AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

YOU CAN'T ALWAYS GET WHAT YOU WANT: WHAT IF THE FEDERAL GOVERNMENT COULD DRIVE IMPROVEMENTS IN HEALTHCARE?

HEARING

BEFORE THE

SUBCOMMITTEE ON CIVIL SERVICE
AND AGENCY ORGANIZATION

OF THE

COMMITTEE ON
GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

SEPTEMBER 13, 2004

Serial No. 108–280

Printed for the use of the Committee on Government Reform

Available via the World Wide Web: http://www.gpo.gov/congress/house
http://www.house.gov/reform

U.S. GOVERNMENT PRINTING OFFICE

98–746 PDF WASHINGTON : 2005

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2250 Mail: Stop SSOP, Washington, DC 20402–0001

COMMITTEE ON GOVERNMENT REFORM

TOM DAVIS, Virginia, *Chairman*

DAN BURTON, Indiana
CHRISTOPHER SHAYS, Connecticut
ILEANA ROS-LEHTINEN, Florida
JOHN M. MCHUGH, New York
JOHN L. MICA, Florida
MARK E. SOUDER, Indiana
STEVEN C. LATOURETTE, Ohio
DOUG OSE, California
RON LEWIS, Kentucky
TODD RUSSELL PLATTS, Pennsylvania
CHRIS CANNON, Utah
ADAM H. PUTNAM, Florida
EDWARD L. SCHROCK, Virginia
JOHN J. DUNCAN, JR., Tennessee
NATHAN DEAL, Georgia
CANDICE S. MILLER, Michigan
TIM MURPHY, Pennsylvania
MICHAEL R. TURNER, Ohio
JOHN R. CARTER, Texas
MARSHA BLACKBURN, Tennessee
PATRICK J. TIBERI, Ohio
KATHERINE HARRIS, Florida

HENRY A. WAXMAN, California
TOM LANTOS, California
MAJOR R. OWENS, New York
EDOLPHUS TOWNS, New York
PAUL E. KANJORSKI, Pennsylvania
CAROLYN B. MALONEY, New York
ELIJAH E. CUMMINGS, Maryland
DENNIS J. KUCINICH, Ohio
DANNY K. DAVIS, Illinois
JOHN F. TIERNEY, Massachusetts
WM. LACY CLAY, Missouri
DIANE E. WATSON, California
STEPHEN F. LYNCH, Massachusetts
CHRIS VAN HOLLEN, Maryland
LINDA T. SANCHEZ, California
C.A. "DUTCH" RUPPERSBERGER, Maryland
ELEANOR HOLMES NORTON, District of Columbia
JIM COOPER, Tennessee
BETTY MCCOLLUM, Minnesota

BERNARD SANDERS, Vermont (Independent)

MELISSA WOJCIAK, *Staff Director*
DAVID MARIN, *Deputy Staff Director/Communications Director*
ROB BORDEN, *Parliamentarian*
TERESA AUSTIN, *Chief Clerk*
PHIL BARNETT, *Minority Chief of Staff/Chief Counsel*

SUBCOMMITTEE ON CIVIL SERVICE AND AGENCY ORGANIZATION

TIM MURPHY, Pennsylvania, *Vice Chairman*

JOHN L. MICA, Florida
MARK E. SOUDER, Indiana
ADAH H. PUTNAM, Florida
NATHAN DEAL, Georgia
MARSHA BLACKBURN, Tennessee

DANNY K. DAVIS, Illinois
MAJOR R. OWENS, New York
CHRIS VAN HOLLEN, Maryland
ELEANOR HOLMES NORTON, District of Columbia
JIM COOPER, Tennessee

EX OFFICIO

TOM DAVIS, Virginia

HENRY A. WAXMAN, California

RON MARTINSON, *Staff Director*
SHANNON MEADE, *Professional Staff Member*
REID VOSS, *Clerk*

CONTENTS

	Page
Hearing held on September 13, 2004	1
Statement of:	
Blair, Dan G., Deputy Director, U.S. Office of Personnel Management	8
Feinstein, Dr. Karen Wolk, Chair, Pittsburgh Regional Healthcare Initiative; Dr. Neil M. Resnick, director, University of Pittsburgh Institute of Aging; and Dr. Alan Axelson, medical director, American Academy of Child and Adolescent Psychiatry	26
Letters, statements, etc., submitted for the record by:	
Axelson, Dr. Alan, medical director, American Academy of Child and Adolescent Psychiatry, prepared statement of	46
Blair, Dan G., Deputy Director, U.S. Office of Personnel Management, prepared statement of	11
Davis, Hon. Tom, a Representative in Congress from the State of Virginia, prepared statement of	7
Feinstein, Dr. Karen Wolk, Chair, Pittsburgh Regional Healthcare Initiative, prepared statement of	29
Murphy, Hon. Tim, a Representative in Congress from the State of Pennsylvania, prepared statement of	4
Resnick, Dr. Neil M., director, University of Pittsburgh Institute of Aging, prepared statement of	36

YOU CAN'T ALWAYS GET WHAT YOU WANT: WHAT IF THE FEDERAL GOVERNMENT COULD DRIVE IMPROVEMENTS IN HEALTHCARE?

MONDAY, SEPTEMBER 13, 2004

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON CIVIL SERVICE AND AGENCY ORGANIZATION,
COMMITTEE ON GOVERNMENT REFORM,
Pittsburgh, PA.

The subcommittee met, pursuant to notice, at 10 a.m., in the City Counsel Room, Greentree Municipal Building, Pittsburgh, PA, Hon. Tim Murphy (vice chairman of the subcommittee) presiding.

Present: Representatives Davis and Murphy.

Staff present: Ron Martinson, staff director; B. Chad Bungard, deputy staff director and chief counsel; Shannon Meade, professional staff member; and Reid Voss, clerk.

Mr. MURPHY. The Subcommittee on Civil Service and Agency Organization will come to order.

I would like to welcome everyone here today and offer a special thank you to those who traveled to Pittsburgh specifically to participate in this hearing.

We are here today to look at how the Federal Employee Health Benefits program can enhance its service to the Federal employees and serve as a model for improving the performance of the U.S. health care system as a whole. The FEHB program which has often been cited as a model for employers' sponsored health insurance programs has room for improvement. In improving its service to employees, the FEHB program, as one of the largest buyers of health care with about 8½ million participants, is in a position where it can positively influence the quality and efficiency of the health care sector throughout the United States.

The U.S. health care system faces major challenges and the FEHB program must lead by example. As health care costs continue to climb by double digits each year, it is clear that we cannot continue to do the same thing and expect different results. Open ended fee for service did not work. Managed care became managed money and that did not work. We need to make fundamental changes in the health care delivery system paragon. These changes would lower costs, improve efficiency and not just give people what they want, but indeed give them the health care they need. Because the Federal Government is the largest purchaser of health

care, we have the opportunity and responsibility to take the lead in driving these changes.

A recent news report began "Scott Wallace's dog Samatha has computerized health records, his car does too, but he does not." While an individual may get computerized treatment information on his 14 year old Buick LaSabre, personal computerized health records that accurately and securely keep a patient's medical history are simply not available.

The same report told the story of a man whose heart stopped due to a "adverse drug event" after one specialist prescribed medication that conflicted with what another specialist had already given him. It took a third doctor to figure out what the first two had done. Unfortunately, this kind of preventable accident is not an anomaly under the current system. It is time for the health care industry to catch up with grocery stores, banks and auto repair shops and provide individuals with their own computerized health records.

Earlier this year President Bush unveiled his welcomed 10 year goal of getting most Americans a personal computerized health record. The President's new national coordinator for health information technology noted that with the adoption of such information technology no longer will up to 100,000 people die each year from medical errors and no longer will we spend up to $300 billion a year on inappropriate treatment or up to $150 billion a year on administrative waste.

The benefits of computerized health records are substantial. Such technology will improve the quality of care, reduce the redundancy of testing paperwork, virtually eliminate prescription errors, prevent adverse effects from conflicting courses of treatment, significantly reduce medical errors and reduce administrative costs.

In announcing his 10 year goal the President admonished the Federal Government has to take the lead. FEHB program is no exception and should leverage its buying power to support these goals.

As the Institute of Medicine's President Dr. Harvey Fineberg stressed in his testimony before the subcommittee in March, he said "The FEHB program could promote data standards and appropriate deployment of information technology providers."

There are many other areas where the FEHB program can lead by example. One area is to expand and enhance high value services. These types of services, such as comprehensive care management, coordination of care, preventative services and end of life care provide a high benefit at a relatively low cost.

First Health, which administers the largest plan in the FEHB program, has offered one such high value service, comprehensive care management. In the program since 2002 and in the private sector since 2000 First Health testified before the subcommittee in March that there has been decreased annual claims filed for patients enrolled in care management and a 2003 First Health survey revealed significant levels of satisfaction with the care management program along with increase in the patient's understanding of conditions, self management and productivity.

By adopting aggressive high value services the FEHB program can serve as an example to the private sector but reaping the rewards for its participants.

I am pleased to hear about OPM launching of its new HealthierFeds campaign and Web site earlier this year, which is designed to educate and support Federal employees in making health care decisions. Health literacy is important at preventing illness, equipping the patient with valuable knowledge when questioning a doctor, nurse or pharmacist or when trying to obtain health information from other public and private sources. The FEHB program should continue to explore ways to increase health literacy and set the standard for the health care sector.

I look forward to the discussion from all the witnesses this morning about the various ways of the Office of Personnel Management through the FEHB program can assume its leadership position in driving improvements to the U.S. health care system as a whole.

I would also like to thank chairman of the Committee on Government Reform Tom Davis for traveling all the way to Pittsburgh to participate in this hearing. Also, thanks to all of the witnesses from Pittsburgh who are going to give us their wisdom throughout the morning as well.

And I would now like to recognize Mr. Davis for an opening statement. Mr. Chairman.

[The prepared statement of Hon. Tim Murphy follows:]

TOM DAVIS, VIRGINIA
CHAIRMAN

DAN BURTON, INDIANA
CHRISTOPHER SHAYS, CONNECTICUT
ILEANA ROS-LEHTINEN, FLORIDA
JOHN M. McHUGH, NEW YORK
JOHN L. MICA, FLORIDA
MARK E. SOUDER, INDIANA
STEVEN C. LaTOURETTE, OHIO
DOUG OSE, CALIFORNIA
RON LEWIS, KENTUCKY
JO ANN DAVIS, VIRGINIA
TODD RUSSELL PLATTS, PENNSYLVANIA
CHRIS CANNON, UTAH
ADAM H. PUTNAM, FLORIDA
EDWARD L. SCHROCK, VIRGINIA
JOHN J. DUNCAN, JR., TENNESSEE
JOHN SULLIVAN, OKLAHOMA
NATHAN DEAL, GEORGIA
CANDICE MILLER, MICHIGAN
TIM MURPHY, PENNSYLVANIA
MICHAEL R. TURNER, OHIO
JOHN R. CARTER, TEXAS
WILLIAM J. JANKLOW, SOUTH DAKOTA
MARSHA BLACKBURN, TENNESSEE

ONE HUNDRED EIGHTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON GOVERNMENT REFORM

2157 RAYBURN HOUSE OFFICE BUILDING

WASHINGTON, DC 20515–6143

MAJORITY (202) 225–5074
FACSIMILE (202) 225–3974
MINORITY (202) 225–5051
TTY (202) 225–6852

www.house.gov/reform

HENRY A. WAXMAN, CALIFORNIA,
RANKING MINORITY MEMBER

TOM LANTOS, CALIFORNIA
MAJOR R. OWENS, NEW YORK
EDOLPHUS TOWNS, NEW YORK
PAUL E. KANJORSKI, PENNSYLVANIA
CAROLYN B. MALONEY, NEW YORK
ELIJAH E. CUMMINGS, MARYLAND
DENNIS J. KUCINICH, OHIO
DANNY K. DAVIS, ILLINOIS
JOHN F. TIERNEY, MASSACHUSETTS
WM. LACY CLAY, MISSOURI
DIANE E. WATSON, CALIFORNIA
STEPHEN F. LYNCH, MASSACHUSETTS
CHRIS VAN HOLLEN, MARYLAND
LINDA T. SANCHEZ, CALIFORNIA
C.A. DUTCH RUPPERSBERGER, MARYLAND
ELEANOR HOLMES NORTON, DISTRICT OF COLUMBIA
JIM COOPER, TENNESSEE
CHRIS BELL, TEXAS

BERNARD SANDERS, VERMONT,
INDEPENDENT

Acting Chairman Tim Murphy
Subcommittee on Civil Service and Agency Organization

"""You Can't Always Get What You Want...What if the Federal Government Could Drive Improvements in Health Care?"""

Opening Statement
September 13, 2004

Thank you all for joining us today as we look at how the Federal Employee Health Benefits Program can enhance its service to Federal employees and serve as a model for improving the performance of the U.S. health care system as a whole. The FEHB Program, which has been often cited as a model for employer-sponsored health insurance programs, has room for improvement. In improving its service to employees, the FEHB Program, as one of the largest buyers of health care with about eight and a half million participants, is in a position where it can positively influence the quality and efficiency of the health care sector throughout the United States. The U.S. health care system faces major challenges and the FEHB Program must lead by example.

As healthcare costs continue to climb double digits each year, it is clear that we cannot continue to do the same thing and expect different results. Open-ended fee for service did not work. Managed care became managed money and that did not work. We need to make fundamental changes in the healthcare delivery system paradigm. These changes would lower costs, improve efficiency and not just give people what they want but give them the healthcare they need. Because the federal government is the largest purchaser of healthcare, we have the opportunity and the responsibility to take the lead in driving these changes.

A recent news report began: "Scott Wallace's dog, Samantha, has computerized health records. His car does, too. But he does not." While an individual may get computerized treatment information on his 14 year-old Buick LeSabre, personal computerized health records that accurately and securely keep a patient's medical history are simply not available. The same report told a story of a man whose heart stopped due to an "adverse drug event" after one specialist prescribed medication that conflicted with what another specialist had already given him. It took a third doctor to figure out what the first two had done. Unfortunately, this kind of preventable accident is not an anomaly under the current system. It is time for the health care industry to catch up with grocery stores, banks and auto repair shops and provide individuals with their own computerized health records.

Earlier this year President Bush unveiled his welcomed ten-year goal of getting most Americans a personal computerized health record. The President's new National Coordinator for Health Information Technology noted that with the adoption of such information technology "no longer will up to 100,000 people die from medical errors" and "no longer will we spend up to $300 billion a year on inappropriate treatment or up to $150 billion on administrative waste." The benefits of computerizing health records are substantial. Such technology will improve the quality of care, reduce the redundancy of testing and paperwork, virtually eliminate prescription errors, prevent adverse effects from conflicting courses of treatment, significantly reduce medical errors and reduce administrative costs. In announcing his ten-year goal, the President admonished, "The Federal Government has got to take the lead." The FEHB Program is no exception and should leverage its buying power to support President's Bush's goal. As the Institute of Medicine's President, Dr. Harvey Fineberg, stressed in testimony before the Subcommittee in March, "the FEHB Program could promote data standards and appropriate deployment of information technology providers."

There are many other areas where the FEHB Program can lead by example. One area is to expand and enhance high value services. These types of services, such as comprehensive care management, coordination of care, preventive services, and end-of-life care provide a high benefit at a relatively low cost. First Health, which administers the second largest plan in the FEHB Program, has offered one such high value service - comprehensive care management - in the Program since 2002 and in the private sector since 2000. First Health testified before the Subcommittee in March that there has been decreased annual claim costs for patients enrolled in care management and a 2003 First Health survey revealed significant levels of satisfaction with the care management program along with increases in the patients' understanding of conditions, self-management, and productivity. By adopting aggressive high value services, the FEHB Program can serve as an example to the private sector, while reaping the rewards for its participants.

I am pleased to hear about OPM's launching of its new *HealthierFeds* campaign and website earlier this year, which is designed to educate and support Federal employees in making health-care decisions. Health literacy is important in preventing illness, equipping the patient with valuable knowledge when questioning a doctor, nurse or pharmacist or when trying to obtain health information from other public and private sources. The FEHB Program should continue to explore ways to increase health literacy and set the standard for the health care sector.

I look forward to the discussion from all of the witness this morning about the various ways that the Office of Personnel Management, through the FEHB Program, can assume a strong leadership position in driving improvements to the U.S. health care system as a whole.

#####

Mr. DAVIS. Well, thank you, Chairman Murphy.

As all of us here recognize the importance of the FEHB program to the Federal Government. It is one of the primary recruitment and retention goals that the FEHB covers over 8.6 million individuals including 2.3 million Federal and postal employees, 1.9 million Federal annuitants and 4.5 million dependents. The program provided approximately $24 billion in health care benefits last year alone.

We also recognize it is one of the Nation's largest purchasers of health care services. The Federal Government can and should lead by example to drive improvements in health care for all Americans.

Market orientation and consumer choice have been hallmarks of the program's success, allowing consumers to tailor their health care coverage through individual needs and enabling them to compare the cost benefits and features of different plans.

Health care premiums have increased by an average of well over 10 percent a year since 1998, a trend which promises to continue into the near future given the increased costs of prescription drugs and outpatient care. The time for action is here.

There are many areas where the Federal Government can promote high quality, affordable, flexible, responsible health care for all Americans through the FEHBP, and it must do so particularly through the hearing today and the issues of promoting preventative care and the use of health information technology to reduce costs and medical errors.

I commend this subcommittee for taking a look at this issue today. I look forward to hearing the testimony of our distinguish panelists. I look forward to working with all of you as we continue to explore how the Federal Government can leverage its unique abilities to see how the FEHBP cannot only continue to be a model for employer provided health care coverage, but also serve as a model for improving health care for all Americans.

Thank you.

[The prepared statement of Hon. Tom Davis follows:]

Statement of Chairman Tom Davis
Government Reform Subcommittee on the Civil Service
Field Hearing, "You Can't Always Get What You Want ... What If the Federal Government Could Drive Improvements in Health Care?"
Monday, September 15, 2004
Pittsburgh, PA

Mr. Murphy and Members of the Subcommittee, thank you for holding this important hearing today.

All of us here recognize the importance of the Federal Employees Health Benefits Program (FEHBP) to the Federal government – it is one of our primary recruitment and retention tools. FEHBP covers over 8.6 million individuals, including 2.2 million federal and postal employees, 1.9 million federal annuitants, and 4.5 million dependents. The program provided approximately $24 billion in health care benefits last year alone.

We also recognize that as one of the nation's largest purchasers of healthcare services, the Federal government can and should lead by example to drive improvements in healthcare for all Americans. Market-orientation and consumer choice have been hallmarks of the program's success, allowing consumers to tailor their healthcare coverage to their individual needs, and enabling them to compare the costs, benefits, and features of different plans.

Healthcare premiums have increased by an average of well over 10 percent a year since 1998, a trend which promises to continue into the near future given the increased costs for prescription drugs and outpatient care. The time for action is here. There are many areas where the Federal government can promote high-quality, affordable, flexible and responsible healthcare for all Americans through the FEHBP, and we must do so. I am particularly interested in hearing today on the issues of promoting preventative care and the use of health information technology to reduce costs and medical errors.

I commend the Subcommittee for taking a look at this issue today and I look forward to hearing the testimony of our distinguished panelists. I look forward to working with all of you as we continue to explore how the Federal government can leverage its unique abilities to see how the FEHBP can not only continue to be a model for employer-provided healthcare coverage, but also serve as a model for improving healthcare for all Americans.

Mr. MURPHY. Thank you Chairman Davis.

I ask unanimous consent that all Members have 5 legislative days to submit written statements and questions for the hearing record and that any responses to written questions provided by the witnesses also be included in the record. Without objection, it is so ordered.

I also ask unanimous consent that all exhibits, documents and other materials referred to by Members and the witnesses may be included in the hearing record, and that all Members be permitted to revise and extend their remarks. Without objection, it is so ordered.

On the first panel we're going to hear from the Honorable Dan Blair, Deputy Director of the U.S. Office of Personnel Management. Let me just give a little bio here first.

He is the Deputy Director since December 2001. Prior to this he served as senior counsel to Senator Fred Thompson of the U.S. Senate Committee on Governmental Affairs. He was also a staff director for the House of Representatives Subcommittee on the Postal Service and minority general counsel for the House of Representatives Committee on Post Office and Civil Service Reform.

Coming from Joplin, Missouri. He received a bachelor of journalism degree from the School of Journalism at the University of Missouri—Columbia and his juris doctorate from the School of Law at University of Missouri—Columbia in 1984.

And now he lives in Washington, DC.

As you know, it is a standard practice for all who testify before this committee to take an oath. So if all the witness today could please stand including those who may be answering questions later, I'll administer the oath.

[Witnesses sworn]

Mr. MURPHY. Let the record reflect that the witnesses have answered in the affirmative. And we are ready to proceed.

Well, Mr. Blair, thank you for joining us today. You are recognized for 5 minutes. Please proceed.

You know how the lights work; green means continue, yellow means windup and red means—well, we will see if we can continue.

Thank you, Mr. Blair.

STATEMENT OF DAN G. BLAIR, DEPUTY DIRECTOR, U.S. OFFICE OF PERSONNEL MANAGEMENT

Mr. BLAIR. Thank you, Chairman Davis, Chairman Murphy. I am glad to be here this morning in Pittsburgh.

I would also like to introduce you to Anne Easton. Anne is our Senior Policy Analyst in OPM's Strategic Human Resources Policy division and will assist me should I get any technical questions. So, I would indulge the committee to help me rely on her as well.

I am pleased to be here on behalf of Kay Coles James and the Office of Personnel Management [OPM] to comment on the role of the Federal Employees Health Benefits Program [FEHBP] in relation to cutting edge health care issues that could impact the delivery of health care services across the Nation.

I have a written statement. I ask that be included for the record. I'm happy to summarize.

To provide a context of our discussion, I want to give you a little background on the FEHB Program and the role of OPM as Program Administrator.

The FEHB Program provides for the offering of health benefits for Federal workers, much like large employers' purchasers in the private sector. More than 8 million Federal employees, retirees, and their dependents are covered by the program. OPM administers the Program by contracting the private sector health plans, offering more than 200 choices to Federal consumers. OPM does not, however, contract the providers. We don't process claims, nor do we do independent clinical research or mandate specific program initiatives. Those functions are carried out by the private sector health care plans.

OPM has consistently encouraged those plans to be creative and responsive to consumer interests and to be innovative in developing plan-specific programs that would benefit the patients while controlling costs. By working closely with the health plans to improve the quality of services they offer, we have moved the program forward without locking the health plans into predetermined solutions.

You have asked me today to focus on six cutting edge issues in the health care arena. I want to highlight our activity in each area. We are closely monitoring these issues, and we work in these areas by encouraging and collaborating with our health plans and our other purchasers of health care services.

First, let me talk about preventive services and chronic care. Our plans offer excellent preventive services and chronic care benefits. In the recent year our annual call letters to the carriers has stressed the importance of both preventive services and comprehensive care for chronic conditions. For example, in our call letter last year, we strongly encouraged carriers to provide coverage for the full range of screenings for colorectal cancer, and the carriers' responses were overwhelmingly positive.

My written statement details some of our collaborative efforts with the health care community, both Government and private sector, to encourage initiatives on preventive services. One particular collaboration is with the Centers for Medicare and Medicaid Services and Johns Hopkins University to assess the needs of patients with multiple chronic conditions.

Let me talk about the impact of good health practices on premiums. At OPM, we believe that Federal employees and their families are intelligent health care consumers, and it is to everyone's benefit to provide them with sound information. Educating Federal consumers leads to more patient involvement in health care decisionmaking and subsequently more consumer responsibility and awareness of costs. To paraphrase a popular advertising line, "an educated health care consumer is our best customer."

