

## *THE CHALLENGES OF REFORMING THE AMERICAN HEALTH CARE SYSTEM*

- While proposals to reform the American health care system vary widely, there is consensus among all stakeholders that there is a need for meaningful and sustainable reform. Increases in the cost of health care have led to higher health plan premiums, which in turn have contributed to the increase in the number of people without coverage. The challenge is to find common ground on how best to provide affordable, quality health care for all. In order to do so, it is important to understand what is driving health care costs, identify the uninsured and the causes for their lack of coverage, and determine how all of us—private health plans, the government, employers, health care providers and each of us as individuals—can improve our health care system.

### *What Are the Real Drivers of Health Care Costs?*

- Health care spending in the United States totaled nearly \$2 trillion last year, divided almost equally between the government and the private sector. The Centers for Medicare and Medicaid Services (CMS) projects expenditures will increase 6.9% annually over the next decade, with private spending increasing 6.3% and government spending increasing 7.6%.
- America's high and growing health care bill is driven by variations in access, quality and costs; consumer incentives to demand high levels of care; financial incentives for providers to deliver high levels of service; and demographic and economic factors.

### **Variations in Access, Quality and Costs**

- The U.S. health system exhibits significant variations in terms of access, quality and costs, which reflects substantial inefficiencies in the delivery of care. Reducing variations could eliminate 10-30% of costs while achieving quality improvements. The data illustrating variations are striking.
  - Access to care is highly variable. This is due to a large and growing uninsured population, compounded by a shortage of providers (both primary care physicians and specialists) in many markets.
  - Quality is highly variable across physicians, providers and markets. Clinical variation results in fewer patients receiving evidence-based care.
  - Prices for treatments vary tremendously—often more than 100%—across geographic markets and across providers within markets. For example, within a two-mile radius of Hartford, Conn., costs for a colonoscopy vary from \$910 to \$1,440—more than 50%.

### **Physician Decision-Making/Consumer Demands and Behaviors**

- Americans have come to expect and demand medical innovation, access to new treatments and technologies, and a wide choice of providers conveniently located near where they live. Many who have been enrolled in health plans requiring little or no out-of-pocket expenses at the point of service have been insulated from the real costs of health care. These consumer expectations and behaviors are a major reason why total health care spending now constitutes 16% of the nation's gross domestic product.
  - Americans are demanding new treatments and more intensive diagnostic testing than in other countries.
  - Americans have access to considerably more nearby hospitals, resulting in higher fixed costs and lower occupancy than hospitals in other countries.
  - Americans also have access to 100% more CT and MRI scanners on average than residents of other industrialized countries.

## Financial Incentives for Providers

- Another major contributor to high costs is that U.S. physicians are paid for services rendered and tests performed rather than for outcomes. Therefore, they have an incentive to provide high levels of service and care. In addition, concerns about malpractice suits encourage defensive medical practices.
  - Physicians with financial interests in equipment and facilities order two to eight times as many CT and MRI scans as physicians in other countries.
  - Physicians in the United States conduct 60% more consultations with patients—and earn 60% more than in other countries.

## Resulting Increases in Costs

- A widely held belief is that increases in the cost of health care are driven largely by administrative expenses in the private sector. In reality, according to an analysis of national health care expenditure data for the period 2000-2005, almost 95% of cost increases can be attributed to medical innovation, expansion of the scope of insurance coverage and benefits, general inflation, and the growth in chronic conditions. Administrative costs account for just 5%.
  - *Medical innovation that results in expanded coverage and costs, often without proven benefit (51%)*—While medical innovation is essential to the advancement of health care, ineffective and unbridled innovation can break the banks for both the public and private sectors.
  - *General price inflation (28%)*—Non-medical price inflation affects the health care sector no differently than any other service sector in our economy.
  - *Chronic conditions (8%)*—The number of people suffering from chronic conditions—many related to poor lifestyle choices including diet, smoking and lack of exercise—is a growing contributor to the rise in health care spending and is expected to increase significantly over the next several years.
  - *Enrollment in public programs and population growth (8%)*—As more people have become eligible for public programs, and as the overall population has increased, health care spending has increased.
  - *Administrative expenses (5%)*—Contrary to opinions held by many, administrative expenses, including profits, are the smallest driver of increases in health care spending in both the public and private sectors. Administrative expenses are higher than necessary, however, because of a lack of common standards.
- Partly as a result of these high costs, the United States has a large number of uninsured. Below is a closer look at who those individuals are.

