# Testimony of Elizabeth Faust
# North Dakota Legislative Management
# Interim Health Care Review Committee
# November 10, 2015

Mr. Chairman and Members of the Committee, my name is Elizabeth Faust. I am the Senior Medical Director for Behavioral Health at Blue Cross Blue Shield North Dakota. Thank you for the opportunity to speak with you today. I have been asked to talk about population health and value based programs. My goal today is not to tell you what to think, but to give you some information about how to think about this complex topic.

A bit of background: I am a psychiatrist and have practiced medicine in Fargo for the past 25 years. I spent a dozen years as co-medical director at Southeast Human Service Center, a dozen doing clinical practice and physician leadership at MeritCare/Sanford Health and a year as Chief of Psychiatry at the Fargo VA before starting at BCBSND a year ago. Population health and care delivery improvement have been longstanding interests of mine and I learned a great deal working in the public, private and federal arenas. My journey brought me to BCBSND because I realized that changing systems requires influence on resources and reimbursement.

What I want to talk about today are three things: the case for change to the US health care system, why I think it is relevant to you and then I want to walk you through my "Health Care Costs for Dummies" analysis. Let's be clear about this—you are not the dummies. I am. I am an immigrant from the world of care delivery to the foreign land of the health payer. I am by no means an expert in health insurance. I actually think that is why I've been asked to speak to you. The state of health care in this country is so complicated that it defies the ability of mere

mortals to comprehend. We have lots of experts who speak with deep but narrow understanding of specific aspects of our dilemmas. We don't focus much on how all the factors fit together. As a "foreigner" at BCBSND, I am constantly aware that my narrow understanding as a physician isn't sufficient, and I spend a lot of time trying to understand the big picture. My third point today is to show you a "roadmap" I have developed to help me keep it all straight.

Let's start with the case for change. Our nation is at a crossroads. We spend 18% of our gross national product on health care. We are #1 in the world in health care spending and we are #38 in health outcomes. According to the 2013 Institute of Medicine report *Shorter Lives, Poorer Health*, Americans have lower life expectancy and higher rates of infant mortality, low birth weight, injuries and homicides, drug-related deaths, obesity, diabetes, heart disease, chronic lung disease and disability than people in other industrialized countries. Racial and economic disparities fail to explain this national health disadvantage in the United States. Americans who are white, insured, college educated and upper income have poorer health than do their counterparts in other industrialized countries. What we spend on health care to be #38 creates tremendous drag on other parts of the economy and the national infrastructure. We are #1 in spending, #38 in outcomes and the only Western democracy that has not elected to make health care universally available. We spend a lot on a portion of the population with mediocre outcomes. We siphon resource from other important priorities in order to obtain those outcomes. Let's dive into that a little more deeply.

There are still 38 million uninsured people, in spite of the fact that the ACA has brought the rate of uninsured down to 11.9% as of first quarter 2015. With broader coverage comes cost. Even if we do not elect to expand coverage, health care costs are expected to grow as we deal with the consequences of our aging Baby Boomers and the future consequences of the current epidemic of childhood obesity and other rising risks in younger parts of the population. In either scenario, whether we cover everyone or we don't, costs are going to rise unless we intervene. If those rising costs are to be covered by increasing taxes, and if those taxes, like the ones that support the Medicare program, are predominantly derived from payroll taxes, we will also have to determine how sufficient tax revenue can be generated to account for the aging Boomer population who will no longer be contributing to that tax base, without negatively impacting the competitiveness of American companies and overburdening individuals. This seems an even more overwhelming challenge when one considers that in the current state, the U.S. government struggles to afford the unfunded liabilities accruing now in the Medicare program.

There isn't consensus about whether health care is a human right or not, but it's clear that the way we deliver health care in this country is not sustainable. We have a health care system that costs too much, creates huge economic drag, leaves tens of millions of people without coverage and provides fragmented care.

An alarming and compelling case for change, right? A case we've known for at least a decade. We can lay blame on insurance companies, inefficient and wasteful hospitals and government programs, malpractice costs, doctors who are reluctant to change, disengaged consumers and skyrocketing costs of pharmaceutical drugs. And we can support all of those factors with data.

We know they are all part of the problem. In addition, there is increasing research and evidence about the role of social determinants of health.

There must be really good reasons we haven't changed. And there are. We perpetuate the status quo because change challenges beliefs we hold dear. Americans love technology and we believe in it. We think it makes our lives better, and it does. We tend to rely on medicine for health solutions more than other countries do. We believe health care should be a right, at least for ourselves. We're not sure it's a right if we have to share it, or pay for someone else's. We love our independence and autonomy. Except when we need help. We hate taxes. But we love entitlements. Policies that restrict personal liberties unsettle many Americans, and there is a timeless tension in this country between individualism and community orientation. My favorite bumper sticker right now is: "Keep your government hands off my Medicare!" Change is easy, as long as it doesn't impact beliefs we hold dear, or feel like a loss to us. Given the breadth of inputs into health, no single agency or player can be solely accountable, rather, the achievement of better health will require shared accountability for change for everyone: consumers, providers, payers and policy makers. How much health care can we afford? How much is enough? Who decides? Budgeting is never easy, and allocating health care resource makes us queasy.

So that's the case for change. And the case for why it seems overwhelmingly difficult. Let's turn now to why I think this matters to you as North Dakota legislators. Clearly, you are citizen participants in this national conversation that I've described. But in addition, you have the role

of stewards of resource and payer for several programs: Medicaid, NDPERS, and Healthy Steps. Poor health outcomes in any segment of our North Dakota population, even the most marginalized, costs all taxpayers money.

Now let's talk about what we *can* do, and what we *are* doing. At the most elementary level, the solutions are going to require us to shift from "win-lose" thinking to "win-win" thinking. In our old world, payers have tried to contain spending, providers have tried to make the best living possible by treating the maximum number of patients possible around the administrative and paperwork burdens placed on them. Individual consumers have tried to extract as much certainty as they can from the medical care complex and are often insulated from the costs of this effort, but employers and government programs balk at escalating costs of care. Doctors have tried to encourage healthy behavior in patients, but lacked time and influence on patients' health habits. And so on.

The fee-for-service model is grounded in winners and losers. It is an incentive system that rewards *volume* of services. The new models, referred to as Value Based Programs, reward *value* of services, and quality of outcomes. They are grounded in "winning" for all stakeholders. Very simply stated: Payers want to pay for services that contribute to health of their populations. Providers want to be paid for the services they render. Employers and government programs want affordable costs. Consumers want access to care that supports them in being healthy.

A succinct statement of the goal of "win-win" is the Institute for Health Care Improvement (IHI)'s statement of purpose for health care improvement called the Triple Aim. Many people

are familiar with this: 1) improving the health of populations (better health), 2) improving the experience of care (better care), and 3) reducing the per capita costs of health care (lower cost). When you start talking about the technical solutions to move toward that "win-win": ACO's, Patient Centered Medical Homes, capitation, narrow networks, total cost of care, pay for performance, care management, Value Based Programs…. the gap between all of these terms and our goals starts to seem wide.

This is where my 3rd point emerges. On page 7 of your packet is a handout called Population Health Cost Factors, if you could turn to that. This is my roadmap to keep myself oriented to how all of the pieces fit together.

References:


1) The American Health Care Paradox: Why Spending More is Getting Us Less by Elizabeth Bradley and Lauren Taylor
2) "Overkill", by Atul Gwande, New Yorker Magazine, May 11, 2015
3) The Creative Destruction of Medicine by Eric Topol
4) U.S. Health in International Perspective: Shorter Lives, Poorer Health, Institute of Medicine January 9, 2013