As one way to achieve this goal, OPM last year launched the HealthierFeds Campaign in support of President Bush's HealthierUS Initiative. The campaign places emphasis on educating Federal employees and retirees on healthy living and best treatment strategies. It established a consumer Web site aimed at providing information on nutrition, physical fitness, avoidance of risky behavior, and prevention. We also operate wellness programs.

One cutting edge issue we would like to talk about today is pay for performance. Many health plans who participate in the FEHB Program engage in techniques that encourage high standards of quality. Our written statement details a few examples of this work. However, since FEHB law does not allow for premium differentials and since OPM contracts with health plans, not providers, we have no mechanism to reward providers directly for superior performance. However, we will continue to monitor and encourage developments in the industry and will consult with health plans as they evaluate various approaches and begin to assess best practices.

In your opening statement today you referenced President Bush's Executive order for health information technology. In response, OPM issued a report expressing our intent to explore a variety of options to speed the nationwide phase-in of health information technology or HIT. These options are detailed in my written statement.

Finally, I would like to talk about measuring efficacy and value of alternative treatments. As I've mentioned, OPM is a large purchaser of employee health benefits, but we do not perform clinical research. We do, however, work with health plans and others and support their efforts. We do not preclude FEHB plans from voluntarily participating in studies, and we encourage them to include our Federal members in such studies. OPM relies on other Federal agencies for medical research. For example, for benefits coverage such as drugs and biologicals, we rely on the Food and Drug Administration.

Further, OPM continues to stress health literacy by encouraging FEHB enrollees to become more informed about their health care. We provide information on our Web site and participate in various groups that stress health literacy, such as the National Quality Forum and the Quality Interagency Task Force.

In summary, while the primary role of OPM as administrator of the FEHB program is to contract with health plans to provide health care coverage for Federal employees, retirees, and their families, we have used our leverage as a major purchaser to facilitate meaningful efforts by the health plans to improve the quality of services they provide. Within the framework of this mission, we believe we can and should contribute to the overall efforts to make and keep the American health care system among the best in the world.

Thank you again for your invitation to testify. I am happy to answer any of your questions.

[The prepared statement of Mr. Blair follows:]

United States
Office of
Personnel Management Washington, DC 20415-0001

STATEMENT OF THE HONORABLE DAN G. BLAIR
DEPUTY DIRECTOR
OFFICE OF PERSONNEL MANAGEMENT

before the

SUBCOMMITTEE ON CIVIL SERVICE AND AGENCY ORGANIZATION
COMMITTEE ON GOVERNMENT REFORM
U.S. HOUSE OF REPRESENTATIVES

on

"YOU CAN'T ALWAYS GET WHAT YOU WANT...WHAT IF THE FEDERAL GOVERNMENT COULD DRIVE IMPROVEMENTS IN HEALTH CARE?"

September 13, 2004

Chairman Davis, Vice-Chairman Murphy and Members of the Subcommittee:

I am pleased to be here today on behalf of the Director of the U.S. Office of Personnel Management (OPM), Kay Coles James, to discuss the role of the Federal Employees Health Benefits (FEHB) Program in relation to a very significant range of issues that taken together may have a major effect on the delivery of health care services and ultimately on the health status of Americans.

In order to provide a context for the discussion, please let me take the opportunity to talk a little about the structure of the Program and the role of OPM as the Program administrator. The FEHB Program provides for the offering of competitive health benefits products for Federal workers, much like large employer purchasers in the private sector. More than eight million Federal employees, retirees and their dependents are covered by this program. OPM administers this employee benefits program by contracting with private sector health plans offering over 200 choices to Federal consumers. OPM does not contract with providers, does not process claims, does not do independent clinical research, and does not mandate specific program initiatives.

Under the leadership of Director Kay Coles James, OPM has consistently encouraged participating health plans to be creative and responsive to consumer interests and to be innovative in developing plan-specific programs that would benefit patients while also controlling costs. By working closely with the health plans and encouraging them to constantly improve the quality of services they offer our enrollees, Director James has succeeded in moving the Program forward in many critical areas without locking the health plans into predetermined solutions. Director James has emphasized flexibility and consumer choice as very important features of a competitive health benefits program.

She has also vigorously opposed mandates within the FEHB. With a clear understanding of the framework under which we operate, I would now like to discuss each of the six issues that are the subject of this hearing in turn and how they relate to activities within the context of the FEHB Program.

Ways to encourage plans to focus on high value services including preventive services and comprehensive care for common chronic conditions

Across the board, the FEHB plans offer excellent preventive services benefits. In the most recent annual call letter sent to the FEHB carriers on April 19, 2004, and in the call letters issued by OPM in the last few years, we have stressed the importance of both preventive services and comprehensive care for chronic conditions. For example, in OPM's call letter last year, we strongly encouraged carriers to provide coverage for the full range of preventive screenings for colorectal cancer, and the carriers' responses were overwhelmingly supportive. And in our negotiations with health plans proposing to offer a High Deductible Health Plan with a Health Savings Account feature in 2005, we have emphasized that under Treasury guidance for administration of this new product, preventive services can be covered before the deductible has been met.

In our call letters and ongoing in our role as Program administrator, we encourage plans to emphasize care management for members with chronic conditions, including flexible benefit options and diagnosis-based programs. Care management programs help educate affected members about their chronic conditions and help ensure that they are getting appropriate services. It is generally accepted that a relatively small percentage of members - primarily those with chronic conditions - use the greatest percentage of benefits. By addressing the needs of chronically ill populations, the results will help to improve the quality of care and promote the effective use of benefit dollars. Examples of disease management programs offered by FEHB plans include congestive heart failure, diabetes, asthma and cardiovascular disease.

OPM has also recently collaborated with the Centers for Medicare and Medicaid Services (CMS) on a study by a Johns Hopkins University research team that assessed the special needs of patients with multiple chronic conditions. Blue Cross and Blue Shield (BC/BS), our largest fee-for-service plan, partnered with Johns Hopkins University and The Robert Wood Johnson Foundation to develop an initiative to improve the care and quality of life for the more than 125 million Americans with chronic health conditions. The partnership is engaged in three major activities:

- Conducting original research and identifying existing research that clarifies the nature of the problem;
- Communicating these research findings to policymakers, business leaders, health professionals, advocates and others; and
- Working to identify promising solutions to the problems faced by people with chronic health conditions.

Thus far, the Partnership has produced three Johns Hopkins School of Public Health Chronic Conditions papers. The first, "Chronic Conditions in a Working Age Population," compares data from a private sector employer-sponsored health plan with data from the Medical Expenditure Panel Survey. Prevalence of chronic conditions, spending, and utilization are examined. The paper provides insights into chronic conditions in the workforce that can be useful in understanding more about how chronic conditions affect health care utilization.

The second paper, "Trends in Chronic Condition Co-morbidities in a Group Health Plan," analyzes basic trends among the privately insured with chronic conditions, by analyzing claims data from 1999 through 2001. The results show a trend toward increasing numbers of younger population groups with chronic condition co-morbidities. The third paper in the series, "Physician Utilization by People with Chronic Conditions," looks at the visit patterns to primary care physicians and specialists among enrollees who had at least one physician visit during 1999. This paper concludes that, with the exception of children with one or no chronic conditions, enrollees see a specialist physician more often than a primary care physician.

Another FEHB plan, the Hawaii Medical Service Association, began a two-year Palliative Care Coordination Pilot Program for its FEHB members on July 1, 2004. Its purpose is to facilitate access to appropriate palliative care for patients with life-limiting disease and an 18-month prognosis without requiring that patients forego continuing curative care. It will provide early identification, timely intervention, and proactive case management for patients and families. The program is designed to bridge the gap between home health and hospice benefits for people who may not qualify for either benefit but who would gain in functioning, comfort, or quality of life from palliative care services for end-of-life care. In turn, the plan will analyze utilization, cost, quality, and patient/family satisfaction.

Another FEHB plan, Group Health Incorporated (GHI) has established several disease management programs including *Positive Actions Toward Health (P.A.T.H.)*. It is designed to detect and reduce gaps between established standards of clinical excellence and actual care provided to patients. The *P.A.T.H.* program utilizes all available patient level data coupled with current medical knowledge to identify issues specific to individual patients. Patient level recommendations are generated and shared with treating physicians. In a Preferred Provider Organization network environment where referrals to specialists by a primary care physician are not required, communication of care delivery can be fragmented. Through the identification of patient specific and timely recommendations as well as physician to physician interaction and education, the *P.A.T.H.* program provides critical information to the plan's network of approximately 50,000 providers and facilitates collaboration among GHI, their members, and physicians. Recently, GHI received a Health Plan Association Achievement Award in the patient care improvement category for the innovative *P.A.T.H.* program.

In summary, these are a few of the ways in which OPM is working closely with the health care community to encourage initiatives on preventive services and treatment of chronic conditions.

The impact of good health practices on premiums

President Bush's *HealthierUS* initiative is based on the premise that increasing personal fitness and becoming healthier is critical to achieving a better and longer life. Extensive research, much of it conducted or funded by the Federal Government, has shown that improving overall health and thus preventing disease and premature death, is as easy as making small adjustments and improvements in the activities of daily life. The President's *HealthierUS* initiative uses the resources of the Federal Government to alert Americans to the vital health benefits of simple and modest improvements in physical activity, nutrition, and behavior. President Bush's *HealthierUS* initiative has identified four keys for a healthier America:

- Be physically active every day
- Eat a nutritious diet
- Get preventive screenings
- Make healthy choices.

Director Kay Coles James launched the *HealthierFeds* campaign last year to support the President's HealthierUS initiative. The campaign places emphasis on educating Federal employees and retirees on healthy living and best-treatment strategies. It pioneers new territory that holds great promise for the general health care marketplace. Through *HealthierFeds*, the Director is going after the "demand" side, incorporating a new focus on personal responsibility and the consumer's role in driving both quality and affordability.

The goal of the *HealthierFeds* campaign is to ensure that Federal employees, retirees, and their families are informed on healthy living and best-treatment strategies.

OPM has established a consumer website at www.healthierfeds.com which is aimed at providing consumer education focused on nutrition, physical fitness, avoidance of risky behavior and prevention. OPM also operates wellness programs that help to keep our own employees informed and focused on their lifestyle choices. In addition, OPM provides leadership in the Federal sector on work/life programs for all Federal employees.

OPM has long-established relationships with FEHB carriers that offer quality health plans with comprehensive benefits packages at affordable premiums. OPM has encouraged FEHB carriers to work closely with us in the *HealthierFeds* campaign to provide education on fitness, healthy lifestyles, care management, and prevention strategies. FEHB carriers have responded by helping to educate their members through health promotion materials and information on their websites, as well as linking to OPM's website.

OPM also has established partnerships with other employer organizations and industry advocates. And, OPM has maintained linkage with the President's *HealthierUS* initiative and the Department of Health and Human Services' Steps to a *HealthierUS*.

In summary, we believe that Federal employees and their families are intelligent health care consumers, and it is to everyone's benefit to provide them with sound information. Educating Federal consumers may lead to more patient involvement in health care decision-making and, subsequently, more consumer responsibility and awareness of costs.

A reimbursement component that allows plans to receive a premium for meeting certain high standards of quality

While FEHB law (chapter 89 of title 5, United States Code) does not allow for premium differentials, many health plans participating in the FEHB program engage in techniques that encourage high standards of quality. Blue Cross and Blue Shield, the largest FEHB plan, has about twenty initiatives in place to reward providers for performance and outcomes. Some examples are Anthem Blue Cross and Massachusetts Blue Cross, both of which have programs based around the recognition of hospital performance. BC/BS of Illinois has announced a program that will reward distance monitoring of its providers' intensive care units as a way to improve quality. In 2003, Empire BC/BS joined forces with IBM, PepsiCo, Verizon Communications, and Xerox Corporation to offer financial incentives to network hospitals that achieve patient safety standards articulated by the Leapfrog Group.

Integrated Healthcare Association has convened six large California health plans (Aetna, Blue Cross of California, Blue Shield of California, Cigna, Health Net, and PacifiCare) in a pay-for-performance program. The health plans award bonuses to physician groups based on an aggregate score that includes clinical measures, patient satisfaction and information technology investment. This initiative is using a set of common measures to evaluate the groups' performance. These are just a few of the examples in which the insurance industry is working to identify new ways to provide incentives for good performance.

CMS is currently conducting a Medicare demonstration project that uses financial incentives to encourage hospitals to provide high-quality inpatient care. Hospitals that deliver the best quality of care will be rewarded with higher Medicare payments. Bonuses will be awarded based on a hospital's performance on evidence-based quality measures for a variety of medical conditions. Only top-performing hospitals will receive monetary bonuses. All hospital patients, including FEHB members can benefit.

We remain vigilant and current on evolving pay-for-performance programs and issues through active membership and association with numerous recognized healthcare quality organizations, such as the National Quality Forum, the Leapfrog Group, The National Committee on Quality Assurance, and the Joint Commission Business Advisory Group. However, pay-for-performance is in its very early stages of development, and the programs I've mentioned are still in the pilot stage. It is too early to determine results; nor are there standard metrics for measuring results currently in place. Further, OPM contracts with health plans, not providers, therefore, we are not in the same category as self-funded employer plans or CMS. We have no mechanism to reward providers

directly for superior performance. However, we will continue to monitor developments in the industry and will consult with the health plans as they evaluate various approaches and begin to assess best practices.

Ways to promote the use of information technology to create cost savings

On April 27, 2004, the President issued Executive Order 13335, Incentives for the Use of Health Information Technology and Establishing the Position of the National Health Information Technology Coordinator. In response to that Executive Order, in July 2004, the Office of Personnel Management issued a report to the President on Interoperable Health Information Technology (HIT). As part of that report, OPM expressed our intent to explore the adoption of a variety of options to speed the nationwide phase-in of HIT as soon as is practicable. Some of the options we suggested we would look at were:

1. Strongly encouraging FEHB Program participating health plans to adopt systems that are based on generally accepted and certified standards.

2. Strongly encouraging health plans to highlight their provider directories to indicate individual provider HIT capabilities.

3. Strongly encouraging health plans to link disease management and quality initiatives to HIT systems for measurable improvements.

4. Strongly encouraging health plans to provide incentives for the adoption of interoperable health information technology systems by key providers under FEHB contracts.

5. Basing part of the service charge, or profit, for fee-for-service and other experience-rated plans on their developing incentives for:

    - Doctors and pharmacies to use paperless systems to fill prescriptions (ePrescribing);
    - Contracting with hospitals that use electronic registries, electronic records, and/or ePrescribing; and
    - Increasing the number of enrollees whose providers use electronic registries, electronic records, and/or ePrescribing.

6. Introducing performance goals for health maintenance organizations (community-rated plans) that are linked to their developing incentives for:

    - Doctors and pharmacies to use paperless systems to fill prescriptions (ePrescribing);
    - Contracting with hospitals that use electronic registries, electronic records, and/or ePrescribing; and
    - Increasing the number of enrollees whose providers use electronic registries, electronic records, and/or ePrescribing.

7. Introducing incentives and performance goals for plans that contract with networks of providers to make records accessible through secure and Health Insurance Portability and Accountability Act compliant interoperable HIT systems.

8. Introducing incentives and performance goals for plans that integrate their provider networks with local and national health information infrastructure initiatives.

9. Encouraging and rewarding pharmacy benefit managers for providing incentives for ePrescribing and health information technology linkage.

HHS has the lead in moving the health information technology agenda forward. Government agencies including OPM, the Departments of Defense and Veterans Affairs, and CMS are collaborating with representatives from the provider and private sector purchaser community in a dialogue on how best to accomplish the important goals established by President Bush.

Ways that the FEHBP can measure comparative efficacy and value of alternative preventives and treatments in a systematic way

As a large purchaser of employee health benefits, OPM does not perform clinical research to assess the value of new health technology. The purpose of the FEHB Program is to provide health insurance to its consumers at the lowest possible cost, and not to conduct medical research. While we are not a research organization, we work with the health plans and others and support their efforts. We do not preclude FEHB plans from voluntarily participating in comparative efficacy and alternative preventive and treatment studies. OPM also relies on other federal agencies for medical research. For example, for benefits coverage, such as drugs and biologicals, we would rely on the determinations of the Food and Drug Administration (FDA). If the FDA has approved a drug, device, or biological product, FEHB plans would provide coverage when the product is used for its intended purposes and labeled indications. Of course, this is subject to the caveat that the product would be considered covered under the health plan's benefit structure and the services would be medically necessary and appropriate for the patient's condition.

For emerging technology assessments, medical advisory panels may be used by health plans. One such panel is exemplified by the Technology Evaluation Center (TEC) founded in 1985 by the Blue Cross and Blue Shield Association. The TEC pioneered the development of scientific criteria for assessing medical technologies through comprehensive reviews of clinical evidence. Since its inception, TEC has been recognized for leadership in producing evidence-based technology assessments. Each TEC Assessment is a comprehensive evaluation of the clinical effectiveness and appropriateness of a given medical procedure, device or drug. Averaging 20 to 25 assessments a year, TEC provides healthcare decision makers with timely, rigorous and credible information on clinical effectiveness. TEC serves a wide range of clients in both the private and public sectors, including Kaiser Permanente and CMS.

Possible avenues on how the FEHBP can better stress health literacy

We continue to stress health literacy by encouraging FEHB enrollees to become more informed about their healthcare. We provide information on our FEHB website such as comparison tools, to assist enrollees with choosing the right health plan that best suits their needs. We participate in various groups that stress health literacy such as the National Quality Forum (NQF), the Quality Interagency Task Force (QuIC), comprised of several Federal partners including the Agency of Healthcare Research and Quality (AHRQ), and the Leapfrog Group. As a part of the NQF we participate in many workshops that discuss ways to continue to stress health literacy. Most recently, we participated in a workshop on September 10, 2004 that discussed how to "Improve Patient Safety Through Informed Consent in Limited English Proficiency/Low-Literacy Populations."

In 1999, a report from the Institute of Medicine found that up to 98,000 people die each year in America's hospitals as a result of medical mistakes that are preventable. As a result, the QuIC tasked itself with developing means to further educate consumers about their health care. The QuIC developed the 5 Steps to Patient Safety, which was adopted by all of our health plans and incorporated in each health plan brochure. The 5 Steps to Patient Safety can also be found on the FEHB and plan websites. As a part of the QuIC, we have also participated in the development of other comprehensive patient safety brochures, pamphlets, and posters designed to educate FEHB enrollees about their health care. We continue to encourage our FEHB health plans to incorporate these materials in their consumer information and educational materials wherever possible.

As a part of the Leapfrog Group we stress support for informed health care decisions by encouraging purchasers to promote high-value health care, educate consumers about their choices, and provide incentives where possible for those that adhere to these principles.

In summary, while the primary role of OPM as the administrator of the FEHB Program is to contract with health plans to provide healthcare coverage for Federal employees, retirees, and their families, under the leadership of Director James we have used our leverage as a major purchaser, often in collaboration with other purchasers, to facilitate meaningful efforts by the health plans to improve the quality of services they provide. Within the framework of our mission, we believe we can and should contribute to the overall efforts to make and keep the American healthcare system one of the best in the world.

This concludes my testimony. I appreciate this opportunity to provide our comments on these important initiatives in the health care industry and the Federal Employees Health Benefits Program.

Mr. MURPHY. Thank you.

I will defer now to Chairman Davis for some questions.

Mr. DAVIS. Mr. Blair, let me ask, health care savings accounts are something that the Congress has now put into application to a limited extent in the private sector. I know that OPM has been looking at this. One of the arguments against it, that I hear from some of my Federal employee groups and particularly the retired Federal employees, is that this takes people that are paying into a larger pool out and their dollars would be out of that, which would raise costs to other people. Obviously, to the government workers and the like and it offers a great opportunity for some savings. What are your feelings and what have we done with that?

Mr. BLAIR. We feel that health savings accounts offer a viable alternative and a good option for Federal enrollees. In our call letter this year we encouraged plans to look at those and to come up with plans to offer something like that.

We believe that if adverse risk selection should occur that we could minimize it by adjusting benefits and looking at this over time.

Federal employees do not migrate dramatically from one plan to another. So I think should adverse selection occur, we can take steps over the plan period to minimize anything like that. But again, I think that this is an example of responding to developments in the health care field. It would improve the way that enrollees utilized their own health care dollars. I think it makes good sense for enrollees to look at something like that. It is an option that is being encouraged in the private sector and we should not deny Federal enrollees that opportunity either.

Mr. DAVIS. Given that the idea of pay-for-performance is beginning to catch on regarding the quality of centered programs, how can the FEHBP use its leverage to encourage plans to develop innovative approaches to improve it quality?

Mr. BLAIR. Well, it is beginning to catch on. It is a relatively new concept in the health care field. There are really no standardized metrics out there.

In addition, since we contract with the insurance plans who then in turn pay the providers, we really have an indirect impact on this. However, it is not an insignificant one, and it is something that we need to continue.

What I think we want to look at is what works best in the field right now.

A number of the plans out there already have some initiatives underway in which pay for performance is being utilized. I believe Blue Cross/Blue Shield has about 20 initiatives out there. And I want to say that a Blue Cross/Blue Shield affiliate in this area, Highmark, is engaged in a similar program. CMS is engaged in looking at pay for performance. And they are a direct provider. They are a direct reimburser of health care providers as well.

So, I think that there is a lot of activity in this field. There are no standardized metrics, however, and this is something that, while we are certainly encouraging plans to move in this direction, we want to take note of what the best practices are before we would standardize anything.

Mr. DAVIS. With regard to quality measures and critical areas in hospital care, such as heart attacks, heart failure, diabetes, how can the FEHBP ensure that such data on providers is in the hands of every plan member?

Mr. BLAIR. Well what we do is urge our plans to get accredited. I am told that almost three quarters of plans do receive accreditation.

In addition, we do consumer surveys. But I think that what we need to do in this area is really move toward what President Bush's vision is, and that is an electronic patients' data file that will be easily accessible by providers as well as by patients. That Executive order was issued last spring. And this past summer OPM issued a report on how we can help the President achieve that vision over the next decade. And we came up with a number of interesting ideas.

One of the things that we suggested that we look at is how can we increase the use of what is called inter-operable health care technology or health information technology [HIT]. And there are ideas such as giving incentives so that when the doctor writes a prescription, that he or she writes that prescription on a hand-held device which is then transmitted to the pharmacy, which is probably an online pharmacy, and then have the prescription filled and delivered to the employee. But you would also want to have other health care providers have access to that information.

You certainly have privacy concerns with this. But as Chairman Murphy referenced in his statement, it is certainly an area that we need to go in if we are going to practice medicine in the 21st century in the right way.

Mr. DAVIS. The chairman did note that. It is an information and transaction process intensive industry. But we choose to spend less on information technology in health care than in almost any other sector of the economy. It is not true that it is OPM's fault, but how can we make the FEHB Program better? How can we promote this health information technology? What else can we do at the congressional level?

Mr. BLAIR. Well, I think that what we use here is the information that we have, the ability that we have when we manage the program. For instance, from our report we would strongly encourage health plans to adopt systems that are based on Federal health architecture standards. We would encourage those plans to highlight provider directories to indicate individual provider HIT capabilities.

We had about nine recommendations, and I would like to include those for the record. But basically what we want to do is provide incentives for health plans to better utilize health information technology.

Right now the fee structure is based such that maybe providing incentives in the profit area for something like this. Again, this is not taking place overnight, but this is a direction that we are going. It is a very exciting area, and I think that it can lead to better health care delivery for everyone.

Mr. DAVIS. OK. Thank you very much.

Mr. Chairman.

Mr. MURPHY. Thank you, Chairman Davis.

Mr. Blair, let me followup on a couple of these issues here.