## Who Are the Uninsured?

- Although almost 250 million Americans have health care coverage—approximately 160 million of whom are covered through their employers—some 47 million are uninsured (for at least part of the year). Part of the increase in the number of uninsured in recent years is the result of the changing nature of the American workforce. The 2006 U.S. Census Bureau data reveals that many of the uninsured appear to be able to afford coverage but do not purchase it; others are eligible for assistance from public programs but have not enrolled; and a significant percentage are not U.S. citizens.
  - 75% of the uninsured are in households in which at least one person works.
  - 40.5% are young adults (18-34), many of whom work but, for various reasons, including their belief that the risk of illness or injury is too low to justify the cost of insurance, have not purchased coverage.

- 18.5% are children under the age of 18, some of whom could be covered under a private plan or are eligible for coverage under the State Children's Health Insurance Plans or other public assistance programs.
  - 38% earn more than \$50,000 a year.
  - 30% meet federal guidelines for public assistance but are not enrolled in public programs.
  - 22% are not U.S. citizens.
- The discussion about the uninsured and costs of care, as well as quality and efficiency, often revolves around whether the private or public sector—or a combination of both—is best equipped to run the U.S. health care system.

## ***A PUBLIC-PRIVATE PARTNERSHIP CAN IMPROVE OUR HEALTH CARE SYSTEM***

- Neither the private sector nor government can do it all alone. A public and private partnership of health care stakeholders—private health plans, federal and state governments, employers, providers and individuals—is critical to expanding access, providing choice, and lowering and controlling costs. Each stakeholder is best positioned and equipped to play certain roles, described below.

### ***Private Health Plans***

- Private health plans are introducing solutions that will strengthen the cost-effectiveness and quality of health care. A growing number of Americans are benefiting from health plans that enable individual control, and health advocacy, which provide individuals with incentives to get and stay healthy and to be more conscientious users of health care services. Health plans also developed pharmacy benefit management programs that have reduced the growth in drug expenditures and have lowered costs through the introduction of products that integrate medical, disability, behavioral, pharmacy and dental programs.
- *Health Plans That Enable Individual Control*—Such plans, developed by the private sector, encourage preventive care and individual participation through the combination of incentives and information—leading to improved health and lower costs. A recent CIGNA proprietary study demonstrated that:
    - Preventive care visits by participants in health plans that enable individual control increased by 8%.
    - The compliance rates for medication use that supports chronic conditions are higher in plans that enable individual control than in traditional plans. At the same time, total pharmacy costs have decreased by 6% because patients are making more cost-effective decisions.
    - Superior clinical quality in chronic medication compliance and the use of preventive services have been achieved without shifting additional out-of-pocket costs to individuals.
    - Overall, health plans that enable individual control had costs that were 16% lower than costs for traditional plans.
  - *Health Advocacy*—To achieve more affordable health care, we must keep healthy people healthy, assist those with unhealthy lifestyles to change their behaviors, and help those who are chronically ill get the benefits of evidence-based medicine. Health plans are working with employers, unions and government to identify people with unhealthy lifestyles (*e.g.*, the obese, smokers) and coach them to change their behaviors *before* they develop a chronic illness or condition and thus avoid costly treatment. For example:
    - According to the Centers for Disease Control and Prevention, obesity-related expenditures account for nearly 10% of health care costs while smoking-related illnesses cost the health care system \$96.7 billion per year.
    - After one year of participation in CIGNA health coaching programs, 35% of participants achieved their weight-loss goal, 25-30% quit tobacco use and 52% reduced stress.

- *Case and Disease Management*—Case and disease management programs are widely accepted critical components of any reformed national health care system in the United States, and they too are the products of private-sector innovation. These programs are designed to help people take control of their chronic, high-risk health conditions and prevent clinical deterioration to a higher risk, higher cost status.

Disease management programs target asthma, diabetes, cardiac conditions, low back pain and chronic lung disease. These chronic conditions drive 42% of total health care expenses. Disease management programs can deliver 5-17% in medical costs savings. Customers that offer a robust program of integrated CIGNA Health Advocacy programs have saved 8-11%.

