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Introduction

Thank you Chairman Gregg, Senator Conrad and other distinguished members of the Committee for the opportunity to testify before you at today's hearing on the cost challenges and opportunities facing the Medicare and Medicaid programs. I am Lois Quam, the Chief Executive Officer of Ovations, UnitedHealth Group's business that focuses on meeting the health care needs of the over-50 population – the very group of Americans who are the primary users of health care within both Medicare and Medicaid.

Ovations, and the other companies of UnitedHealth Group, have extensive experience providing health care services to the federal government, state governments and private payers in many types of competitive environments. As the largest health and well-being company in the United States, UnitedHealth Group's operating businesses provide a diverse and comprehensive array of services to approximately 55 million Americans. We provide services to over half of the nation's 100 largest companies.

UnitedHealth Group has a long-standing commitment to serving older Americans. Our participation in the Medicare and Medicaid programs is fundamental to our core mission – to support individuals, families, and communities to improve their health and well-being at all stages of life. We aim to facilitate broad and direct access to affordable, high quality health care.

My business, Ovations, is the largest provider of health care services to seniors in America. We offer a unique perspective on Medicare and Medicaid because we are a major provider of services through traditional fee for service, health plans, and demonstrations for the frailest beneficiaries that both these programs serve. Our commitment is therefore to the beneficiaries, the programs and the taxpayers who support them – rather than a specific product offering.

Ovations is dedicated to helping Americans in the second half of life address needs for preventive and acute health care services, deal with chronic conditions and respond to unique senior issues relating to overall well-being. We deliver supplemental health insurance products and services to 3.8 million AARP members living in all 50 states, the District of Columbia, Puerto Rico, Guam and the Virgin Islands. Through this program, we provide prescription drug coverage to the majority of all Medicare beneficiaries who receive drug coverage through Medigap plans.

Through Evercare, our business that serves the unique needs of frail elderly and chronically ill patients, we provide care and care coordination to disabled and chronically ill Medicare and Medicaid individuals living on their own, in community-based settings, and in nursing homes. We care for more than 70,000 people in 16 states (Arizona, Colorado, Connecticut, Florida, Georgia, Maryland, Massachusetts, Minnesota, New Mexico, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Texas, and Wisconsin). Nearly 70 percent of our Evercare enrollees are dually eligible for Medicare and Medicaid. We also have over 330,000 Medicare beneficiaries enrolled in our various Medicare Advantage plans, including HMOs and PPOs.

Traditional Motivations for -- and Approaches to -- Medicare/Medicaid Cost Challenges

Not surprisingly, discontent about cost growth is igniting discussions like today's hearing about future directions for both Medicare and Medicaid. Frustration with health care affordability, predictability and financing are generally the issues that drive every major health care debate in this nation. The growth rates and cost projections that have been cited this morning are alarming and do -- and should -- demand attention.

Unfortunately, all too frequently our debates are centered on who is paying and how much rather than addressing the root causes of cost increases. Our solutions in this nation, whether that be in the Congress, State Capitol, boardroom, or dinner table, therefore, traditionally follow two predictable and generally frustrating paths: (1) increasing public subsidies; or (2) cutting public programs and cost-shifting to other payers.

As for the first path, we certainly cannot spend ourselves out of our dilemma, particularly now with the constraints posed by our federal deficit. Ironically, while policies in this arena initially moderate short-term health and financial problems, they can counterproductively delay action on needed delivery reforms.

As for the second traditional course of action, we must understand that across-the-board reimbursement cuts in Medicare's payment rates or growth caps in Medicaid will be almost inevitably poorly targeted and, as a consequence, create as much access and quality problems as they solve short-term cost challenges. Moreover, done carelessly, federal program cuts can, and frequently do, simply cost-shift burdens and risk to other payers (such as states, businesses and families), raising pressure to cut back on needed coverage or raise revenue (through higher premiums or state-based taxes).

Where possible, we need to shift away from these old prescriptions to the health care challenge. They tend to lead to unconstructive disagreements and usually represent little remedy to serious problems.

A New Vision of Health Reform

The only real answer to what ails our nation's health system is to make our entire system work – and work much better for the patient, provider and payer alike. We need to focus on the hard work of better managing the allocation of dollars we now dedicate and ensure we are obtaining the best value for our trillion-dollar plus health care investment. In short, we do need to transform the nation's indisputably inter-related public/private health care system into one that is more modern, more accountable and derives greater value for the money.