On the information technology, I have a bill H.R. 4805 which tries to get electronic prescribing just for Medicare alone with estimates it would save about $27 billion a year plus thousands of lives. It seems to me we need to be doing some of these things, that the Federal Government can help fund some of these startups. The purpose of this hearing, of course, recognizing if we have 8.5 million enrollees just in FEHBP enrollment, we should be the juggernaut that is really driving some change in the Federal Government.

But let us see this information technology issue. What do you see are the practical barriers out there in the health care delivery system that is preventing them from doing this naturally? We are talking about saving lives, saving money by doing these things, but what are the barriers that the Federal Government is going to encounter in trying to enact some of these?

Mr. BLAIR. The FEHB program itself contracts with the health care plans. We need to encourage the health care plans to encourage those providers to have access and learn and develop and utilize such technology. I would not call that a barrier, but that is the direction that we would start to encourage the plans to move.

We work with a number of organizations that have both public and private sector affiliation; the National Quality Forum, the Quality Interagency Coordination Task Force. All these are areas in which better technology is being utilized and which advocate for better use of technology.

The other barriers would be, you know, what do providers on their own have to do? You know, what do doctors, what are hospitals, what do nurse practitioners, the whole wide range of health care providers, have out there now, and what access do they have to technology and how can that technology talk to one another? I think that would be the challenge in making sure that we have a system which is truly interoperable and that can benefit the patient.

Mr. MURPHY. One of the things we will have from our next panel and one of the reasons we are doing this hearing in Pittsburgh, is that we have some local experts who are moving in some of these areas and I hope you will be able to stick around to hear that.

But I want to go back to a point here about the pay-for-performance. Can you give me an example specifically how that works? Now particularly again, thinking here that we are trying to move 8½ million people as being the force behind getting a physician's office, hospital, etc., to move toward this, can you give me an example, or walk me through a patient care and how that would work?

Mr. BLAIR. I can, and why do I not provide that for the record as well. But I have here a Highmark Blue Cross/Blue Shield, and they had a performance based incentive program. And what they have done is that they have tried to encourage quality care by reducing variation in care. They share information with physicians which helped them provide care based on accepted clinical standards, while reducing variations in care. Each physician practice has a designated plan, a medical management consultant who are experts skilled in process, development and improvement.

They estimate that costs for the performance incentive program members did not increase as fast as the network, and they saw an average savings of more than $22 million.

And so you can see where although this is still in its infancy, that pay-for-performance does have the potential for driving better health care delivery to patients and to Americans across the country.

Mr. MURPHY. Well, let me also ask this technical question. I know when I was a member of the State Senate and wrote the patient bill of rights we have now in Pennsylvania, one of the barriers we saw happen with managed care was it was supposed to operate this way. A medical practice or hospital would see the lump sum of money to cover 5 or 10 or 50,000 enrollees with the idea being that if they took good care of those patients, they would save money and there was an incentive with that, and then otherwise they would reap the benefits. It is supposed to be, I guess, a quasi thing of moving in this direction of pay-for-performance, but you are talking about something entirely different. It is not just if you do not spend, you get to keep it, you are talking about a whole different area of almost a rewards system for——

Mr. BLAIR. Well, there are financial rewards. But again, in this area I am told that the metrics are not there yet. And so that is why before you would want to encourage plans to adopt something, you want to make sure that there are some standardized metrics across the board.

This area does have a potential benefit for everyone, but when you are moving in this area you need to be mindful of the physicians' injunction to first "do no harm," and that you want to make sure that encouraging adoption of any standard that might be national, while we would not want to mandate anything like that, we would want to encourage plans to do what is right. And before we do that, though, it seems like there is quite a bit in this field, there is quite a bit of innovation that people are going in different directions. But this is something to continue to monitor. I think there is great potential for cost savings, but more so there is better potential for better patient care, and that is what we want to drive.

Mr. MURPHY. And how about this area of using health education and healthy choices and good health care practices? Again, past barriers have been health care plans have sometimes thought well the average enrollee may have that plan for 18 months or so and then move on into another plan, although here in the Pittsburgh region we have two carriers, basically, the dominant forces in the marketplace. But many times it seems the plans really have not wanted to make investments in prevention and health choice and health education. How would that work in what you are saying?

Mr. BLAIR. Well, we certainly encourage that through our call letters. And I think that we have seen good preventive care plans offered by a wide range of FEHB plans.

Also, each year in the Federal sector we have what is called an Open Season that you can change plans. And during this Open Season you have Web-based information, you have plan brochures, you even have the private sector getting in on this by offering comparisons to other plans.

Again, it is up to the individual enrollee to educate him or herself, but there is information out there that can help them place which health care plan would probably be best to fit their needs. We encourage that. We think it is a good idea.

Plus, the HealthierFeds Program that we have implemented to support President Bush's initiative is another way and we have a Web site devoted to that.

Underlying this whole concept, though, is taking and assuming responsibility for your own health care. That the patient's relationship with his or her doctor, assuming those responsibilities for your health care, making health care lifestyle changes are all part of an overall move that you have to assume responsibility for yourself and educate yourself. The choices are out there. We want to encourage the best education out there. Individual plans will help in this upcoming Open Season and you'll see health fairs around the country. There will be health fairs in individual agencies. I think we even have one up in the Cannon Caucus Room each year in which the plans are up there educating Members and staff on what might be the best choices. But again, I think that's the hallmark and one of the high points of the Federal system is this idea of choice. The idea is that this choice is to be an educated one, and we provide members with that kind of education to make their best choices.

Mr. DAVIS. Mr. Chairman, just to followup.

There has been a lot of talk about extending the principles of FEHBP nationally. One of the problems I have had, representing a district of 50,000 Federal employees, is if you open the current FEHB Program to everybody, it just changes the whole mix. Federal employees tend on average to take better care of themselves than others, and all those things change. But do you think this model could be used nationally, maybe with separate programs, or not?

Mr. BLAIR. Well, I think that is a big question. I am not sure I am prepared to answer that. I would say that the principles underlying the program are something that could stand as a foundation nationally. And, I think the principles are choice and competition, no mandates, but encouraging plans to exercise the dynamic of the marketplace, the dynamic of the health care arena in which new and innovative things are taking place on a daily basis and channeling that to keep costs at a minimum while providing the broadest range of benefits.

So I think the principles behind the FEHBP certainly can stand as a foundation for other reforms.

Mr. DAVIS. I mean one of the problems came when the prescription drug benefit plan was passed. As you know, we wanted to ensure that FEHBP remains available for our retired Federal employees. Currently retired Federal employees are treated differently than active Federal employees in the sense that they can't deduct the cost of their health insurance from their taxes. That is a differentiation, and there is a great fear that with the current plan that was passed by Congress that somehow this benefit would disappear for retired Federal employees. Well, we will just use the prescription benefit plan. That puts us contrary to the philosophy of what we passed, which is we are trying to keep the private plans

in existence. If the Federal Government has to pick up the tab for everybody in prescription drugs, the costs are going to skyrocket, whereas if we can maintain current plans being able to pick up a portion of those costs, do you have any thoughts on that?

Mr. BLAIR. Well, as you know in our plan offerings right now we have a self and family option. We do not discriminate between retirees or active employees. Everyone is together in this insurance pool, and it operates quite well for us and we have no intention of separating employees from retirees at any point that I am aware of.

Mr. DAVIS. So that would not happen at least from your perspective?

Mr. BLAIR. I am not aware of any plans in the works to do anything like that.

Mr. DAVIS. We passed that.

Mr. BLAIR. I am sure we would hear from you folks as well.

Mr. DAVIS. Well, we passed a bill in the House that basically said we wanted to take a look at this benefit for Federal employees and retired Federal employees. It is sitting in the Senate. It did not include any overall bill because the criticism that somehow Congress was getting, is that most of the Members of Congress who retire do not use FEHBP, but there are some that do. And you are set up with the argument that there are those who oppose the prescription drug benefit plan for different reasons, and you know Congress wants their own plan, this is not good enough for them.

I just wanted to touch on that and get your assurances, and I appreciate it.

Thank you, Mr. Chairman.

Mr. MURPHY. Thank you.

What I want to get into, and I do not know if you know the technicalities of this, but it has to do with as we are driving some of these changes, preventive health care and pay-for-performance, health education, and managing diseases before they reach the chronic state or the emergency room access state, which is very, very expensive when you're doing that, you said there are open enrollment times for Federal employees, so they can go from plan to plan. What are the rules with regard to dealing with preexisting conditions? Because some of the complaints I get, for example, in my office, not from Federal plans but from other ones, are that people say I have to hang on to the insurance company I have even though the rates are going through the roof because I have a preexisting condition and no one else will accept me. What happens in the Federal plans when that problem exists?

Mr. BLAIR. Ann, correct me if I'm wrong on this. But we have no preexisting condition exclusion.

Mr. MURPHY. There's no barriers?

Mr. BLAIR. You can go from plan to plan to plan. That said, in the Federal sector you do not see migration between and among plans very often. It is a pretty stable insurance pool out there in that you see most people, although we encourage innovation, encourage the competition, but most employees stay with the plan that they are familiar with and do not change every year.

I think I can provide for the record how many do. And that is one of the arguments that we have always said that with the

health savings accounts that generally speaking the Federal population is a conservative population, not so much politically, but as in lifestyle choices in terms of not changing things. And, so when we offer these new benefits, people stand back and wait and see how they operate.

And, we think that new benefits are important. We think innovations are important. At the same time, we have a very stable population which usually stays with the plan that they know and are most familiar with.

Mr. MURPHY. It probably helps that they look at exclusions from preexisting conditions. In the general marketplace I really think that is one of the things that I hope to achieve, because when you can exclude preexisting conditions, there is not much incentive for insurance companies to get out there and really work on patient education as much if someone does leave a plan, because costs are going up and nobody else has to take them. So that is probably one of the good things we have going for us, and I hope we can continue to help the rest of the Nation do as well.

I know often times politicians are out there saying that everybody should have the Federal plan, too. We should make note that this is not free for employees, including Members of Congress.

Mr. BLAIR. Exactly.

Mr. MURPHY. We also have to pay for it. I just want the record to show that.

Mr. DAVIS. Let me also note that even for the use of the Capitol physician we pay extra on top of FEHBP for that.

Mr. MURPHY. I also want to make sure the record notes that.

I do not have any further questions. Chairman, do you?

Mr. DAVIS. Well, I do not either. We have testimony coming in, and I hope you will be able to stick around and hear that and review that, because there is some very interesting ideas about how we can improve not just FEHBP but the total health care system. And I think that holds some promise for us.

So, I thank you very much.

Mr. BLAIR. Thank you.

Mr. MURPHY. I look forward to this afternoon, you are going to make announcements about the premium rates?

Mr. BLAIR. It is my understanding that Kay will be making announcements sometime this afternoon, and your staffs are being briefed as well.

Mr. MURPHY. OK. Thank you very much.

While we are getting ready for the next panel to come up here, let me go over some of their background so we have that information.

Let us take a couple of minutes while we are getting ready here.

First, we will hear from Dr. Karn Wolk Feinstein. Dr. Feinstein is the Chair of the Pittsburgh Regional Health Initiative. They have been doing great work to improve health care in Pittsburgh.

Dr. Neil Resnick, M.D. is a Chief of the division of medicine at the University of Pittsburgh, co-director of the aging there at the University of Pittsburgh Medical Center. He leads one of the largest and most innovative geriatric programs in the country. He has more board certified geriatricians than any other programs in the country, I believe.

His medical degree is from Stanford. He has an impressive list of credentials there, too, and I am excited to have you on board.

And finally, Dr. Alan Axelson, a psychiatrist, founder and president of Intercare, and for the sake of disclosure I should say I used to be one of his employees, too, prior to coming here. But I asked him here because of his innovative concepts and things that he is going to be describing to us.

He is a member of the American Psychiatric Association's Managed Care Committee, the American Academy of Child and Adolescent Psychiatry Work Group on Managed Care. In these capacities he has participated extensively in the development of level care criteria for these two psychiatric organizations.

Also a well known and renowned writer and public speaker on various managed care related topics.

I believe we will go with Karen Feinstein. I want to refer to you as doctor today, we will keep it formal.

STATEMENTS OF DR. KAREN WOLK FEINSTEIN, CHAIR, PITTSBURGH REGIONAL HEALTHCARE INITIATIVE; DR. NEIL M. RESNICK, DIRECTOR UNIVERSITY OF PITTSBURGH INSTITUTE OF AGING; AND DR. ALAN AXELSON, MEDICAL DIRECTOR, AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY

Dr. FEINSTEIN. And I refer to you as Representative.

Just for disclosure, I do want to say that then Senator now Representative Murphy was part of the Pittsburgh Regional Health Care Initiative from its inception.

The Pittsburgh Regional Healthcare Initiative is a group of stakeholders from our area. 42 hospitals, most major purchasers all four insurance companies who are doing business here now, the attorney general, Representative Murphy who came together around a certain proposition that: Better health care is available at lower costs; that it requires work design or redesign at the point of service to eliminate waste, inefficiency and error; it rewards evidence-based best practices; it requires good information on cost and quality, requiring financing, accounting and clinical measurement systems that are far superior to what we have in operation today; that providers could compete on value and would therefore deliver value; and, it was founded on a truism: What is good for the patient is good for the payer.

So we started to test out our proposition, our value proposition, our hypothesis. We started testing it out in a lot of clinical settings working with providers, mostly in hospital but also ambulatory.

Let me just take one quick example, central line associate blood stream infection. We have found that in intensive care units where people are diligent, we're not talking about high tech technology doing anything that is state-of-the-art, just basic care, we can bring central line associated blood infections down almost to zero. How are we doing it? Simply following protocol vigorously. And, as you know, the estimates of the cost to this country of central line infections is up to $1 billion; 25 to 50 percent of the people who get them die.

We have also found that when you break down the costs, which by the way is a lot of work because of the cost accounting systems

we have now in health care, you find that the provider never makes money on a central line infection. They lose anywhere from $500 a patient to $42,000 depending on the insurer and the nature of the patient's health. But also we found that insurance companies are picking up a large amount of the cost on an almost avoidable occurrence, which is central line infection. So we believe that our proposition seems to be playing out.

And we started out focusing on providers. We are looking at the point of service. We are looking at people who deliver care. But we realized we had made a mistake not attending to the role the payers play, the incredible role that payers play in bringing about a cascading effect to drive this kind of improvement at the point of service in the quality of care delivered in units by the people who deliver care.

So we have been collecting examples of perverse payments within health insurance, which are really quite astounding and we intend to present to Chairman Davis and Representative Murphy some more background on this. It is really pretty astonishing how many things we pay for that reward bad behavior and preventable error and not good practice.

We think that, obviously, FEHB could vastly change the extent to which our value proposition is realized. These are just some ideas.

Plans should be required to pay providers for good and safe care, and on the other hand not to reward errors and waste such as central line associated blood stream infection. Since we have found in almost all units where we have attacked this issue, that it can be brought down to zero, it seems to me that if we were not paying for these infections, if the insurers were not picking up a lot of the cost to providers, people would just eliminate them since we can give you evidence to suggest this is very doable.

Plans need to provide members with available outcome data and really drive the information flow to their members about the differential outcomes in a way that is much more effective and direct than we have now. Having members even just go to a Web site and look it up we think is too indirect. That it should be something that is made easily accessible because we do have proof, as you know from PacifiCare and their quality index, 6½ percent of their members moved to the higher performing providers every year. If you start adding that up year after year, you're going to get a movement, a reward for those who are providing good care.

We are looking at outcomes here, not processes. I think that is very important. I do want to suggest this distinction which is important. People will use different processes to get better and learn from one another.

Plans should be required to accompany the outcome information with cost comparisons and highlight the high quality low cost providers. As you know, again, with PacifiCare they have had a lot of success doing that.

One challenge remains. Most hospital accounting systems do not account the best information and allow you to easily extract this information, as the physician to my left can tell you. But if this were required, believe me, they would have activity-based cost accounting systems that would allow them to know what its costs to

provide care correctly and what it costs to introduce error and waste.

And overall, you should be, we hope, rewarding plans that reward value. That we should pay more for those who give us more value. And we believe that will actually prove our value proposition that the more you increase quality and safety the lower you are going to find your costs.

[The prepared statement of Dr. Feinstein follows:]

How the FEHBP Could Drive Value in Health Care

Testimony delivered to the
U.S. House Subcommittee on Civil Service and Agency Organization
September 13, 2004, 10:00 a.m.

By **Karen Wolk Feinstein, PhD**
Chair, Pittsburgh Regional Healthcare Initiative, and
President, Jewish Healthcare Foundation

I would like to present a value proposition from the Pittsburgh Regional Healthcare Initiative which I chair:

- Better health care is possible at lower cost.
- It requires work redesign at the point of service to eliminate waste, inefficiency, and error.
- It rewards evidence-based best practices, producing better outcomes of care.
- It requires good information on both cost and quality, requiring financing, accounting, and clinical measurement systems that are superior to what we have today.
- Providers compete on value and deliver on value.
- It is founded on this truism: **what is good for the patient is good for the payer!**

What is the ideal? A quality-driven healthcare system, where systems designed for safety result from streamlined work processes, evidence-based practice, and a sparing use of resources. The result is low-cost, high-quality health care.

Let me give you four other key propositions from Michael Porter's article on "A New Competition" from the *Harvard Business Review* of June, 2004.

1. "The most fundamental and unrecognized problem in U.S. health care today is that competition operates at the wrong level... It should occur in the prevention, diagnosis, and treatment of individual health conditions... Providers should be rewarded for the ***best value*** care for particular conditions or diseases."

2. "Information is integral to competition in any well-functioning market. It allows buyers to shop for the best value and forces sellers to compare themselves to rivals. In health care, though, the information really needed to support value-creating competition has been largely absent or suppressed."

3. "The healthcare system can achieve stunning gains in quality and efficiency. And employers, the major purchasers of healthcare services, could lead the transformation."

4. "Health insurers should be rewarded for helping customers learn about and obtain care with the best value."

FEHBP has long been a leader in leveraging its massive scope to make health plans more consumer-focused. As the direction and specific changes needed radically advance quality and efficiency in American health care become increasingly clear, FEHBP can, through aggressive

---

The Pittsburgh Regional Healthcare Initiative is a consortium of the institutions and people who provide, purchase, insure and support healthcare services in the region. Our partners include hundreds of clinicians, 42 hospitals, four major insurers, dozens of major and small-business healthcare purchasers, corporate and civic leaders, and elected officials. Our goals are achieving the world's best patient outcomes by creating a superior health system through the identification and solving of problems at the point of care.

action, "tip" the nation on the critical issues of beginning to link payment to the quality of care provided and arming consumers with the critical information they need to be value consumers.

In 1997, Paul O'Neill, a number of colleagues and I asked ourselves why American health care, for all the miracles it produces, was so expensive, so poorly delivered, and so fraught with waste and error. We asked an audacious question: *Why can't the great medical institutions of Pittsburgh deliver health care flawlessly?* Intrigued by the question and by the notion of healthcare systems learning from one another—then further spurred by the eye-opening Institute of Medicine Report of 1999—45 hospitals, along with insurers, providers and plans eventually came together under the leadership of O'Neill and Feinstein to form the Pittsburgh Regional Healthcare Initiative. The work we've undertaken at PRHI suggests that great change is possible and confirms what more and more policy studies have concluded: that we can provide care of dramatically higher quality—and we can do it at half the cost.

Our recommendations flow from our core conviction: improve quality and safety and you will lower cost, save lives, and produce a healthier labor force! First of all, we are realizing that improving the quality of care delivery is central to solving the problems plaguing American health care. Skyrocketing healthcare costs, diminishing access to health insurance and health care, increasing harm to patients, the malpractice crisis, the nursing shortage and numbing morale problems across health care disciplines—all of these problems emanate from a system often distracted from delivering quality at the point of patient care. From the current hodge-podge system has emerged phenomenal waste and its evil twin, error.

Here is a graphic example of a system gone awry (Figure 1).

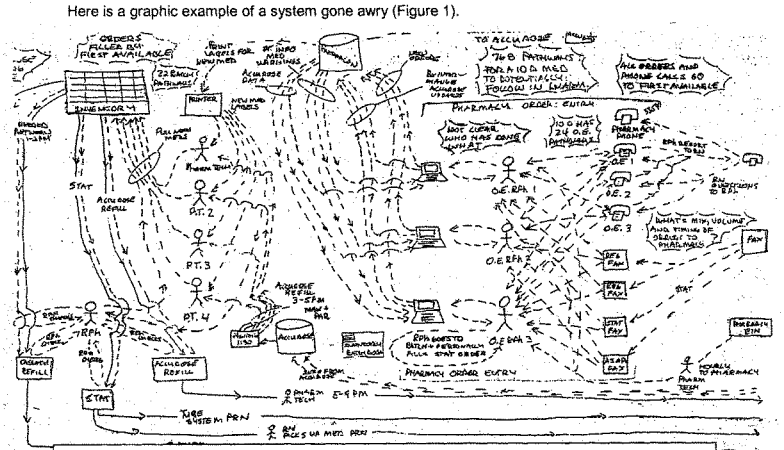


Figure 1. Getting the first dose of medication to a patient

This drawing was made during an observation in a hospital, and it is typical. It shows the steps necessary for a patient to get a newly ordered medication. Counting all the different ways the order can be conveyed, received and passed along, there are over 700 steps in the process. That is, there are 700 opportunities for error. Only through the dedication of heroic professionals do most patients receive the right medication in the right dose at the right time. When you contemplate the effect that such a system has on quality, cost, patient satisfaction and worker morale, you begin to see how interrelated the problems are.

This is a revolution that has to be accomplished on the ground, "at the point of patient care." Accordingly, we have engaged the entire delivery system community in aggressive attacks on infection, medication error, and many other symptoms of the system's dysfunction.

But health plans can play a critical role in setting and maintaining the conditions necessary for excellence. They have in Pittsburgh, and the FEBHP can nationally.

We have four major action recommendations:

1. **Require plans to pay providers more for good and safe care, and not to reward errors and waste.**

2. **Require plans to provide their members with available outcomes data from providers, and drive the creation of more consensus, uniform outcomes reporting across the nation. FEHBP can also be a leader in requiring that consumers have access to accurate price information for medical care.**

3. **Accompany outcomes information with cost comparisons and highlight the high quality low-cost providers.**

4. **Reward, as a plan, VALUE.**

Hospitals should do better than break-even when they get treatment right the first time, and a healthcare-associated complication should also be a bad financial outcome for the institution. Detailed financial analysis of our own safety gains is beginning to show that there are "perverse" payment incentives for certain conditions under which if a hospital performs perfectly, it makes no profit; if they perform badly, they can make a substantial profit. (Thankfully, in more areas, such as certain hospital-acquired infections, professional carelessness hurts the bottom line profoundly.)

While the idea of "pay for performance" is beginning to catch on, current quality incentive programs typically involve less than 1% of annual revenue for a hospital, when hospital CEOs will tell you that at least 5% would be required to "get their attention." Also, incentives that focus on process and not an outcome will have less impact over time. In addition, the standards of performance in the existing programs are not very ambitious. *FEHBP could use its leverage to* radically expand the scale and scope of pay for quality efforts to hospitals, primary care and other settings alike, and to require participating plans to ensure that they are ***not*** rewarding providers for healthcare-associated complications.

Leading plans are beginning to emerge, which FEHBP can require others to emulate. We have been particularly impressed by Pacificare's Quality Incentive Program, which is tied to their Quality Index, and has increased from $14 million to $21 million over the past two years. Our local Blue Cross plan, Highmark, also has a growing incentive program. Nationally, Aetna seems to be moving rapidly in the "pay-for-value" direction. FEHBP can add even more value by pushing for these incentive programs to be tied to uniform, public measures (see below).