- *Cost and Quality Transparency*—The private sector—led by health plans—has developed tools to help patients identify the best doctors and hospitals for their care. These capabilities encourage performance-based competition by shifting spending to higher performing providers, thereby improving clinical quality and health care outcomes.
  - Hospitals designated as Centers of Excellence in CIGNA's national provider network, which meet superior cost and clinical quality standards, have 33.5% fewer deaths, 38.5% fewer complications, and 46.6% lower costs per procedure than other hospitals.
  - Through free-market innovation, patients now have a variety of Web-based support tools and interactive health coaching services available to them 24 hours a day, including drug comparison and pricing tools, hospital value tools, physician evaluation cards, and medical procedure cost and quality outcome measures. Armed with sufficient access to cost and quality data, patients can make informed decisions about their health risks and treatments.
  - Health plans are also working collaboratively with providers to deliver information that supports quality care through the patient-provider partnership, improve payment information and processes, and minimize administrative costs and complexity.
- *Pharmacy Benefit Management*—In 2004, growth in prescription drug expenditures slowed to its lowest level in 10 years. The reduction in the growth rate partly reflects private sector innovations such as drug formularies (lists of drugs based on clinical efficacy, safety, and lower cost) that help patients get the appropriate drugs more cost effectively, resulting in a savings in medical and pharmacy costs.
- *Integration of Product Solutions*—The private sector is also uniquely positioned to achieve cost savings by offering products that integrate medical, disability, behavioral, pharmacy and dental care programs. Numerous studies have confirmed that by treating patients holistically, significant cost savings, better clinical outcomes and productivity can be achieved and maintained. For example, behavioral disorders affect 20% of the U.S. workforce and cost more than \$44 billion annually. The nation's total spending on health care could be reduced by \$10 billion to \$20 billion simply by integrating medical and behavioral benefits and clinical treatment programs.

## Government

- Federal and state governments have vital roles to play in making sure that everyone has access to affordable, quality health care and in eliminating unnecessary spending. When government and the private sector work collaboratively, the result is innovative solutions and programs that provide enormous value to Americans, such as the recently implemented Medicare Part D program. The public sector can and should play a more active role by: facilitating adoption of common regulatory, transparency, technology and transactional standards; enacting tort reforms; making needed changes to the individual insurance market; and providing a safety net for people who do not have the means to buy coverage. Specific areas where the government should be actively involved include:

## Facilitating Adoption of Common Standards

### ***Regulation***

- *Standardizing Insurance Laws and Regulations*—Working with the private sector, government should standardize insurance rules and regulations. Standardization would reduce the growing administrative costs associated with duplicative federal and state regulations and programs, inconsistent practices and the increasing reluctance of regulators to evaluate the cost implications of the current system on consumers.

### ***Cost and Quality Transparency***

- *Transparency*—With the active involvement of the private sector, the federal government should accelerate cost and quality transparency by: (1) standardizing measurement methodology; (2) aggregating data from all payors—commercial, Medicare and Medicaid; and (3) developing and disseminating standard physician and hospital report cards that all payors, employers and consumers can use. The U.S. Department of Health and Human Services’s “Four Cornerstones” initiative, in which the private sector is actively engaged, represents one approach to this issue. The Four Cornerstones were created to support health information technology, provide information about quality of care, provide pricing information, and promote quality and efficiency of care.
- *Evidence-Based Medicine and Comparative Effectiveness*—The federal government should establish and lead a public-private partnership to evaluate health care services and technologies and conduct research to generate better information on the comparative effectiveness of treatments, procedures, drugs and medical devices.

### ***Technology***

- *Electronic Health Records*—Policymakers are beginning to enact individual state reforms governing and promoting Electronic Health Records (EHRs). Concurrently, projects are underway to implement a national system by 2011. It is critical that the private sector work collaboratively with the various stakeholders to address this issue nationally prior to the enactment of a costly patchwork of state regulations. EHRs will require provider cooperation and systems integration at every level. EHRs are the next step in providing individuals with ultimate ownership of their health care.
- *Electronic Connectivity*—Private-sector health plans are working with state and federal governments to create uniform standards for electronic data exchange. Health plans have proactively crafted standards through the Coalition for Affordable Quality Healthcare’s information exchange initiative. Uniformity helps move all participants in the health care system toward a more efficient, less costly paperless system.
- *Standardized Claim Submissions*—Adopting standardized claim submission forms is a critical component of reducing unnecessary administrative costs currently burdening the system. A partnership between the private sector and state and federal governments can best take advantage of this opportunity.

### ***Transactional***

- *Streamlining Credentialing for Providers and Health Care Facilities*—Cooperative initiatives between government and health plans should build on existing industry efforts to establish a national process that recognizes quality and eliminates the costly need for multiple credentialing applications.

## **Tort Reform**

- The threat of unfounded lawsuits distorts the supply of providers—driving doctors out of the medical profession or to relocate their practices to less litigious states. This compromises patient access to care, decreases the quality of care patients receive and generates higher health care costs. A majority of physicians surveyed nationwide reported that, due to a fear of malpractice claims, they order more tests than their professional judgment dictates. Strong medical liability reforms would improve patient access to affordable care and reduce the costs associated with the practice of “defensive medicine.”

