely communicate with Harvard Pilgrim.

In addition, HPHConnect provides online transaction tools that are used by thousands of employers, brokers and providers. By the end of 2004, providers and billing agents were conducting a million electronic transactions a month using HPHConnect and other electronic channels. HPHConnect provides instant checks on patient eligibility and claims status, and ensures that referrals arrive before patients do. This means less paperwork and more control over cash flow for clinicians, and fewer administrative hassles for patients, before and after they receive care. Almost 99 percent of member eligibility checks and 87 percent of claims inquiries by provider offices are completed electronically, rather than by phone or fax.

Harvard Pilgrim is also participating in two Massachusetts regional health initiatives – Massachusetts-SHARE (MA-SHARE) and the Massachusetts eHealth Collaborative (MAeHC). MA-SHARE's aim is to encourage the exchange of health care data through information technology, standards and administrative simplification, to ensure that clinical health information is available wherever needed in an efficient, cost-effective and safe manner. MAeHC is bringing together the state's major health care stakeholders to establish an EHR system that would enhance the quality, efficiency and safety of care in Massachusetts.

Health Alliance Plan (HAP) awarded a grant to the Henry Ford Health System for its Picture Archiving and Communication System (PACS), which replaces x-ray films with digital images. This initiative makes care more seamless for patients as they do not have to repeat tests, provides almost immediate access to results for providers enabling the delivery of timely medical care, and greatly reduces administrative costs. Physicians can simultaneously call up diagnostic images and related information online allowing for multiple consultations. The initiative reduces overuse and misuse of services, and prevents medical errors as radiologists avoid unnecessary retakes of tests and procedures. In 2004, PACS produced a cost savings of $8.84 million.

In addition, General Motors, Ford Motor Company, DaimlerChrysler Corp., and the UAW joined together to launch the Southeast Michigan e-Prescribing Initiative (SEMI) in partnership with HAP, other Michigan health plans, electronic prescribing technology providers, and pharmacy benefit manager Medco Health Solutions, Inc. Eleven medical centers now use e-prescribing

technology as a result of this initiative and physicians have written over 70,000 prescriptions. The Henry Ford Medical Group improved its generic use rate by 7.3 percent, which potentially will save $3.1 million in pharmacy costs over a one-year period.

HAP also has implemented an online reminder tool to help physicians keep more patients up to date with crucial preventative health services. The Member Health Manager (MHM) shows primary care physicians and OB/GYNs electronic, onscreen reminders for breast, cervical and colorectal cancer screenings, well-child visits, and flu and pneumonia immunizations. During a six-month pilot for MHM, more than 3,000 HAP members received preventative services after physicians viewed online reminders. The guidelines are evidence-based, offering recommendations that are well-supported in medical literature.

Lastly, HAP has implemented an automated process to identify and stratify chronically ill members according to the severity of their illness so that HAP providers can deliver the most appropriate and personalized interventions. This process gathers medical claims, ER visits, inpatient hospitalizations, pharmacy claims and lab data. An algorithm then uses this data and ICD-9 codes to assign a Health Risk Indicator score to each member and ensure that they receive the proper case management. The ultimate impact on clinical and financial outcomes is currently being monitored.

Kaiser Permanente is currently in the process of rolling out Kaiser Permanente HealthConnect – a $3 billion, 10-year initiative focused on deploying electronic medical record systems to ensure the best care for their members and provide doctors, nurses and others caregivers with real-time information. In addition to an electronic medical record, Kaiser Permanente HealthConnect involves the development and deployment of a highly sophisticated nationwide information management and delivery system that integrates the clinical record with appointments, registration, and billing. The Kaiser Permanente HealthConnect program is expected to deliver improvements in care delivery and promote cost savings across the entire Kaiser Permanente organization. Through advanced technology and an integrated care delivery system, Kaiser Permanente will eliminate the inefficiencies and error proneness of paper-based systems.

Patients, physicians and other authorized health care staff will have access to complete, up-to-the-minute medical records, including test and lab results. Immediate access to the best-practice medical science will help physicians and other health care professionals streamline patient care processes and improve health outcomes. Referrals to specialists can be made on the spot; prescriptions are sent to pharmacies electronically; and two doctors treating the same patient from different locations can share information in real-time. Through the new system, patients will also be able to schedule appointments, request medication refills, and ask for referrals. Full deployment of Kaiser Permanente HealthConnect across all of Kaiser's regions will be completed by 2007.

Southwest Medical Associates (SMA), the largest multi-specialty physician group practice in Nevada and a subsidiary of Sierra Health Services, began investing in information technology in 2002 to transform the way health care is delivered and managed in Nevada. The first step was the implementation of an electronic prescribing tool from Allscripts Healthcare Solutions. E-prescribing has increased the appropriate use of generic drugs from 59 percent to 65 percent, saving millions of dollars in drug costs for patients and their health plan sponsors.

SMA also migrated all patient paper medical records to an electronic environment. The medical record data for all patients is now documented electronically and is accessible immediately to all SMA providers from any location within SMA and remotely through a secure web-based interface. The end result is that administrative costs for maintaining paper records have declined while the quality and timeliness of the information available to providers at the point of care is dramatically improved. In addition, SMA has implemented a digital radiology environment that allows images to be made available immediately for review and evaluation at any site. The reduction in x-ray film lowered the average cost of a study from $2.67 to $1.58.

In the near future, SMA plans to expand use and access to their TouchWorks EMR beyond health care professionals at SMA to other providers within the Las Vegas Valley as well as to patients themselves. By expanding access of summary medical information to patients, SMA will be contributing to the development of a PHR. In addition, in partnership with Health Plan of

Nevada (HPN), SMA will provide a secure web-based link to summary EMR information. This initiative will enable all providers within the HPN network to view critical medical information and allow patients to view and print their medical record information to share with providers wherever they seek care. The rollout of the PHR for HPN members is expected to begin in the third quarter of 2005.

WellPoint Health Networks launched an extensive private health initiative to equip physicians with health information technology tools in 2004. Approximately 19,500 technology packages were distributed – 17,000 of which were desktop computers designed to help physicians use the internet for administrative transactions and enhance general medical knowledge. E-prescribing solutions were given to 2,700 providers.

This initiative has resulted in over 60,000 electronic prescriptions to date and the number continues to grow. In addition, WellPoint currently has its own electronic medical record using claims-based data deployed at Blue Cross Blue Shield of Missouri (owned by WellPoint), and will soon launch a plan to make this data available to emergency rooms throughout Missouri.