Let's not forget that today chronic disease accounts for 75% of all health care. *Why can't we* shift payment incentives toward inexpensive, effective primary care that can prevent the progression of more serious diseases? Over the past 5 years, the Veteran's Administration has done so, and the result is this: their per-patient costs have stayed steady, while the rest of American healthcare increased 50%; and a recent study confirmed that the VA is providing the nation's highest quality primary care. FEHBP could see that America's public health plans use their dollars to copy the VA's success. It will take political courage; specialists don't like to see their rates reduced and shifted toward primary care.

First, the recent JAHCO/AHA/CMS consensus quality measures in critical areas of hospital care such as heart attacks, heart failure and diabetes are a major step forward. FEHBP should ensure that such data on providers is in the hands of every plan member as soon as it is published. (It was enlightening to us to see that despite the scientific rigor and consensus agreement about the validity of the measures, only a few dozen hospitals participated when it was entirely voluntary. When Congress attached a payment increase to it, virtually every hospital in the US agreed to participate.) Here again, there are leaders among the nation's health plans in getting quality information to consumers.

Second, FEHBP should work to expand the range of critical health areas with such consensus national outcomes reporting, and require that those additional areas also be regularly reported to each plan member.

Third, FEHBP can further promote value purchasing by rewarding plans that get actual pricing information regarding medical procedures into consumer hands, as well as quality data. Preferably, this would be required. Historically, health plans have fiercely resisted disclosing their payment agreements with providers. This has only exacerbated the enormous waste created by the "black box" of health care finance. As Paul O'Neill and, more recently, Michael Porter have argued, transparency is required to drive value creation in health care. Hospitals need incentives as well to move to the kind of activity-based cost accounting systems that would permit the better transparency regarding the actual costs of episodes and procedures.

It has been an honor to testify before this panel. FEHBP has been a model program, and can through decisive action "tip" the nation's healthcare system toward a much sounder structure for high performance. The PRHI is prepared to offer more information on the critical function of health plans in promoting value.

Karen Wolk Feinstein, PhD
Chair, Pittsburgh Regional Healthcare Initiative, and President, Jewish Healthcare Foundation
Center City Tower
650 Smithfield Street, Suite 2330
Pittsburgh, PA 15222
Phone, 412-594-2555; fax, 412-394-5464; email, feinstein@jhf.org

Mr. MURPHY. Thank you.

We'll save questions until the end.

I think that Dr. Resnick, you are next.

Dr. RESNICK. As a geriatrician I've been asked to focus on issues relevant to the concerns of the roughly half million older retirees in the FEHB, and that's a wonderful opportunity for someone who spent their life trying to care for older people in group care, to actually get to talk to people who can effect such a change is a huge honor.

It is probably important to put the issue in context. Everybody knows that there is an explosion of older people, but what is less well appreciated is that chronic disease is the dominate issue in these people and that, second even less well appreciated, is that several features of chronic disease differ in older people compared with younger adults. Few physicians are trained to deal with these conditions in the elderly. That the number of such physicians is declining at the time the number of old people is increasing. Many features of the health care system, which is largely optimized for acute care, will ill suit the needs for older people with chronic conditions.

I'd like to start just saying why chronic disease in older people differs from that in younger people.

First, older people with chronic disease generally suffer from more than one concurrently, making the detection and diagnoses and treatment of the new disease more difficult.

Second, the generally used approach to a given condition may be contraindicated by the other conditions or by the multiple medications that a patient uses to treat them.

Third, while scientific evidence for chronic disease management is limited, it is far more limited for chronic disease in older adults and this impedes development of appropriate guidelines.

Fourth, chronic disease in older adults often occurs in patients who also have mental impairment or depression. And the impact of these is exacerbated by the fact that many older adults do not have a spouse or an advocate and these factors hinder the physician's ability to complete an adequate evaluation or to ensure adherence to therapy.

Fifth, older patients have much shorter life expectancies which requires putting risks and side effects in a very different perspective.

Sixth, considering to the issues just mentioned as well as to ageism, older adults often have different values and goals.

When you put all this together with the multiple possible combinations of coexisting chronic conditions that could occur in an older person, it's easy to understand that application of the type of disease management models currently being developed and advocated at present will be very difficult at best. But it's worse than just the problems with chronic illness. Despite the complexity of chronic illness in older adults, despite the spiraling increase in their numbers, the number of physicians trained to deal with this has gone down. There are a variety of reasons, and they're in my testimony, but it's important to note as well that the number of students are not going into geriatrics as well. Less than 3 percent

of U.S. medical students are enrolled in any geriatric course at the present time.

It has been estimated that if we forced every medical student to take geriatrics today, that it would take 40 years to have enough physicians, to educate all the physicians who need to take care of older people in this country. So we need a way to get out to the practicing physician, and unfortunately that's not happened. Fewer than 1 percent of practicing physicians have any experience in geriatric care, and it's not going up for the reasons that are outlined in my testimony.

But it is more than just the complexity of chronic disease and the lack of access to physicians. Access to appropriate care for older patients with chronic disease also reflects lack of access to institutions. Hospitals often seek to avoid admissions of such patients, especially those who are frail since such patients have a higher risk of complications, longer stays and nonreimbursed readmissions.

Reimbursement issues also leave many nursing homes to try to avoid admitting patients who cannot pay privately. Home care programs are closing nationwide. Insurers are eliminating their HMO Medicare programs, and in the current fee-for-service environment there is little ability or incentive to coordinate care. The resulting fragmentation of care and competing incentives increase the difficulty in managing chronic disease, particularly for older patients who have the most concurrent chronic conditions and the least ability to survive inadequate care.

The result is is a common scenario for older patients, that is to be referred to one patient physician after another, each of whom adds a test or a medication which in turn engenders another symptom so that the cycle continues until the patient's status deteriorates and results in an acute event. The patient is then sent by ambulance at high cost to an emergency department at higher cost, and hospitalized at still higher costs.

The hospitalization is generally longer than for younger patients, more often includes complications and is more often followed by the need for intensive care, subacute or chronic care. The final result is an increased likelihood of the worst of everything: An outcome that neither the patient nor the physician will desire and at a cost that neither the patient or society can afford.

But the situation is far from hopeless. Studies show that students who begin medical school are attracted to caring for older adults and the geriatricians are among the most satisfied of medical specialists. Moreover, while the high complications rates among older adults generate high utilization, neither one of these is inevitable.

In addition, not only are many of the solutions to improve geriatric care relatively inexpensive, but implementing them could decrease the number of emergency department visits, the number and length of hospitalizations, the number of medications and which in turn make these interventions at least revenue neutral, if not substantially cost saving.

What are some potential strategies? Well, in the short term one recommendation that's in this paper is to convene a task force of experts and stakeholders in geriatric care. I think it would be quite

easy to assemble what's already widely known about ways to improve geriatric care. It could be integrated into a coherent system.

The second recommendation would be because this kind of health modification is not going to be easy and not going to be straightforward and its stakes are high, it is certainly going to be worth evaluating. And so my second recommendation would be to consider funding a demonstration project, at least one if not more. For several reasons that are outlined in the testimony, the University of Pittsburgh Medical Center is very well positioned to do that, both because of the high proportion of older people in our region, the high proportion of geriatricians who are available to care for them, one of the country's largest portfolios of research expertise and the fact that we also have an insurance plan so that we can identify every cost of the care and all of the outcomes.

In conclusion, the need is great. The number of retirees in the FEHBP is roughly half a million and growing quickly. And the impact is even greater than the numbers would suggest since the costs are growing more rapidly than the number of retirees and they soon eclipse the ability of the FEHBP or its current employees to afford.

In addition, the lack of appropriate chronic care infringes on the productivity of current workers who must take time off to help their parents deal with this.

Your goal is laudable. We will do everything we can to help you with that. Clearly, I hope that this has helped cast some degree of light on what some of the potential solutions are to what has been a vexing problems for all of us to solve.

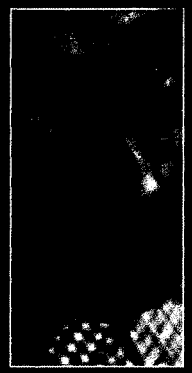
Thank you.

[The prepared statement of Dr. Resnick follows:]

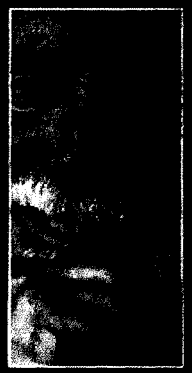
University of Pittsburgh

INSTITUTE ON AGING *in partnership with UPMC*

Seniors



Family & Caregivers



Professionals In Aging

Researchers

Educators & Students

Search GO

Our Website offers detailed information for specific groups. Select the site that pertains to you: Seniors, Family & Caregivers, Professionals in Aging, Researchers, or Educators & Students.

http://www.aging.upmc.com | 1-866-430-8742

University of Pittsburgh
INSTITUTE ON AGING
In partnership with University of Pittsburgh Medical Center

Testimony to the U.S. House Subcommittee on Civil Service and Agency Organization

Neil M. Resnick, MD
Professor of Medicine
Chief, Division of Geriatric Medicine and Gerontology
Director, University of Pittsburgh Institute on Aging

Introduction

As a geriatrician, I have been asked to focus on issues relevant to the concerns of the roughly half million older retirees in the Federal Employee Health Benefit Program. This is an entirely appropriate request from a committee focused on chronic care because the prevalence of chronic diseases in the elderly is approximately twice as common as in younger individuals. In addition, chronic conditions in older individuals also pose many more challenges. Having devoted my career to caring for such patients—and to searching for the causes of their diseases and to optimal approaches to their care—it is a privilege to be asked to share some thoughts with those who may be able to effect change.

Statement of the Problem

It may be important to put the issue in context. It is now widely realized that the number of older Americans is rapidly increasing and will double in the next 25 years. What's less well appreciated is that chronic disease is the dominant issue in such people, that several features of chronic disease differ in older adults compared with younger adults, that few physicians are trained to deal with these conditions in the elderly, that the number of such physicians is declining, and that many features of the health system—which is largely optimized for acute care—ill suit the needs of older adults with chronic conditions.

Differences in Chronic Disease Among the Elderly

For several reasons, the challenge posed by chronic disease in the elderly differs from that in younger patients. First, older patients with chronic disease generally suffer from more than one concurrently, making detection, diagnosis, and treatment of the new one more difficult. Second, the generally used approach to a given condition may be contraindicated by these other conditions or by the multiple medications the patient is taking to treat them. Third, while scientific evidence for chronic disease management is limited, it is far more limited for chronic disease in older adults, and this has impeded development of appropriate guidelines. Fourth, chronic disease in older adults often occurs in patients who also have mental impairment and/or depression, and the impact of these is further exacerbated by the fact that many older adults do not have a spouse or other advocate; these factors hinder the physician's ability to complete an adequate evaluation and ensure adherence to therapy. Fifth, older patients have much shorter life

expectancies than do younger patients, which require putting risks and side effects in a very different perspective. Sixth, owing to the issues just mentioned, as well as to ageism, older adults often have different values and goals. When coupled with the multiple possible combinations of coexisting chronic conditions in the older person, it is easy to understand that application of the type of disease management models being developed at present will be difficult at best.

Lack of Physician Training for the Complexity of Chronic Disease in the Elderly
Despite the complexity of chronic disease in older adults, and the rapidly increasing number of such individuals, few physicians have received even an hour of geriatric education.

The lack of physicians with geriatrics training reflects several factors. Most physicians were educated before geriatrics was offered in medical schools. And for a variety of reasons, acquiring training in geriatrics once they are in practice is difficult. First, there are few geriatricians to teach them since less than 1% of American physicians have geriatric certification. Second, there is little incentive for a practicing physician to seek such training. In addition to the tuition they would pay and the practice revenue they would forfeit during training, reimbursement for geriatric care is low and is no better for those who have received additional training. In addition, caring for older adults requires dealing with a disproportionate amount of paperwork, documentation, and regulations; these not only decrease productivity but also are viewed in many cases as counterproductive to optimal patient care. This view is underscored by the fact that physicians receive no payment at all for services they often provide free for older patients such as counseling for preventive care, telephone management, care coordination, advance care planning, family meetings, anticoagulation management, and pharmacy oversight, among others. Finally, owing to inadequate reimbursement, physicians who agree to care for older patients have to see them in a briefer amount of time, despite the fact that their problems are the most complex. Physicians find such practice frustrating and even dangerous.

Nor is the number of physicians trained in geriatrics likely to increase soon. Only 3% of today's medical students receive geriatrics training. In part this is because geriatrics is only offered at a little more than half of the nation's medical schools and required in less than 10%. And in part it is because there are so few geriatricians to teach them; less than one half of 1% of academic faculty are geriatricians. Although geriatricians report high rates of satisfaction in caring for older adults, the fact that virtually every geriatric division loses money on patient care results in geriatric faculty receiving relatively low salaries and having low job security. It should not be a surprise, then, that while the number of older adults is increasing; the number of geriatricians is actually decreasing. Nor should it be a surprise that students, whose average educational debt exceeds $100,000, are not flocking to the field.

Additional Impediments to Geriatric Care
Access to appropriate care for older patients with chronic disease reflects more than just the paucity of appropriately trained physicians. Hospitals may seek to avoid admissions of such patients, especially those who are frail, since these patients have a higher risk of complications, longer stays, and non-reimbursed readmissions. Reimbursement issues lead many nursing homes to try to avoid admitting patients who cannot pay privately. Home care programs are closing. Insurers are eliminating their HMO Medicare programs. And in the current fee for service environment, there is little ability or incentive to coordinate care. The resulting fragmentation

and competing incentives increase the difficulty in managing chronic care, particularly for older adults who have the most chronic conditions and the least ability to survive inadequate care.

The result is that a common scenario for older adults is to be referred to one physician after another, each of whom adds a test and/or a medication, which in turn engenders another symptom so that the cycle continues until the patient's status deteriorates, and results in an acute event. The patient is sent by ambulance to an emergency department and hospitalized. The hospitalization is generally longer than for younger patients, more often includes complications, and is more often followed by the need for intensive care or subacute and/or chronic care. The final result is an increased likelihood of an outcome that neither the patient nor the physician is happy with and at a cost that neither the patient nor society can afford.

Potential Solutions

The situation is far from hopeless. Studies show that students begin medical school attracted to caring for older adults and that geriatricians are among the most satisfied of medical specialists. Moreover, while the high complication rates among older adults generate high utilization, neither is inevitable. In addition, not only are many of the solutions to improving geriatric care relatively inexpensive, but implementing them could decrease the number of emergency department visits, the number and length of hospitalizations, and the number of medications, which in turn may make these interventions at least revenue neutral if not cost saving.

What are some potential strategies? In the short term, a task force could be created that comprises experts in geriatric care and health care policy. The task force could work with the FEBHS to identify the current regulations that function more as impediments than enhancements to care. One example is the rule that patients must be admitted to an acute care hospital for at least 3 days to qualify for nursing home admission, even if they have no acute care need. The task force could also identify policies that might be inadvertently driving up costs by being "penny wise but pound foolish." The task force might also model potential outcomes of paying more for proactive management of chronic conditions, for instance by paying for routine chronic care planning visits that might prevent the far costlier visit to an emergency room and/or hospital admission. The task force also could consider other potential short-term interventions to improve the training of clinicians and the incentives most apt to accomplish this. To assist in this regard, the Task Force could review inroads being made by the twenty recently funded Reynolds Centers since many of them are developing innovative ways to educate physicians in geriatric care. Finally, the Task Force could develop a list of interventions and prioritize them.

At the same time, it would be worth considering the funding of one or more demonstration projects. Our own work suggests that one promising solution to the scarcity of appropriately trained physicians is to re-engineer care of the older adult to make it feasible for a primary care physician to deliver, attractive enough that the PCP would want to, and feasible enough to allow it. We are working on a model that is proactive, preventive, and led by the PCP, who is supported by a team of appropriately trained specialists, as well as an infrastructure of case managers, care managers, information technology, and pharmacy oversight. Several features make this approach especially feasible. First, it does not require a long lead-time to train a large number of geriatricians; training is designed to be streamlined and focused. Second, the approach relies on developing strategies that any physician can use. This is particularly appealing since

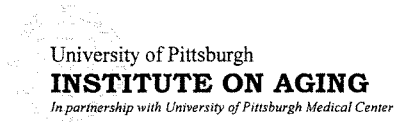
care of the older adult requires input from virtually every type of physician other than a pediatrician. Third, it relies on adapting and integrating approaches that for many of its components have already shown promise but which have never before been deployed as a comprehensive and integrated model. Fourth, while the approach invests more funding up front, it is focused on paying for things like preventive management of chronic disease, advance care planning, identifying patients' values and goals, and care management. The vast majority of the health care dollar for geriatric care currently is devoted to medications, ambulance rides, emergency room visits, and hospitalization, so if such an approach could reduce these costs by only a small amount it would not only be able to pay for itself but it would result in better care as well.

Of course, since the model just described is so different from the current model of care, and since the stakes are so high, such a model must be tested. Fortunately, for several reasons, this could be accomplished relatively quickly and efficiently in a system such as our own. The University of Pittsburgh Medical Center system is situated in what is demographically the oldest region of the country; Allegheny County today has roughly the same proportion of older adults that the country will have in 25 years. Second, the University of Pittsburgh has one of the nation's largest number of clinical geriatricians. Third, its expertise in geriatric research is one of the nation's largest and most diverse, with nationally recognized experts in virtually every area relevant to designing, implementing, and evaluating such an intervention. Fourth, UPMC has one of the nation's largest integrated health care delivery and financing systems, which also spans the entire health care continuum. Finally, UPMC's system includes an insurance company, which could design and deliver the product as well as collect data on the actual costs and outcomes of care.

Conclusion

In conclusion, the need is great. The number of older retirees within the FEHBP is roughly 500,000 and growing quickly. And the impact is even greater than the numbers alone suggest, since the costs are growing more rapidly than the number of retirees and may soon eclipse the ability of the FEHBP or its employees to afford. In addition, the lack of appropriate chronic care impinges on the productivity of current workers who must take time off to help their parents deal with this.

Furthermore, your goal is laudable: to not only deal with the plight of these individuals but in the process to attempt to develop solutions that could serve as a model for the US health system as a whole. I hope that I have been able to provide some perspective on how the needs of your older retirees who suffer from chronic illness differ from those of your younger enrollees. I hope you also share my optimism that much can be done. But it will require creative planning, more research, and changing regulations to reduce barriers to care.



NEIL M. RESNICK, MD

Dr. Resnick is a Professor of Medicine, Chief of the Division of Geriatrics, and Director of the Hartford Center of Excellence in Geriatrics at the University of Pittsburgh; he is also the Director of the University of Pittsburgh Institute on Aging.

Dr. Resnick has devoted his career to caring for older adults and to studying the causes of some of the chronic conditions from which they suffer. During the 15 years he was at Harvard, he founded and directed the nation's first Continence Center. His research led to novel ways for primary care physicians to care for incontinent individuals and establish guidelines that have been adopted by the U.S. government for all incontinent adults, including those in nursing homes. More recently he was asked to help the World Health Organization adapt these guidelines for more widespread dissemination. He has conducted similar research into other common geriatric conditions, including osteoporosis, prostatism, and delirium (aka acute confusion), among others. His work has been funded for two decades by NIH, CDC, and several foundations, and he has published nearly 150 articles and book chapters. He also has served as co-editor of a leading geriatric textbook and he authors the chapter on geriatric medicine for leading medical textbooks, including *Harrison's Principles of Internal Medicine*

A graduate of Yale University and Stanford Medical School, Dr. Resnick's work has been honored by awards from the American Geriatrics Society, the American Urological Association, the International Continence Society, and the National Institutes of Health. In 2002, Dr. Resnick received the F. Brantley Scott Award from the American Foundation for Urological Disease (American Urological Association) "for extraordinary efforts to improve the quality of life for children and/or adults with bladder or sexual abnormalities." In 2003, he received the first John Humpal award from the Simon Foundation, one of the world's largest lay organizations for people with incontinence, for "outstanding dedication to people with incontinence and the relentless pursuit of knowledge to find a cure." Dr. Resnick has been included in both the *Best Doctors in America* and in *America's Top Doctors* since their first editions, as well as in the city's "Best Doctor" lists by both *Boston* and *Pittsburgh* magazines.

UNIVERSITY OF PITTSBURGH INSTITUTE ON AGING

The University of Pittsburgh Institute on Aging (UPIA) was established to re-engineer geriatric care. Its goal is to improve the quality and overall health and well being of older adults in western Pennsylvania. Its strategy is to leverage and integrate the considerable aging-related clinical, research, and educational expertise of the University of Pittsburgh, the University of Pittsburgh Medical Center, and other government and publicly funded organizations.

The University of Pittsburgh Medical Center has been ranked by U.S. News and World Report among the very top health care systems in the country six years in a row, and its Geriatrics Division is among the nation's largest and best as well. Additionally, the health system's emphasis on information and technology has resulted in its recognition as one of the most wired by "Hospitals and Health Systems".

The University of Pittsburgh also has a long tradition of academic excellence. Moreover, it is the only university in the past 30 years to break into the "Top 10" of National Institutes of Health funding, where it currently ranks sixth, and it also has been recognized by *U.S. News and World Report* as one of the "Best Public Universities" in the nation.

Through the innovative partnerships, the Institute provides access to:

- A multidisciplinary network of comprehensive care and quality services
    - At least twenty acute care hospitals in the ten counties of southwestern PA
    - Nearly 3,000 affiliated physicians, 1200 of whom are University faculty
    - More than one million outpatient visits in the various hospital based clinics
    - More than 70 board-certified and fellowship-trained geriatricians at UPMC; at least 40 of who are University faculty. This makes it one of the nation's largest geriatric divisions. In addition, another 70 UPMC physicians have practices with a focus on older adults.
    - Three Geriatric Division staffed geriatric assessment centers provide primary and consultative care to more than 4,000 patients.
    - Specialty clinics for older adults that are led by geriatricians who have additional subspecialty training in memory disorders, arthritis, assistive technology, hearing and balance disorders, falls prevention, incontinence, late-life depression, osteoporosis, pain management, sleep disorders, and palliative care.
    - Two inpatient acute geropsychiatry units
    - A rehabilitation network comprising a freestanding rehabilitation hospital, rehabilitation units at several acute care hospitals, and outpatient rehabilitation facilities at more than 50 locations throughout Southwestern PA.
    - More than 2,500 long-term care beds/units offering a comprehensive range of sub acute, skilled care, assisted living, and independent living in at least 20 different locations in Southwestern PA
    - Medical directors in many area nursing facilities
    - Almost half a million home care visits
    - Three innovative models of care for Program for All Inclusive Care for the Elderly (PACE), an alternative to nursing home
- Cutting edge information technology to support the clinical and research initiatives of the System
- Multiple health insurance products through the UPMC Health Plan serving approximately 500,000 enrollees in the Western Pa region.
    - Commercial HMO and PPO
    - UPMC for You – Medical Assistance HMO
    - UPMC for Life – Medicare HMO and PPO
- One of the largest and most diverse portfolios of aging-related research in the country, approximating $140 million in extramural funding. Key research areas include:
    - Alzheimer diseases and other dementias
    - Depression and late life mood disorders
    - Diabetes
    - Disease prevention and health aging
    - Epidemiology of aging
    - Geriatric pharmacology
    - Incontinence
    - Osteoporosis

- Chronic pain
- Informatics and aging
- Innovative care models
- Medication errors
- Influenza and pneumonia prevention in nursing homes
- Caregiving

- One of the most extensive geriatric and gerontological education and training programs in the country served by the sixteen schools of the University of Pittsburgh.