## **Individual Market Reform**

- The individual market should remain the primary source for working-age individuals who do not have access to employer-sponsored coverage, but state and federal governments should enact reforms to increase access to individual coverage and to make it more affordable by:
  - Providing premium subsidies to those individuals who do not have the means to purchase health coverage on their own and acting to limit individual financial exposure in order to minimize bankruptcies caused by high medical expenses;
  - Ensuring access to high-risk pools so that individuals with health problems can obtain affordable coverage;
  - Permitting health plans to have greater rating flexibility to ensure that individuals are not charged excessive rates; and
  - Enacting tax reform to “level the playing field” between the tax benefits currently provided by employer-sponsored health insurance and individually purchased coverage.

## **Providing a Safety Net for Vulnerable Populations**

- The federal government should provide incentives to states to develop strategies that would lead to—and sustain—coverage for the most vulnerable Americans who cannot access coverage through other means.
  - The states should strengthen their means-testing capabilities to ensure that public programs provide coverage—or subsidies to purchase coverage in the private market—only to those who meet certain income criteria.

## *Employers*

- Approximately 160 million Americans now benefit from the innovation, wide range of choice, and administrative cost efficiencies of the employer-provided health care market. The worksite should remain the primary source of coverage for working individuals and their families, and companies should continue to receive tax benefits at the state and federal levels.
- Employers should continue to adopt plan designs that help employees improve their health and quality of life and, ultimately, reduce costs for individuals, employers and the health care delivery system. The sharp decline in member costs for those enrolled in health plans that enable individual control, including HSAs and HRAs, has been achieved without reduction in care or shifting costs to members.
- Employers should promote prevention and wellness at the workplace through screenings, health risk assessments, health coaching, lifestyle behavior modification, and other resources available to them, and they should reward healthy behaviors.

## *Health Care Providers*

- Physicians and other health care providers should help reduce health care costs and improve health care quality through support of national quality, cost and health information technology standards.

- Providers should educate and give information to patients to help them take greater ownership of their health.
- Physicians, hospitals and other providers should train their medical and support staffs to understand how health issues differ by gender, ethnicity and culture. They should be able to communicate well with diverse patients to ensure people understand their conditions and the recommendations related to their health.

### *Individuals*

- Individuals with access to health care coverage have a responsibility to obtain it for themselves and their dependents. Those who are eligible for public programs, but have not signed up for them, should be encouraged to enroll and provided the necessary assistance in doing so.
- Individuals have a responsibility for achieving and maintaining their best health care status and for making use of information that will help them to make informed choices and meaningful comparisons when selecting a health plan, hospital and doctor, or when choosing among treatment options. They should take full advantage of available quality and cost information and tools, and they should use available coaching, prevention, wellness and disease management programs to maintain and improve their health, well-being and security.

### *CIGNA BELIEVES . . .*

- Everyone should have access to quality and affordable care and the ability to choose coverage that meets his or her needs.
- Neither the private sector nor government can do it all alone. A public and private partnership of health care stakeholders—private health plans, federal and state governments, employers, providers and individuals—is critical to expanding access, providing choice and controlling costs.
- Health plans should continue to provide innovative solutions that create individual responsibility for health, wellness and financial security and that achieve cost savings.
- The government should play a more active role in facilitating adoption of common regulatory, transparency, technology and transactional standards; enacting tort reforms; making needed changes to the individual insurance market; and providing a safety net for people who do not have the means to buy coverage.
- Employers should continue to provide access to—and assist in the financing of—meaningful health care coverage for their employees and offer benefit plan designs that help their employees improve their health and quality of life.
- Providers should support standards designed to improve both the quality and efficiency of the care they deliver and educate their patients by providing them with the information they need to take greater ownership of their health and wellness.
- Individuals should obtain coverage for themselves and their dependents and take personal responsibility for their own health decisions to the extent they are able, making use of available information and programs that can help them make informed choices.

CIGNA is committed to working with government, employers, health care providers and individuals to help provide health coverage for all. The true underlying causes of rising costs and the uninsured must be addressed in fact-based discussions in order to find common ground on how best to provide affordable, quality health care for everyone. This paper represents the guiding principles we believe are necessary to help all stakeholders engage in those discussions. We look forward to working with our partners toward the common goal of basic, affordable, high quality health care for every American.