Today, I want to focus on four ways to achieve greater accountability and affordability in Medicare and Medicaid, as well as throughout the nation's health system. We can achieve this laudable goal by: (1) better managing and coordinating care for the chronically ill; (2) substantially improving productivity within the health care delivery system; (3) developing evidenced-based benefit packages; and (4) applying the strengths of both the public and private sectors to any reforms this nation pursues, recognizing that neither has a monopoly on wisdom or positive outcomes.

(1) Better Managing and Coordinating Care for the Chronically Ill

First, we must focus on the real driver of health care costs – the expenses associated with care for the chronically ill. As Senator Conrad has pointed out, only 5 percent of the Medicare and Medicaid populations account for nearly 50 percent of these programs' costs. What is perhaps even more startling is that health care spending for a person with one chronic condition is two times greater than spending for someone without any chronic conditions, while spending is about 14 times greater for someone with five or more chronic conditions. Beneficiaries with five or more chronic conditions represent 20 percent of the Medicare population, but account for 66 percent of the spending. (*Chronic Conditions: Making the Case for Ongoing Care*; Partnership for Solutions, December 2002).

At least as important, of course, is that chronically ill Medicare beneficiaries have historically received poor care and, as a consequence, had poor (and not just expensive) outcomes. When one considers the state of medical practice on behalf of these vulnerable Americans it is perhaps not surprising that this is the case.

Chronically ill Americans are too frequently forced to cope with totally inadequate coordination between their multiple health care providers. There is poor adherence to prescription drug regimens by beneficiaries because there are so many medications being taken for so many conditions. Moreover, there is often-times even worse communication between and amongst health care professionals who may even be unaware that there are other physicians prescribing medical treatments that may be at odds with care beneficiaries are already receiving. The result is unnecessary and expensive hospitalization or nursing home placement.

Unfortunately, our current system has too few health professionals in the system who have been tasked to help navigate patients through the complicated web of modern health care delivery. And, likewise, there are too few patient advocates who can help seniors access non-medical services, such as transportation or meal services, which can make all the difference in the world to maintain good health and remain out of expensive institutional care settings. Simply put, the result of these shortcomings is poor outcomes as well as costly and inefficient care.

Recognizing these shortcomings, we at Ovations pioneered demonstrations in 1987 with our Evercare product that were designed to serve frail, disabled, elderly and chronically ill populations with complex medical and social needs in both nursing homes and community settings. In five, and soon to be six states (currently in Arizona, Florida, Massachusetts, Minnesota, and Texas and soon in Washington), Evercare integrates Medicaid and Medicare benefits and provides a geriatric care manager who coordinates all acute care, long-term care, prescription drugs and social services for each member. Evercare also has been providing services to the British National Health Service since 2002.

The coordination of care by our nurse practitioners translates into comprehensive medical reviews of the range of conditions each patient has as well as the services they are receiving. This process includes a review of all the medications chronically ill beneficiaries are receiving and red flags any obvious problem for review by the patient's physician(s). Our nurses are also trained to help address psychosocial issues and service needs (like "Meals on Wheels," transportation, and respite services – which provide modest and brief breaks for caregivers).

The results of our work to date have been impressive. We have seen a 50 percent reduction in hospitalizations, a 97 percent satisfaction rating among families and a 20 percent reduction in the number of medications consumed by enrollees. In Texas, the implementation of our program in one county saved approximately $123 million from February 2000 to January 2002. In Arizona, our participation in its program has contributed to a dramatic turn-around in the use of community-based services over institutionally-based care.

We are proud to say that our success in improving outcomes and cost effectiveness for the nation's chronically ill received bipartisan attention and support from, among others, Senator Conrad, Finance Chairman Grassley, Senator Hatch, Senator Lincoln, Ways and Means Health Subcommittee Chair Johnson and Ways and Means Chairman Bill Thomas, and Representatives Ramstad and Cardin. Their leadership provided for the important inclusion of provisions in the Medicare Modernization Act (MMA) that authorize a major expansion of these chronic care management programs within the Medicare program in both the managed care and fee-for-service sides of the program.

We are pleased to report that we intend to be very active in this arena by participating in Special Needs Plans (we have already transitioned all of our Evercare demonstration programs into SNPs, and have plans to develop other SNPs) as well as the traditional fee-for service Chronic Care Improvement Program (CCIP). These new options will provide chronically ill beneficiaries the choice to enroll in chronic care programs with well-trained care coordinators, prescription drug monitoring plans, and other enhanced benefits.