  - Three geriatric fellowship programs: medicine, psychiatry and family medicine
  - The nation's first Geriatric track for Internal Medicine Residents
  - Training in geriatrics for many other residencies, including family medicine and gynecology
  - Geriatrics courses and field experience offered to students from high school to undergraduate and post graduate students
  - A graduate certificate training program in gerontology

- University-based Centers of Excellence dedicated to the field of aging. Some of these include:

  - Alzheimer's Disease Research Center
  - Claude D. Pepper Older American Independence Center for Mobility and Balance
  - NIH-funded Cancer and Aging Center, one of the nation's first
  - Geriatric Research Education and Clinical Center
  - Geriatric Education Center
  - Center for Late-Life Mood Disorders
  - Center for Research in Chronic Disorders
  - Epidemiology of Aging Programs
  - Hartford Center of Excellence in Geriatric Medicine
  - Udall Center for Parkinson's Disease

Mr. MURPHY. Thank you, Dr. Resnick.

Dr. Axelson.

Dr. AXELSON. Thank you.

I am Alan Axelson. I am building on the previous two presenters because I work with Karen Feinstein at Pittsburgh Regional Healthcare Initiative and am very concerned.

I do see patients every week, and I am speaking from 30 years of experience in health care systems. Also, I should say that I am consultant to Highmark for the past 3 years, the Blue Cross/Blue Shield franchise carrier in this area.

The thing I want to emphasize is innovative approaches to behavioral health care as part of it, and then I want to present a little bit of data. So I have a PowerPoint presentation. I tried to get the appropriate music, but the Rolling Stones were aging and could not make the trip to Pittsburgh, and it is too hard getting the electronic permission.

Traditional behavior health treatment is often considered a separate category of illness, treated separately by a group of specialty practitioners, often only partially treated through a series of incomplete patient encounters rather than a full comprehensive treatment plan. And many patients with psychiatric illnesses are presenting in primary care offices and are not identified and effectively treated.

Psychiatric disorders often co-occur with medical illnesses and complicate effective and efficient treatment of those medical illnesses. The issue is, what is the impact and what can be done about it.

We have heard about the retirees, and certainly that is a major issue. But the focus is also on the employees. This is the difference in the average cost of the annual cost of the employee both with depression and without depression. And you can see that the costs are about double. And some of those are in direct costs, some are in prescriptions and certainly in lost productivity.

When you look at depression and the cost of medical illnesses; back pain, diabetes, headache, migraine and heart failure all increase substantially in costs when there is complicating depression, particularly when that depression is not appropriately treated.

The Pittsburgh Regional Healthcare Initiative is particularly focusing on the co-occurrence of diabetes and depression and looking at ways to comprehensively treat them.

The treatment of chronic illnesses is a major opportunity for system improvement. In contrast to the inpatient care we have been hearing about, this is primarily an outpatient process and is very high volume. So you have to do things that can apply to large numbers of patients and large numbers of physicians.

Unless treatment is part of an integrated, comprehensive continuing treatment plan, higher costs and sub-optimal outcomes will be the result. It occurs more frequently in patients that have diabetes so that you have almost a third that have depressive symptoms. Patients with a psychiatric history, the blood evidence of control of their diabetes shows that it's not in control. Then the thing that's very interesting is if you treat the depression, the diabetes gets better, and there are reasons for that have been hypothesized.

The annual costs incurred by employers on patients, 225,000 patients, there's 57 percent increase in the annual medical costs depending on whether there is both diabetes and depression or just without the depression.

We have the same situation with complications with post-myocardial infarction. We have done a lot to improve the care of myocardial infarction, but the emphasis has been a lot on various aspects of reducing stress, regular exercise, medication compliance. And this is what is happening in terms of these things in the average patient.

When you look at the patient that is depressed, they fall down in every area so they are just really not able to follow the treatment plans that their physician prescribes. This has a direct implication. This is a very interesting connection between the depression inventory, a sign of the issues of depression, and you can see when they are not depressed, these are the cardiac deaths. When you add depression, this is the outcome; huge increases in cardiac deaths.

So depression is undertreated, and we have problems with it here in therapy. What do we suggest? Innovative programs.

The wrong kind of competition has made a mess of the American health care system. The right kinds can straighten it out. This is from Harvard Business Review. We should support systems that are integrated, innovative, information driven and incentive based.

Integrated primary care physicians must effectively connect with psychiatrists, psychologists and other mental health professionals receiving timely consultations and support. It is just not in the way the systems are organized today.

Treatment guidelines must be integrated into the daily system of office-based care. Information about provider performance should be trustworthy and transparent, available to purchasers and consumers.

Information driven. We need electronic systems and information shared with imbedded systems of decision support so that we can use the systems. The information that we have, it is very well supported in medical literature and accepted in terms of treatment guidelines to be able to have that right there when we are treating the patient and prompt us to order the tests and to communicate with our other colleagues.

And it must be incentive based. Physicians are too busy and have gone through too many "just do this one more thing." We have to find systems, pay-for-performance systems, that really do pay and really get physicians' attention so that the compensation is related to participation and the development of quality programs and the effectiveness of service delivery.

So structuring the Federal benefits program to support these things would be very helpful, and we would certainly encourage you to do this so that it motivates physicians and helps them get on the bandwagon, so to speak, to do the best that they know that they can do.

Thank you.

[The prepared statement of Dr. Axelson follows:]

U.S. House Subcommittee on Civil Service and Agency Organization –

"You can't always get what you want...What if the Federal Government could drive improvements in health care?"

Reid.Voss@mail.house.com

Innovative Approaches to Managing Behavioral Health –
An Essential Component of the Federal Employee Health Benefit Program

America's healthcare system is not sustainable in its present configuration. After a period of relative calm in the mid nineties when managed care strategies had some influence on health care and cost inflation moderated, consumer demand for unfettered access to a growing array of sophisticated medications and health care technology, among other factors, has resulted in the reemergence of double digit premium increases. Kaiser Family Foundation survey of 3,000 large and small employers showed insurance costs rising 11.2% in 2004, the fourth straight year of double digit increases. In addition to this increased employer cost, employees are paying a larger share of their health care cost in terms of deductibles and co-payments.

The increase in cost does not have a corresponding increase in quality and safety. Analysis of various aspects of the health care system consistently show problems of fragmentation, failure to apply well established evidence based treatment and missed opportunities for improvement.

There are many efforts directed toward analysis of cost and quality drivers and collaborative efforts to support system change but the pace of change is slow and the complexities are enormous.

Competition, a strength for the most sectors of the business community of the United States, is not working for the health care system. As Michael Porter and Elizabeth Olmsted Teisberg describe in their June 2004 Harvard Business Review article* "The wrong kinds of competition have made a mess of the American health care system. The right kinds of competition can straighten it out." While there are many positive efforts supported by governmental, commercial and foundation resources the federal government's responsibility to purchase health insurance for its employs offers a unique opportunity to have a significant impact the health care system through the constructive support of a healthy competitive system. By establishing an innovative set of specifications for its health plan contracts it can harness the creative energies of health plans to move the system in a constructive direction.

In the past behavioral health care was treated as a special category of treatment to be delivered by a network of specialty practitioners organized and managed separated from the mainstream to the system that delivers medical and surgical treatments. This was designed to manage the direct costs of behavioral health care but has contributed to problems in the comprehensive treatment of patients, especially those suffering from the

chronic diseases that consume the bulk of our health care costs. It also contributed to limitations in addressing the consumer life-style and treatment adherence issues that contribute to sub-optimal health outcomes.

Research has established that depression, anxiety and substance abuse disorders are major contributors to the outcomes and costs of treatment for diabetes, heart disease and pulmonary problems. Depression, a serious and costly disease in itself, when it co-occurs with other diseases significantly increases the cost of treating the disease state and the amount of time that the employee is away from work. Better consumer awareness of the effectiveness of treatment and a decrease in the stigma associated with psychiatric treatment has resulted in a substantial increase in the demand for treatment of psychiatric symptoms, especially with psychotropic medications. These medications, long in the top ten of prescribed medications are soon to be number two in terms of pharmacy costs. This needs to be addressed by quality focused systems that are sure that these medications are used when needed and in ways that are supported by established research findings. The kind of interventions needed to improve the process of prescribing psychotropic medications and the care of chronic diseases by addressing co-occurring psychiatric illnesses will also have a positive effect on other aspect of the health care system. Specifications for the next round of bidding for the Federal Employee Program should assertively address behavioral health aspects of treatment in a comprehensive system of care.

Participating health plans should support the development of delivery systems that are:

Integrated: They must demonstrate that primary care physicians, who prescribe 60 to 70 percent of the psychiatric medications, have readily available to them the consultation and treatment services provided by psychiatrists, psychologists and other mental health professionals. Communications among professionals need to be accessible and timely. Health plans must assertively support this integration, working with primary care physicians, specialists and patients to assure collaborative participation in treatment.

Innovative: The process of translating research into treatment guidelines as matured in a full range of psychiatric illnesses. The guidelines need to be effectively introduced and integrated into the daily processes of care. Quality improvement must relate to the delivery of care in primary care and specialty settings. The purchaser, in this case the federal government must demonstrate that it is serious about innovative approaches to the delivery of evidence based medical and psychiatric treatment. Information about provider system performance should be trustworthy and transparent, available to purchasers and consumers.

Information Driven: The complexity of health care decision-making and the level of integration required can only be approached through the full adoption of systems of electronic information sharing and imbedded decision support. The recent focus on the issues of privacy and information sharing has moved the behavioral health field to the point that it can now be part of a larger health information system.

Incentive Based: For any system to work there must be the buy-in of significant stakeholders, psychiatrists and particularly those that deal with children and adolescent are in short supply. They are removing themselves from integrated systems of care. The can only be induced, not forced to participate. This is also true for other health care providers. Compensation should be significantly related to the quality of services provided and participation in the long term constructive objectives of the healthcare system.

The tools to reconstruct the health care system are available. There is ambivalence about applying the healthy competitive principles that have strengthened other aspects of the services enjoyed by Americans. Leadership in the development of the Federal Employee Health Benefit Program can support constructive system change.

Alan A Axelson, MD - Board Certified Child and Adolescent Psychiatrist
Medical Director
InterCare Psychiatric Services
180 Fort Couch Road
Pittsburgh, PA 15241

*Michael E. Porter and Elizabeth Olmsted Teisberg "Redefining Competition in Health Care" Harvard Business Review - June 2004

Innovative Approaches to Managing Behavioral Health

An Essential Component of the Federal Employee Health Benefit Program

Alan A Axelson, MD
Medical Director
InterCare Psychiatric Services

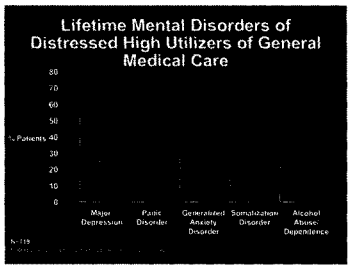
Behavioral Health Treatment

Traditional

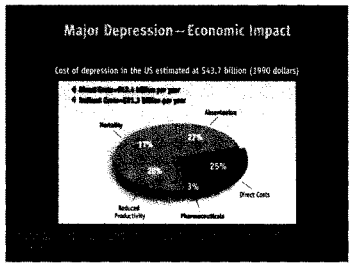
- Separate category of illnesses
- Treated separately by a group of specialty practitioners
- Often only partially treated through a series of incomplete treatment encounters
- Many patients with psychiatric illnesses are not identified and effectively treated

Psychiatric Disorders Often Co-occur with Medical Illnesses and Complicate the Effective and Efficient Treatment of Medical Illnesses

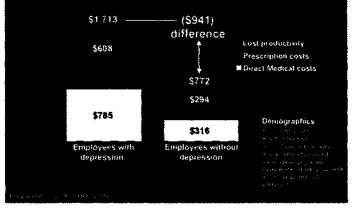
- What is the impact?
- What can be done about it?


Lifetime Mental Disorders of Distressed High Utilizers of General Medical Care
80
70
60
50
% Patients 40
30
20
10
0
Major Depression
Panic Disorder
Generalized Anxiety Disorder
Somatization Disorder
Alcohol Abuse/ Dependence

Direct Costs of Depression & Anxiety*
Depression:
$12.4 Billion
$1.2
$2.8 Billion
Pharmaceutical Costs
Outpatient Care
Inpatient Care
Anxiety:
$36.8 Billion
$22.8 Billion
$13.1 Billion
$9.8
Pharmaceutical Costs
Psychiatric Medical Care
Nonpsychiatric Medical Care

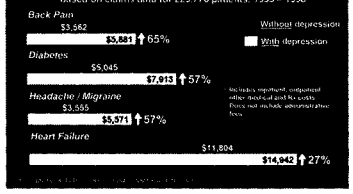

Major Depression -- Economic Impact
Cost of depression in the US estimated at $43.7 billion (1990 dollars)
Mortality
Absenteeism
17%
27%
25%
3%
Direct Costs
Reduced Productivity
Pharmaceuticals

Economic Impact of Depression



Impact of Depression on Total Medical Costs*

Actual annual medical costs incurred by employers per patient, based on claims data for 229,776 patients, 1995 – 1998



Treatment of Chronic Illnesses Is a Major Opportunity for System Improvement

Depression clearly complicates the treatment of diabetes and heart disease.

Unless its treatment is part of an integrated, comprehensive, continuing treatment plan, higher cost and sub-optimal outcomes will be the result.

Depression in Children & Adolescents Incidence

- All Children ages 8 - 12 1% - 2%
- Diabetic Children ages 8 – 12 12%

- All Adolescents 6% - 8%
- Diabetic Adolescents 18%

Diabetes and Co-morbid Depression in Adults

- 11% Have Major Depression –
- 31% Have Depressive Symptoms -
- Odds of depression in the diabetic group is twice that of the non-diabetic comparison group.
- Diabetic Women – 28%
- Diabetic Men – 18%
- Clinical Sample – 32%
- Community Sample – 20%

Diabetes Complicated By Depression

- Insufficient energy or motivation to maintain good diabetic management
- Depression is frequently associated with unhealthy appetite changes.
- Stress of depression may lead to hyperglycemia.
- The suicidal diabetic adolescent has constant access to potentially lethal doses of insulin.

Diabetes Complicated By Depression

- Depression may occur
  - As a reaction to the experience of chronic illness
  - Changing social circumstances
  - Metabolic effects on the brain
  - Impact on self perception and identity

Diabetes Complicated By Depression

- Patients with a psychiatric history have a higher average glycosylated hemoglobin a1C.
- Glucose levels were shown to improve as depression lifted. The better the improvement, the better the diabetic control.

Effective Evidence Based Treatment of Diabetes, Heart Disease & Depression

- Evidenced Based Treatment / Measurement – American Medical Association Physician Consortium for Performance Improvement
  - Diabetes
  - Depression
  - Heart Disease
- Accreditation by NCQA - National Committee for Quality Assurance
- Comparison of Quality Indicators - HEDIS – Health Employer Data Information Set

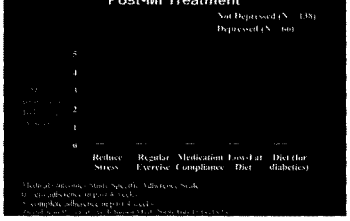
Impact of Depression on Total Medical Cost for Diabetes

- Actual annual medical costs incurred by employers per patients based on claims data for 229,776 patients
- 57% increase in annual medical costs
  - Diabetes without Depression - $5,045
  - Diabetes with Depression - $7,913

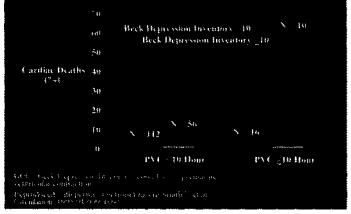
Diabetes and Depression The Impact of Treatment

- Thirty patients treated 8 weeks with fluoxetine compared with 30 controls on a placebo.
- Beck Depression Index -14.0 vs.-8.8
- Reduction in Glycosylated Hb -0.40% vs. -0.07%

Depression Reduces Compliance with Post-MI Treatment



Depression and PVCs: 18-Month Mortality



How Does Depression Increase Cardiovascular Risk?

- ↓ Adherence to lifestyle changes and medical regimen
- ↓ Heart rate variability
- ↑ Cardiac events
- ↑ Platelet aggregation

Depression, Platelets, and Coronary Heart Disease

- Psychological stress/depression → platelet reactivity
- Increased platelet activation → thrombosis → Coronary Heart Disease

Major Depression
Impact on the Healthcare System

- Compared to those without depression, depressed individuals may:
  - Utilize healthcare services more often
  - Incur 1 ½ to 2 times health care costs
  - Have an increased length of hospital stay
  - Report significant worsening physical, social and role functioning

INCIDENCE OF RECURRENT MAJOR DEPRESSION

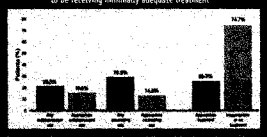
- Observation: Approximately [illegible] experience a depressive episode, in their life – 20% women – 10% men
- Most depressed patients will have at least one subsequent episode of depression during their lifetime
- Antidepressant medications are one of the most frequently prescribed medication categories
- Even when treated, the risk of recurrence of major depression is significant
  - 50% after 1 episode
  - 70% after 2 episodes
  - 90% after 3 episodes

SUICIDE AND MAJOR DEPRESSION

- One out of seven patients with recurrent depressive illness commits suicide
- 70% of those who commit suicide have depressive illness
- 70% of those who commit suicide see their primary care physician within 6 weeks of suicide

Major Depression – Undertreatment

In a 12-month period
A minority of patients with depressive disorder were found to be receiving minimally adequate treatment

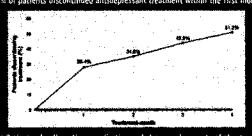


ADHERENCE WITH ANTIDEPRESSANT THERAPY

- In primary care:
  - 25%–28% stop therapy within 1 month
  - Over 40% stop within 3 months
  - Under dosing can be a problem

Major Depression – Nonadherence to Treatment

In a study examining adherence
28% of patients discontinued antidepressant treatment within the first month



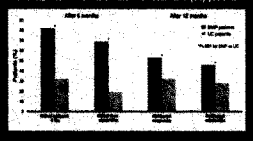
- Patients who discontinue medication early have a relapse rate of about 25% within 2 months

Issues Affecting Long-term Therapy

- Guidelines indicate therapy for ≥ 4-9 months after recovery from an acute episode
- Continue antidepressant indefinitely after ≥ 3 episodes or episodes in patients with risk factors
- Adherence problems remain a common obstacle to acute and long-term treatment
- Issues that may affect adherence
  - Early-onset adverse events (e.g., nausea, anxiety, insomnia, somnolence)
  - Sustained adverse events (e.g., insomnia, somnolence, weight gain, sexual dysfunction)

Major Depression – Results From a Depression Management Program Study

Depression management program (DMP) intervention patients showed greater adherence and response and remission rates than usual care (UC) patients



NCQA HEDIS Measures
Antidepressant Medication Management

1. Optimal Practitioner Contacts for Medication Management:
   - Percentage with at least three follow up contacts during the 12 week acute treatment phase
2. Effective Acute Phase Treatment:
   - Percentage remaining on an antidepressant during the entire 12 week acute treatment phase
3. Effective Continuation Phase Treatment:
   - Percentage remaining on an antidepressant for at least 6 months

Follow up after hospitalization for mental illness
- Percentage with follow up visits within 7 days
- Percentage with follow up visit within 30 days

Summary - Major Depression

- Will effect 1 in 6 adults at some time in their lives
- Depression can
  - [illegible]
- Complicates the care of many medical conditions
- Is inadequately treated in our present system
- Team support can improve diagnosis & treatment
  - [illegible]

Innovative Structuring of the Federal Employee Health Benefit Program Can Accelerate the Process of Constructive Change in How the Health Care System Deals with Chronic Diseases

Creative Competition

- "The wrong kinds of competition have made a mess of the American health care system. The right kinds of competition can straighten it out."

Michael E. Porter
Elizabeth Olmsted Teisberg
"Redefining Competition in Health Care"
Harvard Business Review
June 2004

- Support delivery systems that are:
  - Integrated
  - Innovative
  - Information Driven
  - Incentive Based

Integrated

Primary care physicians must be effectively connected with psychiatrists, psychologists and other mental health professionals, receiving timely consultation and support.

Innovative:

Treatment guidelines must be integrated into the daily system of office based care. Information about provider system performance should be trustworthy and transparent, available to purchasers and consumers.

Information Driven:

Behavioral health care must promptly adopt electronic systems of information sharing with embedded decision support.

Incentive Based:

Stakeholders must be induced not forced to participate. Rapid change is costly and requires significant effort. Compensation should be significantly related to participation in the development of quality programs and the effectiveness of services delivered.

Structuring the Federal Employee Health Benefit Program:

To the extent that health plans meet the objective of integrated, comprehensive treatment of chronic diseases, including effective management of behavioral health issues, they should be afforded special advantage that would encourage consumer selection.

Mr. MURPHY. I thank the panelists.

Chairman Davis, you want to go first?

Mr. DAVIS. I will try. Probably be a couple of rounds on this.

Dr. Resnick, let me start with you on the geriatric side because we are all moving to a higher percent of the population being geriatric. That is just a fact. The baby boomers come of age and it puts tremendous strains on our retirement systems, our health care systems and it sounds like the medical community really at this point is not getting ready for it.

Dr. RESNICK. Your opening remark made me think that of the line that becoming an older person is the only minority of which we will all become a member.

You are exactly right. We do not yet have the tools at hand to be able to deal with chronic disease in older people. We are just beginning, we are at the infancy of our ability to deal with chronic disease in nonolder people, which occurs generally as a single condition, and we have very few pieces of evidence in which doing what you heard about works. It does seem to work for depression. It does seem to work for heart failure. It does seem to work for diabetes and asthma. You have heard from Dr. Feinstein how it works for central line infections. The problem is in older people you aggregate all of those together at one time.

Mr. DAVIS. Everything breaks down?

Dr. RESNICK. That is correct. So, for instance, if you have chronic lung disease, the guideline says do not use this drug. If you have heart disease, it says you must use that drug. Well, old people generally have both so what is the physician to do. He cannot comply with both of the guidelines.

Mr. DAVIS. It is a lawyer's dream, is it not?

Dr. RESNICK. Well, it is, but it is a physician's nightmare and a patient's nightmare. So the physician cannot do what the few guidelines available say. Most guidelines are not developed for the diseases old people have. All of them are unwieldy because they are way too much in the hectic pace of primary care, and the physician cannot figure out what to do.

The bigger problem is the patient cannot figure out what to do because when the physician says here is what I want you to do, the patient says, "well, let us see, you told me to do this for this disease and this for this disease and that for that disease and my other doctor told me." Then the patients who are doing this are scared. Often they have mental impairment. They have depression. You put it altogether and it is way beyond the ability of medicine as it is currently structured to exist. And that is why we think that a new model would be quite useful. But we believe that a new model, that the elements for a new model are already at hand and all they need to be is integrated into a coherent way and tested out. We do not think we have to start all over from scratch.

Mr. DAVIS. But there is a supply and demand issue. You just do not have that many physicians that understand this, that are going into this and you have a rising number of patients?

Dr. RESNICK. That is correct. And that is why the approach that we advocate is instead of trying to train more geriatricians, which is useful but will never happen, we need to change the health system in a way that every doctor in American can now apply. And

we think that we can form a model literally within a year that every doctor in American could then follow to take better care of older patients. In other words, we bring geriatrics into the mainstream of medicine rather than dragging medicine into the mainstream of geriatrics.

Mr. DAVIS. Do the Medicare reimbursements play a role in getting people out of this business basically?

Dr. RESNICK. Major. The Medicare reimbursements.

Mr. DAVIS. And they have paid in some cases when you get into some of the nursing homes?

Dr. RESNICK. Yes. Yes. And in fact, they conflict with each other, too. Let me give you an example.

A patient is in a nursing home paid by Medicaid. They have urinary incontinence and they do not have the staff to deal with it. They put a tube into the bladder. That tube increases the risk of infection. Now the patient gets an infection. Well, that is no problem for the nursing home because they are going to get transferred to the hospital for that care. And that is on Medicare. But everybody loses.

The patient could die in the process. They certainly have their care disjointed and worse, and it is because there are conflicting incentives.

In terms of the amount of reimbursement, huge problem. For the last 3 years prior to the current one, the care was ratcheted down and you almost certainly know that the AMA has documented the proportion of doctors who participate in Medicare. And it was at a high of 96 percent, and if the last one had gone through this last time, it would have been down to 75 percent. That is just participating.

And furthermore, much of what doctors do in Medicare is not paid for. Some of it is denied. And there is no payment for what patients most need. There are barriers built in.

For instance, if a doctor wants to get a patient into a nursing home, you have to put them in the hospital for 3 days even if they do not need a hospitalization.

Now, in the hospital they can get infections and get drugs and get all sorts of bad things. The cost to society is huge. There is no point to that. That is from another era.

There are other things. Care coordination is huge, preventive services are huge, proactive chronic care management is huge. None of that is paid for by Medicare. Neither is telephone management.

Mr. DAVIS. We are starting to move in that direction getting some preventive care in Medicare.

Dr. RESNICK. There are for procedures, but the limitations at present are that nobody asks the patient what you want. So we will pay for your colonoscopy, but nobody talks to the patient about what we will do if we find a cancer. And then what we have is the unfortunate situation where the patient and the doctor are faced with a cancer there, and the patient says what, you mean you are going to have to open up my belly and take this out. I do not want that. I do not have enough time to live. I do not want to have 6 months recovery. And the doctor says I would not do it anyway because you have trouble with your heart and your lungs, and you

would not withstand that surgery. So we have paid for a procedure that had no point in being done. So we expended resources and caused everybody anxiety because we are not paying for the counseling and determination of the values and goals the patient has.

Mr. DAVIS. We will come back.

Mr. MURPHY. Thank you.

Let me followup on something here. This is really pretty incredible testimony you have, and unfortunately it is so often what happens in health care. What I hear a lot of, similar to Chairman Davis, the people say my health care plan is too expensive, let the Federal Government take over. And I am sure you have heard that in psychology and psychiatry, that insanity is doing the same thing over and over again and expecting different results. And it seems to be that it is absurd to think just have the Federal Government pick the tab and continue the way we are doing things.

Dr. Feinstein, you have a chart with you, a totally incomprehensible chart, which I love.

Dr. FEINSTEIN. Yes.

Mr. MURPHY. To get the patient the first dose of medication, some 700 steps involved with this?

Dr. FEINSTEIN. Yes.

Mr. MURPHY. All of which can result in some error?

Mr. MURPHY. This was documented at Deaconess-Glover Hospital outside of Boston. And a team from Harvard Business School went in.

This is what happened when one patient's medication did not come on time. One medication did not come on time. The work around on the part of the nursing staff and the unit staff to get from the pharmacy the pill that never arrived.

And we wished this was funny, but if you would show this to any nurse, they will just nod their head, oh absolutely, yes. And that is why we talk a lot about safety and evidence-based practice, both of which are safe practices, evidence-based practices are very important. I do not think most people outside of health care, particularly anyone that has ever been to business school, would even believe the chaos that is involved in the administration of health care at the point of service. None of these professionals have had an hour of systems theory, work process improvement training other than maybe something they get stopped on in their job and it is hardly ever followed through until the next new idea comes along.

But the inefficiency and waste in health care also contributes very much to the high cost. It also contributes to error and bad practices.

Mr. MURPHY. I know I have worked at several area hospitals in Pittsburgh and each one had some different procedure for doing the same thing. Whenever I raised the question, the most common response is that just the way we do things here. It's absurd that they have adapted to that sort of practice.

Dr. Axelson, your testimony it is absolutely incredible in terms of untreated depression, which first of all has a higher incidence among these chronic illnesses and yet when it is not treated, the morbidity and the mortality rate go through the roof. I mean, several times I think the costs were double you said?

Dr. AXELSON. Yes. And particularly with myocardial infarction. Some people say it is more important to treat the depression than to put the patient on aspirin and beta blockers, that the outcomes in terms of death in the 6 months following myocardial infarction is so high.

And the problem is that the general wisdom of the physician is, yes, no wonder you are sort of sad. Anybody would be sad if you have this kind of disease.

Mr. MURPHY. I mean you just talking about——

Dr. AXELSON. We are talking about the depression, yes. We are talking about depression and what we are doing with physicians is educating them to make the diagnoses of depression and differentiate that from just distress. That the patient that is depressed needs active treatment for depression by the primary care physician because similar to the geriatric situation, you are not having psychiatrists in growing numbers being available to care for these patients, and the patients do not migrate very well. So the emphasis needs to be on developing the skills of the primary care physician and then having just in time consultation for them so they treat the patients with diabetes and with heart disease and with lung disease who also have depression and anxiety. Otherwise, you get this manifold number of tests, bad outcomes, patients are not satisfied and the physician is frustrated.

Mr. MURPHY. So we add these together. Most health costs come from those who are chronically ill. And among those who are chronically ill, most of their health care costs come from not treating the whole patient with regard to their multiple diagnoses.

Dr. AXELSON. Yes.

Mr. MURPHY. In this, I am sorry we were trying to track this down, we could not get it in terms of knowing what the copayment is for mental health treatments within the Federal system. I know with Medicare one of the concerns I have if it is for infections or heart disease, etc., it is at 80 percent that the insurance picks up on many of these doctor visits, but only 50 percent for mental health services.

Dr. AXELSON. That is correct.

Mr. MURPHY. So within that the system is doomed to failure. And if that same thing exists within Federal employees' benefits, I don't know what is, for example, postal employee etc.; but it is doomed to failure because we have set up a system that operates against getting comprehensive treatment.

Dr. AXELSON. Yes. My experience is that the copays are not to discriminatory in the Federal system. There are some problems with that. The copays are higher than they are for medical illnesses, but the Medicare is certainly something that is a great discrimination. And physicians, primary care physicians do not code psychiatric diagnoses because of this concern that they will get the 50 percent reimbursement. And so you get a situation where they are not paying attention because not only are they not getting paid, they are getting paid less. And so changing that; I was very disappointed. I know that came up in the legislation about the pharmacy benefit, that was a missed opportunity there.

You cannot get physicians to change their way of practicing if they think the system is cynically designed to work against them.

And that is what I hear from primary care physicians all the time is you are not paying us for this stuff, you know, nobody wants to hear about it. If we do bring it up, we and our patients get discriminated again.

So you really need to in bold letters say the FEHB Program wants behavioral illnesses treated as part of the total system of health care and not as some very separate system that is handled a discriminatory way.

Mr. MURPHY. And I know my time's up, and we will get back to this. But let me just followup. In terms of the data you were presenting here in terms of these morbidity and mortality and costs being double or so, is this being done comprehensibly with any other, for example, private business who has made this move toward treating this comprehensibly, or would any of you know and are they seeing any savings both in terms of the extra cost of health care dollars that increase productivity?

Dr. AXELSON. The best company I'm aware of is Bank One in Chicago that really looks at particularly productivity and treatment of psychiatric illnesses. And they have showed dramatic improvements in both reduced disability costs, patients being at work and patients doing more work when they are at work; a thing called presenteeism. And so it is just beginning to get down into the employer system.

The figures I was giving were for employees, because that is part of the message to employers. Encourage their employees to take better care of their health and to expect better care when they go to the physician.

Mr. MURPHY. Thank you.

Chairman Davis.

Mr. DAVIS. I'm intrigued on the geriatric thing. I guess as I get older I start thinking about these things. The good news is that people are getting older later, is that not true? People are physically taking care of themselves better?

Dr. RESNICK. Well, it is a mixed picture. One of the biggest threats to health is decreased exercise and increased weight. And both are a problem in older people.

Exercise programs are not widely used, even among the elderly and the middle aged. And the weight of this country is going up. And what happens is as you get older, much of what happens is replicated in younger people who weigh too much. So when you combine obesity with age, you actually end up getting the ravages of both, and it could backfire that we could be in worse shape than we would otherwise.

What is happening now when you say that we are getting old later, that is a reflection of the fact that we are getting better at treating heart disease and recognizing risk factors such as high blood pressure. So because we are more aggressive at treating those, people then do not get the strokes and the debility that they used to get. Second, we now know that the debility they used to get are not aging, but diseases. So we look for the cause and treatment.

If people as they age still do not exercise as they should and gain more weight than they ever have before in the history of this country, then that could undue much of the benefit.

Mr. DAVIS. You are probably right. I hang around with a group that works out. And I see a lot of older people running, more than I think I would have seen 10 or 20 years ago. But you are right, a lot of people do not do that.

Dr. RESNICK. That is right. And the other issue is that——

Mr. DAVIS. And they tend to be more of a burden on the system, are they not?

Dr. RESNICK. That is right. That is right.

Mr. DAVIS. Let me ask, Ms. Feinstein, you talked about paying for bad behavior not just in the health care system, but do you not do that with individuals as well, people who choose bad diets, who are obese, sometimes who smoke. I mean there is discrimination, I guess, in terms of what they pay, what health insurance companies charge them. You know the smokers and nonsmokers get different insurance rates in some of these areas. But in some of these other areas you get treated the same when you take care of yourself or not. Is that appropriate incentive?

Dr. FEINSTEIN. Well, I have a personal opinion on that. Not just speaking for the Regional Health Care Initiative.

Mr. DAVIS. That is fine. I would be glad to hear your opinion. I would like to hear everybody's personal opinion.

Dr. FEINSTEIN. This is personal. I do not see why we would not take that into account as well. I think that there is a contract mutual responsibility for the cost, the high cost of care in this country. And certainly there is a consumer role in protecting their own health. You could take it down a chain and, you know, you could require more and more and more of the consumer. And I think that for some of the tiered consumer directed health plans, consumers are expected to choose the best outcome, lower cost option or they pay for it. I think that's the beginning of a responsibility that could spread to other areas.

Mr. DAVIS. Yes. I should not say this. I ended up watching the Jerry Springer Show late one night. There was nothing else on. The ball games were over. It does not happen very happen. He brought these tremendously huge people on there that just are, you know, 400 or 500 pounds. Probably had depression. They probably had a whole lot of things. But I am just saying, that is where my health insurance might be.

You have a small group of people eating up most of the money, and is there not some way to get some incentives to help. Treatment for depression would certainly be part of that. I think that you made the case on that. And, sometimes before we get back, we are going to do some talking about this. But also people who make poor choices ought to be paying more and the people who make right choices, we ought to be able to get a discount and build that into the system as well, it seems to me. It is individual. The same way with health care plans as we look at that.

Dr. FEINSTEIN. It is hard as an employer to know that you are picking up the cost of people who are taking a smoke break every half hour.

Mr. DAVIS. Right. Right.

Dr. FEINSTEIN. You are picking up the health costs.

Mr. DAVIS. Of course you have the labels on those things for 40 years and they still sue the companies and blame the companies

for it. So nobody wants to take responsibility for anything, and we are moving in that society. And yet the foundation of freedom is that people take responsibility for their own actions and their bad decisions.

We get divided in Washington. You know, does the government know what is best for people do or should people be allowed to make their own decisions? And I always come down the side people should make their own decisions. But a lot of times they make stupid decisions, and there should be some follow on penalty. If not penalty, not reward for making those decision. That is what freedom is all about.

Dr. FEINSTEIN. Well, and there are some health plans that are saying if you choose a low volume, poorly performing and high cost provider, you pick up the difference. You know, we are not. And that's a beginning. That is a beginning of a challenge to consumer responsibility.

Mr. DAVIS. I just know sometimes people can do everything right and things can go wrong. And I had two melanomas. And I did not spend a lot of time in the sun, but I am more of your opinion. I reviewed and caught it early enough each time. One doctor the first time I had it said, "You just saved yourself 30 years by finding it. If it had gone on much later, you know, this moves, it is very, very nasty."

So, you know, educating people is a critical part of this. You talk about savings in the system, that is probably the best place where you can start; educating people to make smarter decisions, identify this earlier. You are right, none of these systems really take that initiative.

I just want to ask one other question. I had asked this in the previous panel. There is a movement to bring the health care savings accounts into the Federal system, the FEHBP. My retired Federal employees really are nervous about that because they think at this point that is going to raise their premium costs because basically the folks that would opt for the health care savings account tend to be the younger workers who are paying into the system and not using much. Any thoughts on that? It is an ongoing debate in Washington, and I favored these at the national level. Interested in your comment.

Dr. FEINSTEIN. Well, I would say it is moving in a direction that you were kind of going down the road about consumer responsibility; what is the consumer's responsibility to the point that they can control their demand for health care, and there are areas where they can control it, there are areas where they cannot.

My only concern with HSAs is they kind of break the social contract. I mean, they distract from what I think is our, and obviously this is a biased one because the Pittsburgh Regional Care Initiative is founded on that, but I think our basic responsibility right now is to deliver the best care and only the care that is required by a person's health situation. And to do that the stakeholders have to work together. And the HSA distracts from that.

To that extent, you know, if you could convince me that it was an important driver of quality and delivery at the point of care, I would be enthusiastic. But it seems to me a bit of a distraction right now.

What the Federal health plan could do, is have a program to produce this kind of transparency. Even when the consumer wants to do the right thing for their health, they lack information. There is an extraordinary lack of information. They do not even know what procedures cost. In fact, it is kind of scary, the plans often do not know what procedures cost. Nobody knows what procedures cost.

As an example, we are in so many ways paying for preventable bad practice. And to get the information that would allow us, the clinical and accounting measurement systems that would allow us to bring that information to the consumer, to me is kind of a first step, the most important step.

And so, you know, not distracting it, I do believe that consumers need to be engaged and need to make decisions. HSAs encourage that, but I worry that if we do not get the information to people, really good information, they will not be able to make the right decisions; do they need care, do they not need care, where should they get care and what are their options to, say, surgery, hospitalization and expensive care.

Mr. DAVIS. OK. Let me ask Dr. Axelson, let me ask you another question, too.

Mental health parity is something that has come before Congress. It has really never come before the House. It has come before the Senate. Every member supports it, you know, signs on the bill but they try to keep it from voting because of the rising costs. But your testimony really says there is a limit in terms in some of these areas between regular health care and what we would call the physical health care costs and being able to control the other side. Can I hear your thoughts on that?

Dr. AXELSON. As soon as we get untangled.

I think that parity is essential. I still would make the same statement. I think parity for mental health benefits is essential and the separation in treating them in a discriminatory way is really not supported economically.

Many people get health care and get reimbursed for paying, they get payment for behavioral health services just by not putting the diagnoses down in terms of primary care particularly. When you have parity you begin to make sense of the system.

The costs that I work to save everyday is not so much the direct costs in terms of psychiatric care. It is the indirect costs in terms of inefficient medical care. Because the patient that has an anxiety disorder is getting a huge cardiac workup or the patient that needs very thoughtful care in terms of his diabetes, just does not have the emotional energy to participate in the diabetic care plan because they are depressed. So we need to address parity.

I talked to Congressman Murphy about it, oh, every month or so and say what are you doing?

Mr. DAVIS. He talks. He brings it up.

Dr. AXELSON. Oh, I know he brings it up.

Mr. DAVIS. But the other side of it is you get efficiencies in other areas. Maybe not the health care system or in the economic system by having people alert and on the job——

Dr. AXELSON. Absolutely.

Mr. DAVIS [continuing]. That kind of stuff that you cannot measure directly but there is obviously data from the charts and from what everybody has said, that is an important.

Dr. AXELSON. The idea of psychiatric care being costly is 15 to 20 years old. We have moved systems. There was a time when, yes, there was——

Mr. DAVIS. If you just left it in the box?

Dr. AXELSON. Yes. But even now——

Mr. DAVIS. Even in the box it is costly. It is more money out than you get in.

Dr. AXELSON. But even now that box really is not very constant. Other measures have been put into place that control those costs. And so what we need to do is just make a part of the overall system.

Mr. DAVIS. Right. Thank you very much.

Thank all three of you very, very much. It has been very helpful to me.

Mr. MURPHY. Thank you.

I have a couple of things I want to know. Dr. Feinstein, is this, the chart, the 700 steps, is this part of a published report?

Dr. FEINSTEIN. Yes. It is a Harvard Business School case. It is called the Deaconess-Glover case. And I am not allowed to hand it out, but——

Mr. MURPHY. But if you could give us a reference, I would like to include it in our record, please?

Dr. FEINSTEIN. It is Harvard Business School. They have a whole case series. And this is called Deaconess Glover.

Mr. MURPHY. OK.

Dr. FEINSTEIN. Part A.

Mr. DAVIS. Chair, I would then ask unanimous consent that be put in the record. That the staff can find it and put that in. I think it would be helpful.

Mr. MURPHY. And without objection, so ordered.

Similarly, I would like to ask that we include in the record this article provided by Dr. Axelson from the Harvard Business Review, June 2004 in terms of Redefining Competition in Health Care by Porter and Tiesberg. And without objection, so ordered. We will include that in as well.

I know we are just about out of time here. I just want to really thank the panel for your comments here. Again, it distressed me every time we see someone come up and say health care costs so much, let us have the Federal Government pick up the tab. And I am fond of saying the Federal Government can provide whatever you want as long as you let us raise your taxes so we can pay for it. And providing health care the way it is is not really health care as much as it is just paying the bill for a system that is broken and extremely expensive. It is not the answer. And in this election year, like any other time, people are out there saying we are going to take your costs off your shoulders and have the government pay for it, have somebody else do it. We really need to have a tremendous bottom to top, top to bottom innovations in this system which is actually going to save a lot of lives, keep people out of hospitals and make them healthier and more accountable on every level. And it is the very things that the three of you brought up, whether it

is for the elderly and how we need to look at them comprehensively and recognizing at least on the Federal level half a million people out there can have their health improved is helpful, as well as the many employees that whatever the level they are in the Federal Government to look as such things that we think are so simple by keeping infections down in hospitals. There are a lot of things that we are paying for and everything. Looking at the comprehensive aspect of behavioral health is tremendous, too.

So I thank all of you for this. You may have some staff back in touch with you to get other information for this. We will make sure to send it to Members of Congress and help them understand that the issue of saying you cannot always get what you want is a barrier to us, but if I can just continue off the metaphor of this sung, if you try sometimes you might just find you get what you need. Because we have to change the system to get people what they need and stop this system that pays for inefficiency and ill health. And that is what we're going to continue to do.

Dr. FEINSTEIN. Thank you, Representative Murphy. We like to hear that.

Mr. MURPHY. Keep up the good work.

And if Members have additional questions for our witnesses, they can submit them for the record.

I would like to again thank everybody who was here today.

And this hearing is now adjourned.

[Whereupon, at 11:30 a.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

"YOU CAN'T ALWAYS GET WHAT YOU WANT...WHAT IF THE FEDERAL GOVERNMENT COULD DRIVE IMPROVEMENTS IN HEALTH CARE?"
Subcommittee on Civil Service and Agency Organization
Tim Murphy, Acting Chairman
Questions Submitted for the Record
September 28, 2004

PANEL 1

Honorable Dan Blair, Deputy Director, U.S. Office of Personnel Management

PANEL 2

Karen Wolk Feinsten, PhD, President, Jewish Healthcare Foundation
Dr. Neil Resnick, Director, University of Pittsburgh Institute of Aging
Dr. Alan Axelson, American Academy of Child and Adolescent Psychiatry

QUESTIONS

PANEL 1

OPM

- At the hearing, Dr. Axelson referenced BankOne in Chicago as a model which provides comprehensive mental health insurance benefits for its employees, which has resulted in dramatic improvement in employee productivity and reduction in overall health care costs. Clearly, there are lessons to be learned from the private sector, particularly from such companies that have taken bold steps toward combating depression in an effort to reduce medical expenditures and increase employee productivity in the workplace. I would appreciate your thoughts and comments on the possibility of OPM exploring such initiatives taken in the private sector regarding comprehensive care for depression and how some of those innovative initiatives might be incorporated into the FEHBP.

- With regard to performance based incentive programs, you testified that pay for performance has great potential for cost savings and quality care, but that because it is still in its early stages of development that standard metrics for measuring results are not yet in place. Is it possible, rather, for OPM, as the administer of the FEHBP, to take a proactive approach and lead the initiative in this area by educating and strongly encouraging participating health plans toward the adoption of pay for performance nationwide?

- In the area of health literacy and consumer education, your testimony states that OPM operates wellness programs to its own employees to

keep them informed and focused on their lifestyle choices. Could you comment on the success of this program and your view of encouraging this type of program across the board?

- I like what I see in your testimony about OPM's HealthierFeds campaign, together with the President's "HealthierUS" initiative. I am also intrigued by your testimony about working with insurance carriers to provide education on fitness, lifestyles, care management and prevention strategies. Could you comment on just what these efforts will entail?

PANEL 2

Karen Wolk Feinstein - Jewish Healthcare Foundation

- Your written testimony references a drawing which diagrams over 700 steps necessary for a patient to get a newly ordered medication. Pursuant to this mind-boggling illustration and taking into account all the different ways the order can be conveyed, received and passed along, there are likewise 700 opportunities for error. What are your thoughts on how the implementation of electronic medical records and prescriptions could help alleviate such errors and improve patient quality care?

- Given that pay for performance is beginning to catch on, how do you suggest the FEHBP could use its leverage to encourage and expand the scope of such quality incentive programs?

- Consumers clearly have a responsibility and role in protecting their own health. You indicated, however, that often times even when the consumer wants to do the right thing for their health, they lack information. In the area of health literacy, what can the FEHBP do to better educate consumers and to make sure they are fully informed and engaged when making healthcare decisions?

- You stated that healthier choices, obviously, result in lower healthcare costs. Based, however, on the notion that health is a personal responsibility and priority, can you make specific recommendations for how OPM through the FEHBP could encourage good health practices in an effort to incentivize individuals toward healthier living?

Dr. Neil Resnick - University of Pittsburgh Institute of Aging

- You recommend the creation of a task force comprised of experts in geriatric care and health care policy as a potential solution to help combat the challenges facing geriatric care. Specifically, how could OPM through the FEHBP work with the task force to enhance geriatric care?

- You identify the lack of physicians with geriatric training as an impediment to appropriate geriatric care, citing that few physicians have received even

an hour of geriatric education. Given the complexity of treating chronic disease in older adults, are there opportunities for the FEHBP to help incentivize physicians toward receiving geriatric training to ensure appropriate care for older patients with chronic disease?

- Other than appropriately trained physicians, what additional impediments to geriatric care do you identify, particularly with regard to coordinated care of chronic diseases? What incentives could the FEHBP provide to coordinate care for older patients?

- A common scenario for older adults who have multiple chronic conditions is to be referred to one physician after another, each of whom adds a test and/or a medication. Could you comment on the implementation of electronic medical records and electronic prescribing and how these technological advances would help in managing chronic care, particularly for older adults who have the most chronic conditions?

Dr. Alan Axelson - American Academy of Child and Adolescent Psychiatry

- You stated that psychiatric disorders often co-occur with medical illnesses and complicate the effective and efficient treatment of medical illnesses. How can the FEHBP contribute to better consumer awareness of the effectiveness of psychiatric treatment associated with other illnesses and also help to decrease the stigma associated with it?

- You commented that innovative programs, such as pay for performance, are the key for improving the healthcare system. Other than pay for performance, what other types of innovative programs do you endorse and how can OPM through the FEHBP foster adherence and improvements to these programs?