There no doubt will be transitional challenges for Medicare, for beneficiaries and for participating plans. For Ovations, we believe it is extremely important that there be a workable and accurate risk adjustment payment that reflect the actual population served in the Special Needs Plans. We were recently awarded one of the CCIP contracts, and will be working with the Visiting Nurse Service of New York to serve chronically ill beneficiaries in Brooklyn and Queens.

Over time, we see these programs achieving substantial savings for beneficiaries, the Medicare program and taxpayers by avoiding hospitalization and nursing home placement. We have invested in enhanced benefits for beneficiaries, which will be designed to maximize our success at keeping health care affordable.

As for Medicaid, we hope to be able to rapidly expand the use of our Evercare integrated care model for this program. For the nearly seven million Americans who are dually eligible for Medicare and Medicaid, we believe there is great potential to improve care and achieve savings. We hope to accelerate expansion of our program, but also recognize that we face a number of barriers, including a complex and time consuming federal Medicaid waiver process. Also, prior to broader implementation of these programs, some stakeholders have reservations about this model. We well recognize that part of our mission is to illustrate that the services we provide can have benefits for all stakeholders and we are striving to do just that.

Chronic care management must be a central component of both the Medicare and Medicaid programs. It can no longer be treated as a peripheral and sporadic boutique concept. Chronic care costs are the driver of the primary challenges confronting these programs and must become the focal point of our commitment to improving care and constraining cost growth.

(2) Substantially Improving Productivity Within the Health Care Delivery System

Second, as we are targeting the number one cost driver of catastrophic expenditures, we must apply the same types of productivity demands we have done in the rest of the business sector. In short, as we have done in virtually every other sector, we must make our health system more efficient and accountable utilizing the most up-to-date and appropriate technologies and management techniques.

Productivity in the health care sector has consistently operated at levels far lower than in the economy as a whole. If American health care productivity were simply on par with that of the American economy as a whole, we would see improvements in care and increased financial resources. We have found that technology can bring improvements in productivity and, most importantly, patient care in several ways:

- **Improving the way work and patient care is organized.** We have found that fully engaging our work force makes their work more rewarding and interesting. Shifting the organization of our customer service teams from a traditional factory model to an engaged neighborhood model has resulted in increased productivity.

- **Empowering the workforce to improve patient care through appropriate use of technology.** Technologies represent tools to improve and enhance the work of caregivers. Using technologies, such as internet applications, consumer cards, and e-prescribing decrease administrative costs and complexity as it improves care and medical outcomes. New ways of working and better informed patients and caregivers are keys to success. In other words, technology as a stand-alone resource is important but it cannot achieve positive outcomes on its own.

- **Instituting rapid learning models to strengthen our knowledge base about good care.** We have found that holding a case conference every time one of our Evercare members is hospitalized helps us learn new ways to keep the patient healthy enough to avoid future hospitalization. As we gain new knowledge, we can and we do rapidly apply this information to new practices to avoid recurrences of old problems.

While productivity cannot be legislated, legislation using standards and investing in technology infrastructure can help make improvements possible. The keys are reward structures tied to preferred outcomes, incentives for investment in productivity tools, like technology, and regulatory processes that minimize delay and expense.

One of the keys to productivity increases is greater use of health information technology (IT), which makes it possible to pay more for desired outcomes and facilitate effective patient choices through transparency of results. Other business sectors have used IT successfully to increase productivity, and health care can learn from those sectors. Understanding that there will be up-front costs involved, promoting greater use of IT begins with our clinicians. At UnitedHealth Group, we have invested over $1.5 billion in new technologies and approaches.

We also need to make interoperability understandable to people by allowing information to be portable and to move with consumers from one point of care to another. The outcome will be transparency of results, which will facilitate effective patient choices. This is another area where the federal government can be helpful by developing universal standards related to interoperability of health IT. Without some type of standards, it is very difficult to create portable IT tools for consumers.

Productivity improvement is possible, feasible and desirable for the U.S. health sector. Research has shown that as much as 26 percent of productivity improvement since 1995 may be directly related to good information systems, and even more may be indirectly related to the actions people take to improve performance. If health sector employees increase their productivity at par with employees in the non-farm business sector, we should be able to enjoy necessary and sufficient health care from the current health sector labor force at affordable levels of investment.

(3) Building an Evidence-Based Benefit Package

Another way to constrain costs and improve care is to develop a national consensus around a clinically defensible, evidenced-based health insurance benefit package. We need to ensure that the best treatments are covered and encouraged, just as we need to stop subsidizing benefits that are harmful or ineffective. In the absence of doing this, we will have a wide variety of benefit packages that serve neither the patient nor our nation's taxpayers.