- You indicated that treatment for depression must be a collaborative effort among primary care physicians, specialists and patients. How can the FEHBP support this level of integration to assure collaborative participation in treatment?

- Because so many patients with psychiatric illnesses are not identified and effectively treated, how can the FEHBP specifically, in an effort to combat this problem, make sure that treatment guidelines for psychiatric illnesses are introduced and integrated into the daily processes of care? Also given the prevalence of chronic disease, please discuss your thoughts on considering the possibility of depression in every patient treated for chronic disease.

Responses to Questions for the Record

Honorable Dan Blair
Deputy Director
U. S. Office of Personnel Management

Follow-up Questions to the September 13, 2004 Hearing Entitled, "You Can't Always Get What You Want. . .What If the Federal Government Could Drive Improvements in Health Care?"

Q. At the hearing, Dr. Axelson referenced BankOne in Chicago as a model which provides comprehensive mental health insurance benefits for its employees, which has resulted in dramatic improvement in employee productivity and reduction in overall health care costs. Clearly, there are lessons to be learned from the private sector, particularly from such companies that have taken bold steps toward combating depression in an effort to reduce medical expenditures and increase employee productivity in the workplace. I would appreciate your thoughts and comments on the possibility of OPM exploring such initiatives taken in the private sector regarding comprehensive care for depression and how some of those innovative initiatives might be incorporated into the FEHBP.

A. The Federal Employees Health Benefits (FEHB) Program implemented full parity for mental health and substance abuse benefits three years ago, on January 1, 2001. Full parity is defined as coverage for mental health and substance abuse that is identical to traditional medical care deductibles, coinsurance, co-payments, and day and visit limitations. At the time of implementation, the Office of Personnel Management (OPM) encouraged FEHB plans to use managed care approaches in achieving parity to restrain any additional costs to the Program, including the use of in-network behavioral health providers. Even before parity, FEHB plans used managed behavioral health organizations or administered managed care techniques themselves to provide for mental health care management. But, the implementation of parity meant that plans provided benefits for all diagnostic categories of mental health and substance abuse care, including depression, using appropriate care management techniques. The FEHB Program has a long history of offering coverage for mental health benefits. In 1999, medical visits, pharmacotherapy, and testing to monitor drug treatment for mental conditions were included as pharmaceutical disease management. Before that, OPM's tough negotiations with health plans were aimed at eliminating lifetime and annual maximums in the FEHB Program.

OPM has also encouraged FEHB plans to provide care management for members with chronic conditions, through flexible benefit options and diagnosis-based programs. It is generally accepted in the insurance industry that a relatively small percentage of members - primarily those with chronic conditions - use the greatest percentage of benefits. By addressing the needs of its chronically ill population, plans can help to improve quality of care and promote the effective use of benefit dollars. Depression is one example of a chronic condition that some plans are focusing on for quality improvement. For instance, Aetna established a Depression Disease Management Program in 2003. Their program focuses on various components involving assessment, education, case management, and integration with Aetna's Patient Management and Pharmacy Program.

Aetna emphasizes the fact that depression often accompanies chronic illness. For this reason, depression screening and referral are key components of all their management programs. They have also established an enhancement component, Caring for Depression

in People with Chronic Physical Conditions. They report summary scores that show marked improvement. Of particular note is the "average days gained" at work, school or business being more than three days each month. Like other plans, Aetna also offers a formal depression program through its behavioral health program.

Another FEHB plan, Advantage, implemented a depression program that includes a Behavior Health Quality Committee to assure access to behavioral health services while providing member and provider education regarding depression. This program includes several key interventions including education to members regarding medication compliance, providing members with diabetes information regarding the incidence of depression among diabetics, as well as other activities that support the identification and treatment of depression.

Blue Care Networks Disease Management Program includes a Depression Management Initiative that is coordinated through its Behavioral Health Vendor. The program offers member and practitioner intervention components. Through data collection, they have been able to begin documenting improvements in areas such as optimal practitioner contacts during acute phase (38 percent improvement), continuous refill of new antidepressant medications in acute phase (19 percent improvement) and continuous refills in the continuation phase (17 percent improvement). The program also contains an "associated savings" measurement that will be conducted later this year.

Kaiser Permanente established a Care Management Institute (CMI) to help improve the quality of care and health outcomes for its members. CMI has a comprehensive population-based program that includes evidence-based clinical practice guidelines, patient identification and selection tools, standardized clinical and outcome measurements, risk stratification methodologies and other components that round out this extensive program. This program received a two-year National Committee for Quality Assurance Disease Management Certification in program design for diabetes, asthma, heart failure and depression. CMI works to share best practices for addressing comorbid conditions, recognizing and emphasizing that almost half of Kaiser's patients with coronary artery disease also have one or more other chronic conditions, including diabetes, depression, and heart failure.

Q. With regard to performance based incentive programs, you testified that pay for performance has great potential for cost savings and quality care, but that because it is still in its early stages of development that standard metrics for measuring results are not yet in place. Is it possible, rather, for OPM, as the administrator of the FEHBP, to take a proactive approach and lead the initiative in this area by educating and strongly encouraging participating health plans toward the adoption of pay for performance nationwide?

A. Through our activities in a variety of memberships and associations related to quality, we are monitoring this initiative. Many other employers and health plans are actively engaged in these organizations as well. We share the desire and common goal of improved quality and performance that ultimately leads to safer and more cost-effective health care. How-

ever, pay for performance remains an emerging concept. Since most pilot programs and projects are just beginning or are underway, there is very little outcome data or measurements of success. As more experience is gained and data on results becomes more available, common approaches to pay for performance will emerge and become accepted in the insurance industry.

The Leapfrog Group, of which OPM is a member, recently developed a web-based compendium of incentive and reward programs that are aimed at improving health care. This compendium is designed to help raise awareness among purchasers, health plans, and health care providers about innovative approaches to improve the quality and affordability of health care. It is the intent of the compendium to provide an educational vehicle to disseminate lessons learned, best practices, and program comparisons. Just as the concept itself is evolving, so is the compendium. It will remain a dynamic tool that will be continuously added to, improved and refined. We believe that this is an excellent example of the collaborative efforts being made by purchasers, health plans and providers to inform and educate each other as this concept continues to evolve.

To this end, we will remain active in the employer-purchaser community and vigilant on the issue of pay for performance programs. And, we are working within this community on the development of a common approach that works for all.

Q. In the area of health literacy and consumer education, your testimony states that OPM operates wellness programs to its own employees to keep them informed and focused on their lifestyle choices. Could you comment on the success of this program and your view of encouraging this type of program across the board?

A. The U.S. Department of Health and Human Services, the Office of Personnel Management, and the President's Council on Physical Fitness and Sports have teamed up to challenge the Federal workforce to become more active through the HealthierFeds Physical Activity Challenge. This exciting new program challenges Federal employees to become more active, and it also challenges agencies to enter into a competition to see which agency has the most active employees.

For the eight week period, employees will be encouraged to enroll in the challenge and become more involved in physical activities to earn points for their agencies by participating in the HealthierFeds Physical Activity Challenge. It is easy to compete in this program by simply engaging in physical activity for 30 minutes a day for a minimum of six out of the eight weeks. As part of the HealthierFeds Challenge, each participant has access to an online "activity log" that allows tracking of activities that qualify for points toward meeting the challenge. Activities range from archery to gardening to skating to walking. During registration, each participant is asked to indicate his/her agency. Although individual results are not available, an agency's cumulative results will be accessible. At the end of the program, we will determine which agency's employees are the most active based on the percentage of people who registered and completed the program in the specified time period.

The HealthierFeds Physical Activity Challenge is a response to the rising trends in obesity and overweight resulting from, among other things, inactivity and poor dietary practices by many Americans. These conditions are adding an additional burden to an already strained healthcare system and contributing to rising healthcare costs. Work is a great place to promote healthier habits, and the leadership at Federal agencies realizes that healthier employees make happier and more productive employees. Therefore, this campaign was launched as a response to the need to increase the awareness of the importance of physical activity among Federal employees and to send a message to employers everywhere that they can have a positive impact on employee health and, as a result, employee happiness and productivity.

Q. I like what I see in your testimony about OPM's HealthierFeds campaign, together with the President's "HealthierUS" initiative. I am also intrigued by your testimony about working with insurance carriers to provide education on fitness, lifestyles, care management and prevention strategies. Could you comment on just what these efforts will entail?

A. OPM has worked with FEHB plans to routinely provide education on fitness, lifestyles, care management and prevention strategies for FEHB enrollees. OPM's HealthierFeds campaign provides a further means to bring about even more awareness among enrollees. About a year ago, FEHB plans were asked to provide a link to OPM's web site for HealthierFeds, and they responded with enthusiasm to demonstrate their commitment to this initiative. We plan to recognize their efforts by periodically featuring the plans' activities on the HealthierFeds website. We believe by helping to publicize these efforts, we are also encouraging healthy lifestyles and fitness awareness among FEHB members. We will also encourage plans to provide their suggestions on how to better serve the needs of our FEHB members and work together to bring unique ideas into action.

INTEROPERABLE HEALTH INFORMATION TECHNOLOGY

A REPORT
FOR:

THE HONORABLE GEORGE W. BUSH
PRESIDENT
UNITED STATES OF AMERICA

ON

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM INITIATIVES TO PROMOTE THE USE OF HEALTH INFORMATION TECHNOLOGY

BY

KAY COLES JAMES
DIRECTOR
U.S. OFFICE OF PERSONNEL MANAGEMENT

Dear Mr. President:

On April 27, 2004, you issued Executive Order 13335, Incentives for the Use of Health Information Technology and Establishing the Position of the National Health Information Technology Coordinator. This order establishes the importance you place on the development and implementation of a nationwide interoperable health information technology (HIT) infrastructure to improve the quality and efficiency of health care.

The Executive Order embodies your vision to develop a nationwide interoperable health information technology infrastructure that:

a) Ensures appropriate information to guide medical decisions is available at the time and place of care;
b) Improves health care quality, reduces medical errors, and advances the delivery of appropriate, evidence-based medical care;
c) Reduces health care costs resulting from inefficiency, medical errors, inappropriate care, and incomplete information;
d) Promotes a more effective marketplace, greater competition, and increased choice through the wider availability of accurate information on health care costs, quality, and outcomes;
e) Improves the coordination of care and information among hospitals, laboratories, physician offices, and other ambulatory care providers through an effective infrastructure for the secure and authorized exchange of health care information; and,
f) Ensures that patients' individually identifiable health information is secure and protected.

In order to help fulfill your vision, you directed me to submit a report within 90 days of your order on options to provide incentives in the Federal Employees Health Benefits (FEHB) Program to promote the adoption of interoperable health information technology. I am pleased to submit this report to support this

important undertaking.

Sincerely,

Kay Coles James
Director

INTRODUCTION

OVERVIEW

The Federal Employees Health Benefits (FEHB) Program began in 1960. It is the largest employer-sponsored group health insurance program in the world, covering more than 8 million Federal employees, retirees, former employees, family members, and former spouses.

Public Law 86-382, enacted September 28, 1959, created the FEHB Program. The law governing the Program is chapter 89 of title 5, United States Code. The law authorized the Civil Service Commission (now the Office of Personnel Management OPM) to write regulations necessary to carry out the Act. These regulations are in part 890 of title 5 and chapter 16 of title 48, Code of Federal Regulations.

Over 200 health plan choices currently are offered under the FEHB Program. There are twelve fee-for-service plans, of which seven are open to all enrollees, while the rest are available only to specific categories of employees. In addition, health maintenance organizations (managed care plans) are available in many specific local areas throughout the United States. Premiums and benefits are negotiated annually. Premiums and benefits vary among the plan offerings allowing Federal employees and retirees a wide choice to suit their individual circumstances.

This consumer-based choice is a key hallmark of the FEHB Program. The Government pays on average about 72% of the cost of the health benefits coverage, and enrollees pay the remainder, based on a formula set by law.

The FEHB law provides OPM wide authority to contract with various private health insurance plans. Annual contract negotiations are a bilateral process, and both OPM and the plan must agree on the final terms. Individual policies or contracts are not issued to FEHB Program enrollees. Each enrollee is given a detailed description of benefits so the consumer may use the open enrollment period to choose the best protection for his or her circumstances.

NEGOTIATIONS

The negotiation process in the FEHB Program formally begins in the spring of each year. OPM sends all current and newly approved qualified health plans the annual Call Letter to advise them on goals and procedures for negotiation of contracts that will be effective the following January. In conjunction with the Call Letter, OPM issues instructions for premium rate negotiation for the upcoming contract year. There are two rating types, experience rating and community rating. All proposals are due by May 31.

The Office of the Inspector General audits health plans to make sure our costs are appropriate.

PREMIUM RATE NEGOTIATIONS

Experience Rating

Experience rating bases the FEHB Program premiums on its benefit costs and administrative expenses. OPM's actuaries also evaluate each plan's rate proposal in relation to past premiums and anticipated future premium requirements to ensure the plan's premiums will be reasonably stable, represent good value for the benefits provided, and remain competitive with other FEHB plans. Fee-for-service plans and some HMOs are experience rated. The goal of the experience-rate negotiation is to make sure premiums are set high enough to support the plan's expenses but low enough to be competitive. Rate negotiations reflect a dynamic between premiums and costs and covered expenses. OPM rate instructions for experience rated plans are detailed and feature protection for the Government, enrollees, and plans. Funds in excess of a plan's current needs are held in the Employees Health Benefits Fund in the U.S. Treasury. The reserves provide a protective cushion against unanticipated costs and help achieve rate stability.

Each year specific profit margins are negotiated. This is the only profit allowed for experience rated plans. If at the end of a contract period there are excess funds over expenses, the excesses are credited to the reserve, not kept by the plan.

Community Rating

The majority of FEHB plans are health maintenance organizations (HMOs) and use community rating. This rate-setting methodology is based on what the plan charges its other groups. OPM analyzes and reviews each plan's rate to ensure the FEHB rates are fair. Our community rates are based on the best rates the plan offers its two subscriber groups most similar to the FEHB group. Preferential rates granted to a group similar to the FEHB group must be granted to the Government.

Like experience-rated plans, the FEHB maintains reserves to mitigate rate instability, rate increases, and benefit changes.

SUPPORT FOR INTEROPERABLE HEALTH INFORMATION IS GROWING

Below are brief summaries of typical initiatives related to interoperable health information technology that are currently emerging.

WellPoint, a Blue Cross and Blue Shield local plan, recently began a program called Prescription Improvement Package. The program offers physicians, at no charge, a wireless, handheld electronic prescribing unit, a wireless access point, and a one-year subscription to an e-prescribing service. Initially, WellPoint will target 2,000 physicians who can support the technology. The WellPoint effort is aimed at reducing medication errors and saving costs by decreasing duplication of services. This allows physicians to discard their prescription pads in favor of electronic transmissions to any pharmacy. WellPoint, with Microsoft's Healthcare and Life Sciences Group acting as technology consultant, provides Microsoft e-prescribing software to the 19,000 physicians in WellPoint's network in California, Georgia, Missouri, and Wisconsin.

Empire Blue Cross and Blue Shield is in the last stages of a program that awards bonus payments to hospitals that meet certain Leapfrog standards. Payments are paid by participating employers and equal a percentage of the hospital claims for employees of the participating employers. The self-funded employers are IBM, Verizon Communications, PepsiCo, and the Xerox Corporation. The goal of this program is to reduce errors and improve health care quality through the increased use of Computer Physician Order Entry (CPOE) and other Leapfrog Group standards; reward technical

innovation; and raise the standards for all hospitals in health information technology HIT adoption and health outcomes. A formal evaluation to assess the impact on improvements in quality of care and error avoidance is planned when the program concludes.

Blue Cross & Blue Shield of Massachusetts will start paying primary care physicians at Beth Israel Deaconess Medical Center, Caritas Christi Health Care, and Baystate Health System for "Web visits" with their patients beginning August, 2004. Harvard Vanguard Medical Associates, the large Eastern Massachusetts doctors' group, and the insurer Harvard Pilgrim Health Care, also are experimenting with doctor-patient e-mail programs. At Beth Israel Deaconess, patients can enroll in "PatientSite," an online system that allows them to schedule appointments, look up test results, and e-mail their doctors. Blue Cross only is paying doctors who use a standardized Web visit form developed to provide secure online communication.

Anthem Blue Cross and Blue Shield provides a member Website that provides members with an individually tailored online experience that offers quicker, easier, and more efficient access to self-service tools and member-specific health information.

Members use the Website for four reasons: to view their membership information, to choose or change health care providers, to learn about health and wellness, and to shop for health-related products and services at discounted prices. Members log in and then

have one-click access to MyServices, MyProviders, MyHealth, and MySpecialOffers B all efficiently organized by tabs and links - for easy navigation.

MyAnthem offers members the opportunity to become more involved in their health care through online capabilities that allow greater clarity, simplicity, and management over their health care benefits. MyAnthem provides an easy way to help members gain more control over their health care benefits through secure access that=s available at any time and from any place. The new Website satisfies many member needs in that it offers a personalized experience, customized content, simplified user interface and improved communication, and enhanced relationships that can translate into more information and tools at the member level allowing the member to make informed decisions about his or her health care.

Integrated Healthcare Association (IHA) has convened six large California health plans in a pay-for-performance program. The health plans award bonuses to physician groups based on an aggregate score that includes clinical measures, patient satisfaction, and IT investment. While each health plan sets its own dollar award, IHA suggests a bonus amount of 5-10% of the per-member capitation payment. The IT portion of the bonus is based on the physician groups= ability to match multiple clinical data sets at the patient level and to deliver electronic data at the point of care (electronic health records, electronic lab results, patient registries, etc.).

Bridges to Excellence (BTE), a Robert Wood Johnson-sponsored initiative, is focused on creating system-wide improvements in care delivery by linking physician payment and performance. This initiative, which includes a consortium of quality partners, health plans, and providers has two current projects underway – Physician Office Link (POL) and Diabetes Care Link (DCL). POL stresses the necessity and value of an HIT infrastructure in a physician's office to promote error reduction and quality improvements. Rewards are based on a physician's use of clinical information systems and evidence-based medicine; patient education and support; and care management. The intent is to establish a HIT infrastructure and link it to improvements in the providing of more efficient and higher quality care. The DCL's intent is to test the effectiveness and impact of the HIT infrastructure by using HEDIS measures for patients undergoing treatment of diabetes. These proven measures will help the program assess the success of the POL.

MVP and Taconic IPA (TIPA) have developed a partnership, MedAllies, to provide technical assistance, IT support, and other related services. The objective is to develop a community-oriented model through progressive improvements in the continuity of care and connectivity across all providers in the TIPA. Through a phased implementation of an electronic health record EHR, the ultimate goal is to have a highly integrated community data exchange to include physicians, labs, and hospitals. There is no planned, formal, quantitative evaluation, with success being measured by the level of participation. Participation is high and growing to include local community hospitals. MedAllies has

discontinued payment for most of the technology upgrades in physician offices because TIPA and MVP expect financial incentive bonuses to offset the costs for hardware/software upgrades.

Health and Human Services, Centers for Medicare and Medicaid Services (CMS), is in the process of implementing a three-year demonstration project, the Doctor Office Quality-Information Technology (DOQ-IT) project. Medicare Advantage plans will be providing financial incentives to physician offices to adopt HIT and meet certain performance measures. Physicians must treat a certain number of Medicare beneficiaries and meet specific systems and process requirements that include adoption of IT and care management. The physicians also must agree to phase in, over the three-year timeframe, the use of HIT to manage clinical care and electronic reporting of clinical quality and outcomes measures data. Several goals of this project are to adopt HIT in small- to medium-sized physician offices to promote continuity of care and stabilization of medical conditions, and to reduce adverse health outcomes of those beneficiaries with chronic illnesses.

CMS currently is conducting a Medicare demonstration project that uses financial incentives to encourage hospitals to provide high quality inpatient care. Hospitals that deliver the best quality of care will be rewarded with higher Medicare payments. Bonuses will be awarded based on a hospital=s performance on evidence-based quality measures for a variety of medical conditions. Only top performing hospitals will receive

monetary bonuses. While there is not a specific HIT component, information on each hospital's performance will be made available to health care providers and consumers that will contribute to a wider availability of information and informed choice.

WHAT OPM IS DOING NOW

OPM recognizes that in order to achieve shared goals and broaden the health care spectrum, there must be a collaborative effort from all organizations involved in the process. As the largest purchaser of employee health care benefits, OPM has undertaken and affiliated itself with a variety of organizations working toward common goals such as quality and affordable health care, positive medical outcomes, reduction of medical errors, wider availability of health information, and the creation of a competitive marketplace that provides choice to the consumer.

OPM'S COLLABORATIVE EFFORTS TO SUPPORT HIT

National Quality Forum (NQF)

NQF is a membership organization that is developing and implementing a national strategy for health care quality measurement and reporting. OPM currently serves as the Quality Interagency Coordination Task Force (QuIC) representative to NQF's Board of Directors.

Quality Interagency Coordination Task Force (QuIC)

The QuIC is an interagency task force charged with ensuring all Federal agencies involved in purchasing, providing, studying, or regulating health care services are coordinating their work on improving health care quality. OPM chairs the Patient and

Consumer Information Workgroup, one of five workgroups carrying out the QuIC's mission.

Leapfrog Group (LFG)

Sponsored by the Business Roundtable, the LFG's goal is to mobilize employer purchasing power to initiate breakthrough improvements in the safety and overall value of health care to American consumers. OPM participates as an LFG liaison member of the Board.

National Committee on Quality Assurance (NCQA)

NCQA's mission is to improve the quality of health care delivered to people everywhere. NCQA is active in quality oversight and improvement initiatives at all levels of the health care system. NCQA is best known for its activity of assessing and reporting on the quality of the nation's managed care plans through its accreditation and performance measures program. NCQA currently is supporting HIT by its new standards that support the Bridges to Excellence. OPM has a long standing association with NCQA.

National Business Group on Health

Formerly the Washington Business Group on Health, representing over 200 large employers, health care companies, benefits' consultants, and vendors, it is the nation's only nonprofit organization devoted exclusively to finding innovative and forward-thinking solutions to the nation's most important health care and related benefits issues.

Joint Commission Business Advisory Group

Created by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Business Advisory Group provides counsel on employer priorities in the evaluation of health care quality and assists the Joint Commission in identifying quality and safety issues important to employers. OPM is a member of the Board. The group meets several times each year and includes a cross section of individuals and coalitions representing businesses of varying sizes and different types of purchasing arrangements across the country. The Joint Commission relies on a variety of advisory groups in its continuous effort to improve the safety and quality of care provided to the public. These groups provide feedback to help JCAHO develop and revise standards, policies, and procedures that support performance improvement in health care organizations.

Center for Health Transformation

OPM has become actively engaged with the Center for Health Transformation through discussion and attendance at conferences sponsored by the Center. The Center for Health Transformation's vision is to accelerate the transformation of health and health care into a dynamic 21st century intelligent health system that results in better health, more choices, and lower costs to all. We share the Center's idea that the key drivers to health transformation are:

- patient safety and patient outcomes;

- information and communication technology;
- a system and culture of quality; and
- individual knowledge, responsibility, and power to choose.

eHealth Initiative

OPM has just been invited to join the Employer and Purchaser Advisory Board of the eHealth Initiative. The eHealth Initiative is moving forward aggressively to create national and local collaborative efforts with employers to support a common goal of higher quality, safer, and more efficient health care enabled by information technology. The eHealth Initiative supports the improvement of measurement ability, data integrity, and efficiency of collection and transmission of data.

The Employer and Purchaser Advisory Board of the eHealth Initiative and its Foundation is a vehicle for high-level discussions of issues important to the employer community and members of the eHealth Initiative. The group was formed to support the further development of the eHealth Initiative's strategy and the successful execution of its mission, which is to improve the quality, safety, and efficiency of health care through information and information technology.

Below are summaries of OPM's initiatives already underway that can help leverage its purchasing power to support HIT.

Pharmacy Benefit Management Arrangements

Many FEHB plans have had contractual arrangements with pharmacy benefit managers (PBMs). Prescription drug costs represent a high percentage of total FEHB costs. PBMs provide real time online access to member enrollment records to facilitate point-of-sale transactions. This technology can be leveraged to promote patient safety and connectivity. The interconnectivity that PBMs have with retail pharmacies can serve a vital role to link providers and pharmacies.

Care Management

FEHB plans generally provide care management services for members with chronic conditions, including flexible benefit options and diagnosis-based programs. Care management programs help educate affected members about their chronic conditions and help ensure they are getting appropriate services. It is generally accepted that a relatively small percentage of members, primarily those with chronic conditions, use the greatest percentage of benefits. By addressing the needs of this chronically ill population, health plans help improve the quality of care and promote the effective use of benefit dollars. Online decision support tools available to members help facilitate their access to information and educational materials.

Further, OPM has asked plans to begin the process of establishing a link between their care management programs and Long Term Care Partners, the administrators of the Federal Long Term Care Insurance Program (FLTCIP), so enrollees with FLTCIP coverage can experience a smooth transition to long term care when necessary.

HealthierFeds

OPM's *HealthierFeds* campaign places emphasis on educating Federal employees and retirees on healthy living and best-treatment strategies to reduce demand on the health care system. This OPM initiative is featured at www.healthierfeds.gov on OPM's Web site. It supports the President's *HealthierUS* initiative which follows a simple formula: *every little bit of effort counts*. The Administration's initiative has identified four keys for a healthier America: be physically active every day, follow a nutritious diet, get preventive screenings, and make healthy choices. OPM has reinforced with FEHB plans that educating their members may lead to more patient involvement in health care decision making and, subsequently, more consumer responsibility.

Quality Initiatives

Quality is a very important aspect of managing health care programs. Quality is how well health plans keep their members healthy, or treat them when they are sick. Good quality doesn't always mean receiving more care. Good quality health care means doing the right thing at the right time, in the right way, for the right person, to achieve the best possible results.

OPM is continuing to provide FEHB members with resources that will help them choose high-quality health plans. OPM provides FEHB members with the accreditation status of participating health plans in our annual *Guide to FEHB Plans*. Accreditation demonstrates an organization=s commitment to providing quality, cost-effective health care. Providing FEHB members with accreditation information allows consumers to choose a high quality health plan.

OPM also provides Federal employees and retirees with individual health plan ratings based on the results of our annual Consumers' Assessment of Health Plans Survey. This consumer survey allows current plan members to rate their health plans and providers in several key areas, including overall satisfaction, satisfaction with their providers, access to care, customer service, and claims processing. Providing FEHB members with this consumer survey information allows them to consider the feedback of other consumers when choosing a health plan.

E-Initiatives

OPM is continuing to expand the use of the Internet as a valuable communications and resource tool. During the annual open season events, OPM provides in various ways, comprehensive program information, including health plan brochures, FEHB guides, premiums and other useful information our customers need to choose a quality health plan. The FEHB Website, linked from the OPM website, www.opm.gov, links to a report

card designed by the National Committee for Quality Assurance (NCQA). This report card helps users learn more about the quality of care and service provided by HMOs. FEHB consumers also have access to an OPM health plan comparison tool. Most plan consumer information can be linked through OPM's portal.

Patient Safety

During the past few years, the health care community has stressed the importance of a culture of patient safety. We are continuing our work with FEHB plans adding information on their patient safety initiatives and programs to the FEHB Website.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), subtitle, Administrative Simplification, requires the Secretary of Health and Human Services (HHS) to adopt standards for: ten electronic administrative and financial health care transactions; unique identifiers for individuals, employers, health plans, and health care providers; protecting the privacy of individually identifiable health information; and providing security for individually identifiable health information and electronic signatures. HHS has now published several final HIPAA regulations. The compliance deadline for electronic transactions was October 2003. OPM successfully migrated from its proprietary enrollment transaction format to the HIPAA standard format. The final HIPAA privacy regulations were effective April 2003. The security regulations will become effective April 2005 for most plans and April 2006 for small plans. The

national provider identifier regulations will become effective May 2007 for most plans and May 2008 for small plans. All OPM contracts require HIPAA compliance. OPM is working closely with FEHB plans to ensure a smooth transition in meeting these important requirements.

PROVISIONS AVAILABLE TO OPM TO PROVIDE INCENTIVES

OPM purchases health benefits coverage for over 8 million employees, annuitants, and dependents. OPM's significant purchasing power is powerful leverage to contract for a comprehensive set of health benefits at affordable prices. Through this leverage, OPM continues to capitalize on the great efficiencies and economies that can be achieved. OPM fully supports initiatives to further an effective and competitive marketplace as it explores ways to adopt HIT in the FEHB Program that will bring knowledge-based tools to the hands that deliver health care.

The end result of any such program is to raise the bar so that everyone is performing at a higher level. It should be a program that fosters an environment of winners, not winners and losers. In this era of budget consciousness, investment and return on investment are pivotal to purchasers and providers. Therefore, to use purchasing leverage to gain a meaningful and lasting move toward the adoption and full implementation of HIT, OPM needs to move forward in a way that is shared by all stakeholder groups. Incentives

should be properly aligned and meaningful to ensure that both costs and returns are shared by all.

As OPM exerts its purchasing power, it will support the adoption of common standards of performance, outcome, and incentives. The use of accepted standards developed by recognized quality and accreditation organizations lends itself to greater leverage and earlier adoption. OPM will leverage its purchasing power to move forward, not to reinvent the wheel.

OPM's goals in the marketplace will be to:

- Reduce health care costs by increasing efficiency and reducing medical errors, inappropriate care and incomplete care;
- Improve health care quality;
- Ensure appropriate information is available to guide medical decisions at the time and place of care;
- Improve care coordination; and
- Partner with ONCHIT and collaborate with Federal partners and other public and private stakeholders.

Incentives may be provided several ways in the FEHB Program. OPM can explore regulatory changes to help encourage profit incentives for plans to foster HIT adoption and implementation. Experience-rated plans can be rewarded for progress toward

adopting or adapting incentives for HIT. Using plans' profit motive should help OPM leverage its market position to help HIT adoption.

Community rated plans incorporate both their administrative expenses and any profit amount into their rates. Community rated plans are subject to performance goals and incentives. OPM can explore regulatory changes to align current plan performance elements to include HIT adoption.

OPTIONS

OPM will explore adoption of a variety of options, such as those below, to speed the nationwide phase-in adoption of HIT as soon as practicable.

1) Strongly encourage FEHB Program participating health plans to adopt systems that are based on the Federal Health Architecture standards.

2) Strongly encourage health plans to highlight their provider directories to indicate individual provider HIT capabilities.

3) Strongly encourage health plans to link disease management and quality initiatives to HIT systems for measurable improvements.

4) Strongly encourage health plans to provide incentives for the adoption of interoperable health information technology systems by key providers under FEHB contracts.

5) Base part of the service charge, or profit, for fee-for-service and other experience-rated plans on their developing incentives for:
    - Doctors and pharmacies to use paperless systems to fill prescriptions (*e*Prescribing);
    - Contracting with hospitals that use electronic registries, electronic records, and/or *e*Prescribing; and
    - Increasing the number of enrollees whose providers use electronic registries, electronic records, and/or *e*Prescribing.

6) Introduce performance goals for HMOs (community rated plans) that are linked to their developing incentives for:
    - Doctors and pharmacies to use paperless systems to fill prescriptions (*e*Prescribing);
    - Contracting with hospitals that use electronic registries, electronic records and/or *e*Prescribing;
    - Increasing the number of enrollees whose providers use electronic registries, electronic records and/or *e*Prescribing.

7) Introduce incentives and performance goals for plans that contract with networks of providers to make records accessible through secure and HIPAA compliant interoperable HIT systems.

8) Introduce incentives and performance goals for plans that integrate their provider networks with local and national health information infrastructure initiatives.

9) Encourage and reward pharmacy benefit managers for providing incentives for *e*Prescribing and health information technology linkage.

OPM has great respect for the power and creativity of the private sector to determine solutions. We will continue to collaborate with our private sector partners as well as our public sector partners to achieve the goals set by President George W. Bush in his Executive Order. We believe these goals can be achieved without violating the key principle that desired outcomes can be achieved through negotiation rather than imposed through mandates.

	TOTAL				Employees			
	1999-2000	2000-2001	2001-2002	2002-2003	1999-2000	2000-2001	2001-2002	2002-2003
	4,690,931	4,670,916	4,677,893	4,670,319	2,468,030	2,440,271	2,439,951	2,432,027
Plan Changes	227,742	219,455	321,755	193,652	179,132	176,656	255,040	154,867
FEHBP Gains	50,423	50,938	65,121	50,192	48,561	47,923	62,828	48,024
FEHBP Drops	43,799	33,006	78,946	51,239	38,622	26,207	31,355	26,307
Total Changes	321,964	303,399	467,777	296,478	266,315	250,786	350,873	230,275
Percent Change	7%	6%	10%	6%	11%	10%	14%	9%

	Annuitants				Survivor Annuitants			
	1999-2000	2000-2001	2001-2002	2002-2003	1999-2000	2000-2001	2001-2002	2002-2003
	1,664,449	1,668,256	1,672,945	1,673,738	558,452	562,389	564,988	564,554
Plan Changes	42,241	38,090	59,574	35,040	6,369	4,709	7,141	3,743
FEHBP Gains	1,559	2,588	2,043	1,888	303	427	250	280
FEHBP Drops	3,825	5,293	42,363	20,833	1,352	1,506	5,228	4,099
Total Changes	47,625	45,971	104,133	57,923	8,024	6,642	12,771	8,280
Percent Change	3%	3%	6%	3%	1%	1%	2%	1%

The Performance Based Incentive Program (PBIP): A Model for Quality Improvement and Cost Efficiency in Large Primary Care Groups

"Studies indicate that a shift from fee for service payment to incentive programs such as PBIP can have a significant positive impact on the overall healthcare system in the United States, by improving quality of care and holding down healthcare costs. Highmark BCBS's program emphasizes evidence-based medicine guidelines, attempting to reduce the underutilization of effective care."

~ Harvard Medical School Researchers

Highmark Blue Cross Blue Shield launched the Performance Based Incentive Program (PBIP) in 2000 to encourage quality care by reducing costly variation in care. Geography, training and access to scientific evidence are just some of the reasons that treatments often vary from doctor to doctor and patient to patient. The PIBP program helps physicians by sharing practice-specific data, pinpointing practice variation from accepted clinical guidelines, providing a medical management consultants to identify areas for improvement and providing financial incentives for improved performance.

Sharing information with physicians helps them provide care based on accepted clinical standards while reducing variation in care. The PBIP program helps monitor and streamline medical guidelines so that physicians are informed of medical breakthroughs, new techniques and improved technology. Most importantly, physicians are given data that illustrates the magnitude of variation of their practice from the norm and from "best practices." By collaborating with physician groups, Highmark continues to ensure that medical guidelines stay up-to-date.

Each physician practice also has a designated plan medical management consultant – experts skilled in process improvement. Consultants and participating physicians review past performance to identify areas for improvement, and develop plans to create systems and processes that help assure more consistent care. These process improvements focus on four general areas – clinical quality, member satisfaction, member access and electronic connectivity. Participating physician groups are rewarded if they exceed other physicians (in and out of the program) in these four key areas.

This unique partnership fosters positive relationships with Plan physicians and has reduced overall healthcare costs for members. Of the 840 participating physicians serving approximately 400,000 Highmark members, 88 percent report that the program has helped them improve their practice's ability to care for its patients while keeping down costs. The program helps control overall health care costs. In 2003, costs for PIBP members did not increase as fast as the network, an average savings of more than $22 million. And member satisfaction is higher for participating providers. In 2003, the average quality scores were 17 percent higher for doctors participatring in PBIP.

From Karen Wolk Feinstein
Jewish Healthcare Foundation Pittsburgh PA to

Reid Voss
Subcommittee on Civil Service and Agency Organization
Committee on Government Reform

Response to Panel 2 "You Can't Always Get What You Want" Questions for the Record
September 28, 2004
Tim Murphy, Acting Chair

Questions:

1. EMRs and CPOE systems will add many enhancements in our move to quality and safety. However, they are expensive, high tech, novel solutions to the problem of medical error and should never supplant the basic improvements in work design, interdisciplinary teamwork, and service delivery that would remove the conditions for medical error. In addition, we are increasingly aware that new technologies introduce new opportunities for error and we must stay alert and cognizant of these newer pathways for failure. Many of our errors occur because we have not perfected human interaction and system design barriers to serious patient harm. These system and human factors breakdowns are capable of solution at relatively low cost. They require will. Until our purchasers, payers and patients hold our delivery systems accountable for rapid improvements at the point of service, the "will" may limp along.
2. This lever, pay for performance outcomes, is of inestimable value in creating the will among providers to provide care that is as perfect as possible. It is critical to emphasize the essentiality of paying for outcomes (lower mortality, fewer re-hospitalizations, fewer complications, etc.) and even value and efficiencies (lower cost paired with better outcomes) and not for processes (e.g., the administration of beta blockers.) That is because there are always patients who don't fit a process mold, who would not benefit or may be hurt by what seems to be best practice. Physician discretion here is a good thing. Also, we will never move the wall of knowledge to continuous improvement in practice if we don't let different health teams try different methods to achieve best outcomes. FEHBP should only direct its employees to plans that publish risk adjusted and comparable data on outcomes for various procedures along with comparable data on cost and volume for different providers and institutions. Otherwise, the public cannot purchase value in health care and traditional market forces will never drive progress in cost and quality. It would also be helpful to aware health care teams that achieve the best outcomes or value with higher reimbursements.
3. I would encourage FEHBP to form a pact with employees. I would lower premiums or provide some reward for those who: quit smoking or do not smoke; lower their BMI; are clearly compliant with protocols to manage their chronic condition, etc. Also, work units and workplaces can mount health awareness efforts of their own. Materials could be distributed that alert employees to beneficial behaviors, e.g., buying value when seeking medical care; following protocols re their chronic conditions; best practices in prevention; avoiding environmental hazards; the essentiality of good diet and exercise, etc. It would be worthwhile to hold workshops, focus groups, lunch meetings etc to educate employees about how to

choose a provider, the dangers in pharmaceutical overuse or underuse, the importance of having their medications reviewed regularly by a pharmacist, how to protect themselves or loved ones when hospitalized. I also think it is helpful to everyone to educate employees about the real reasons/root causes for the high cost of health care, the plethora of preventable medical errors, and other dilemmas if they are going to be engaged in changing their behavior to solve these issues.

4. I would make good health behaviors easy; I'd engage employees in festive behavior change. I'd emphasize in every way that you regard it a function of good citizenship, team membership, responsible parenthood and productive labor force participation that they respect their health and act accordingly. A nation of smoking, obese, addicted, inactive and noncompliant adults is frightening. I'd remove garbage foods from vending machines. I'd give people places to exercise and showers to clean up. I'd have office competitions that involve exercise and outdoor activity. I'd make available at low cost the healthiest meals and, on the other hand, charge a great deal for non-nutritious foods. I'd give rewards to managers who figure out new and important ways to create positive health behaviors.

University of Pittsburgh

INSTITUTE ON AGING

In partnership with University of Pittsburgh Medical Center

To: Hon. Tim Murphy, Acting Chair
Subcommittee on Civil Service and Agency Organization
From: Neil M. Resnick, MD
Director, University of Pittsburgh Institute on Aging
Re: Further questions regarding testimony delivered to the subcommittee on Sept 13, 2004

1. **Create a Task Force comprising experts in geriatric care and health care policy:** The Task Force could identify which current regulations in Medicare that function more as impediments than enhancements to care. One example is the rule that demands patients be admitted to hospital for 3 days before they can qualify for nursing home admission—even if they do not need acute hospital care. This is both costly and risky for older adults. Lack of payment for many other services also functions as an impediment. For instance, thinning of the blood in appropriate patients can reduce the risk of stroke by 85%. But it requires monitoring to ensure the blood doesn't get so thin as to cause bleeding. No payment mechanism covers this service, however. Phone management is key to providing prompt care for older adults in whom symptoms of dire conditions are often muted and hence brushed off until an office visit can be scheduled several days later. But these are not covered. There also is no coverage for followup phone calls to ensure that, after discharge from hospital, older patients are continuing to recover and rehabilitate as expected, that they have information needed for followup appointments and tests, and that they understand changes that were made in their medication regimen. Current CMS regulations require extensive time consuming effort to document encounters; much of this information is of minimal if any use to anyone. One unintended consequence, however, is to discourage many physicians from accepting Medicare assignment. Case management, pharmacist management, chronic disease management, preventive services counseling, etc. also all remain non-reimbursed services. For each, the short-term costs would likely be offset by at least as much in savings while simultaneously improving care. These ideas are just the tip of the iceberg.

2. **How to incentivize physicians to become better educated in geriatrics:** Physicians wish to provide optimal care for older patients but few have received geriatrics training because it is relatively new and because most medical schools still do not include it in the curriculum. Thus, to train tomorrow's physicians, agencies that accredit medical schools could mandate such training. For current physicians, incentives would likely work best. They could be in two forms: (1) incentives to acquire and prove mastery of such training; (2) payment for providing appropriate care. As to the second option, remuneration for caring for older patients could be higher for those who are so accredited and maintain such accreditation. And in the same way that CMS is now piloting a program that pays more for excellence, it could add to its metrics and pay for those that are appropriate for caring for older adults.

3. **Additional impediments to geriatric care, especially with regard to coordinated care of chronic diseases?** As described in #1 above, there are many impediments.

Optimal care of chronic disease requires a team. Led by a physician, it should also include access to case management, pharmacist oversight, and decision tools/support best provided by improved information technology. Many of these services could be provided immediately, others will need to be developed. All would benefit from some degree of testing "in the real world." CMS's new initiatives—both the Chronic Care Improvement Program and the High Cost Medicare Beneficiary Program—should provide important data relevant to this issue.

4. **Patients with multiple chronic conditions often "bounce" from physician to physician, accumulating more prescriptions and side effects with each. How could an Electronic Medical Record (EMR) and Computerized Physician Order Entry (CPOE) improve the situation?** Both would help substantially, but neither yet exists in the appropriate format and most physicians do not have access to them. An EMR would greatly facilitate monitoring of care and quality improvement efforts. It also could reduce the need for duplication of tests and consultations. What's missing, though, is a useable and continuously updated "snapshot" of the patient's EMR since physicians do not have the time or expertise to wade through the volumes of information. EMRs also need substantial simplification; compared with paper charts, the EMRs widely available at present increase the patient encounter time required of a physician.

   CPOE also has the potential to be very helpful but it still needs more work as well. At present, ordering a medication takes more effort by computer than by paper. In addition, currently available decision aids are inadequate for at least two reasons: (1) strategies for identifying drug-disease interactions are in their infancy and essentially not available; (2) drug-drug interaction programs have a difficult time individualizing the information, erring on the one hand by burying the physician with reports of every conceivable interaction however unlikely or unimportant vs. failing to provide caveats on more than simply the most dire interactions. Moreover, many such interactions are difficult to predict, not only because many are idiosyncratic but because such interactions are also affected by the dose, the route, and the patient's other conditions, medications, and physiological function. Research in this area is much needed and apt to yield important improvements in patient safety as well as societal cost.

   As stated in the testimony, we at the University of Pittsburgh Institute on Aging would be pleased to help as you strive to address any of these issues.

"YOU CAN'T ALWAYS GET WHAT YOU WANT...WHAT IF THE FEDERAL GOVERNMENT COULD DRIVE IMPROVEMENTS IN HEALTH CARE?"
Subcommittee on Civil Service and Agency Organization
Tim Murphy, Acting Chairman
Questions Submitted for the Record
September 28, 2004

PANEL 1

Honorable Dan Blair, Deputy Director, U.S. Office of Personnel Management

PANEL 2

Karen Wolk Feinsten, PhD, President, Jewish Healthcare Foundation
Dr. Neil Resnick, Director, University of Pittsburgh Institute of Aging
Dr. Alan Axelson, American Academy of Child and Adolescent Psychiatry

QUESTIONS

Dr. Alan Axelson - American Academy of Child and Adolescent Psychiatry

- You stated that psychiatric disorders often co-occur with medical illnesses and complicate the effective and efficient treatment of medical illnesses. How can the FEHBP contribute to better consumer awareness of the effectiveness of psychiatric treatment associated with other illnesses and also help to decrease the stigma associated with it?
    - Health plans, professional organizations, pharmaceutical companies and the popular press are all involved in consumer awareness and the issue of stigma. To the extent that FEHBP has effective direct communication with its members it can reinforce these messages.
    - Co-payments for the treatment of psychiatric illnesses should be the same as physical illnesses. Medical necessity reviews and case management are more rational and ultimately effective means of cost control that visit limits and high co-payments.

- You commented that innovative programs, such as pay for performance, are the key for improving the healthcare system. Other than pay for performance, what other types of innovative programs do you endorse and how can OPM through the FEHBP foster adherence and improvements to these programs?
    - Primary care physicians needs decision support information to prompt them to address the issue of depression co-occurring with

other chronic illnesses. Integrated patient registries that identify patients with chronic illnesses who have been diagnosed with depression or treated will antidepressants, can help physicians address the complexity of these problems.

- You indicated that treatment for depression must be a collaborative effort among primary care physicians, specialists and patients. How can the FEHBP support this level of integration to assure collaborative participation in treatment?
    - FEHBP should require its contracting health plans to effectively address the issue of integration. Information systems should be integrated so that the patient treatment experiences related to physical symptoms and psychiatric illnesses can be tracked in an integrated data base. Primary care physicians and behavioral health specialists should be part of one network. Carve-out behavioral managed care programs have disrupted relationships between primary care physicians and behavioral health specialists. Health plans should demonstrate active programs to reestablish these relationships.
    - Primary care physicians are the practitioners that provide first line treatment for depression. Health plans should pay primary care physicians on the same basis for treating physical illness and mental illness.

- Because so many patients with psychiatric illnesses are not identified and effectively treated, how can the FEHBP specifically, in an effort to combat this problem, make sure that treatment guidelines for psychiatric illnesses are introduced and integrated into the daily processes of care? Also given the prevalence of chronic disease, please discuss your thoughts on considering the possibility of depression in every patient treated for chronic disease.
    - Health risk assessment questioners are one means of identifying individuals who need further evaluation for depression. Providing incentives for employees that complete these instruments will increase screening rates.
    - It appears that most patients that get to specialty care by a psychiatrist receive treatment that is consistent with basic treatment guidelines. When prompt psychiatric support is not an integrated part of the treatment system both in terms of consultation services to primary care physicians and collaborative treatment with non-physician psychotherapists there is concern that patients will not receive the treatment that they need. At the present time NCQA does not differentiate between mental health professional, physician and non-physician practitioners. Evaluation of the adequacy of behavioral health networks should address the two categories of specialists.

- True enhancement of care will need to be supported by electronic decision support. The demands of primary care practice make it unlikely that there will be complex changes at that level.
- Scientific literature supports screening for depression in patients with diabetes, heart disease and pain syndromes. Ideally this screening should occur as part of the physician contact. Realistically it will probably require direct patient outreach by health plans to consistently screen these patients. Employers (FEHBP) should support such screening programs in their communications with employees and families. It should also be considered as part of the FEHBP contract requirements.
- Post partum depression is a special circumstance. Health plans should have specific programs to reach out to new mothers and educate obstetricians and pediatricians regarding the identification of this specific psychiatric illness.