To make progress in this area, we need to invest in research to develop an evidenced-based benefit package. Last year, in the Medicare Modernization Act, we took steps towards this end by investing in comparative effectiveness for drugs and devices. The MMA authorized an investment for the Agency for Healthcare Research and Quality (AHRQ) to conduct research on outcomes, comparative clinical effectiveness and appropriateness of health care items and services, including prescription drugs. Publicly funded comparative clinical effectiveness studies of prescription drugs and other treatments will provide science-based, objective information on the relative clinical effectiveness of different prescription drugs and other therapies used to treat the same condition. This type of information will provide physicians, pharmacists and other health professionals, patients, and private and public purchasers of health care ready access to objective, authoritative, reliable evidence and information regarding the clinical comparative effectiveness of prescription drugs in order to make the best decisions when selecting drugs for the treatment of patients.

Now we need to continue down that road by empowering an independent entity to develop an evidence-based benefit package, which is clinically based. This entity should be akin to a private/public Institute of Medicine (IOM) that could develop a benefit package and share their research with private and public purchasers. In this way, we can ensure that neither the government nor private insurers are subsidizing wasteful care and creating disincentives for cost-effective, appropriate care. The federal government can play a critical role by funding such research and, over time, consider realigning tax incentives for the widespread use of evidenced-based insurance packages.

(4) Applying the Strengths of Both the Public and Private Sectors to Health Reforms

And fourth, all too often we find ourselves in a counterproductive debate between public and private sector approaches to health care. I work for one of the nation's largest well-being companies, yet I would be the first to acknowledge the importance and benefits of public programs, and the need for a public-private partnership.

Indeed, the reason why Medicare and Medicaid exist is because there was a very accurate recognition that the private insurance industry alone could not be able to universally provide reliable, affordable insurance to the oldest and poorest of our citizens. They are a very difficult population to insure and, in the absence broad participation, financing and general oversight rules, a substantial number of some of our most vulnerable fellow citizens would go without coverage or would cost-shift to others. While we must recognize and address the serious financing and delivery shortcomings of these programs, we must also acknowledge their critical role and need for their continued existence. Likewise, seeing private plans as the focal point of all problems within our health care delivery system is also unconstructive. The truth is both government and companies have very definable and unique strengths. They include:

- Public programs are better at operating a consistent health system nationally, at concentrating resources on the most vulnerable populations and enforcing operational rules that ensure fairness to beneficiaries and amongst plan and provider competitors.

- Companies can innovate more rapidly, can adapt to local areas needs and strengths more quickly, have great pressure to be efficient, have easier and more rapid access to capital resources and skilled staff that can quickly apply innovations to address priority infrastructure needs.

We must understand that both the public and private sectors have essential roles to play. And both bring strengths and weaknesses to the table. The opportunity is to take advantage of each sectors' strengths and maximize their advantages within a more flexible, responsive and cost-effective health delivery system.

Conclusion

I am confident that the issues and initiatives that I have raised this morning have great potential to substantially respond to and relieve some of the major cost and financing challenges we face. However, there is no silver bullet that addresses all of the cost, access, quality and demographic challenges facing our multi-faceted health care systems.

As this nation ages and the number of older Americans doubles from 40 to 80 million, there will be more health care dollars spent. Covering and treating millions of more seniors will cost billions of dollars more. This fact should not be surprising or troubling. We invested more on colleges and job training programs for the baby boomers, and it led to an explosion of productivity and an extraordinarily strong economy. However, if baby boomers through their 60s, 70s, 80s and beyond experience a transformed and more cost-effective health care delivery system, we can reduce per patient costs substantially below current projections while improving health status, lessening suffering and extending life.

Moreover, if we focus persistently on the key areas that can make a difference in improving our health care system, I believe we may well find that the health challenges we face will not be as severe a drain on our economy and our budget as many fear. More specifically, if we prudently manage chronic care costs, utilize a modernized and more productive health care delivery system, use a more rationale, evidenced-based benefit package and take advantage of the strengths of both the public and private sectors, we will make enormous inroads on the seemingly overwhelming challenge ahead of us.

We at Ovations and throughout UnitedHealth Group hope that we can be a constructive force to that end, and we look forward to working with you in the weeks, months and years to come. We appreciate the committee's leadership on this important matter and thank you for the opportunity to share our thoughts. I would be happy to answer any questions you might have for me.