



TESTIMONY OF
CONNECTICUT PUBLIC HEALTH ASSOCIATION
regarding
Proposed SB No. 1
AN ACT INCREASING ACCESS TO AFFORDABLE, QUALITY CARE
and
Proposed HB 6332
AN ACT INCREASING ACCESS TO HEALTH CARE

COMMITTEE ON PUBLIC HEALTH
January 31, 2007

Representative Sayers, Senator Handley, and members of the Public Health Committee, I am pleased to provide this testimony on behalf of the Connecticut Public Health Association. I am Charles Huntington, and I serve as immediate past-president on the CPHA Board of Directors. I am also a member of the faculty at the University of Connecticut Health Center, where I am responsible for the Connecticut AHEC Program and am part of the UConn Center for Public Health and Health Policy. CPHA is part of the Be Healthy CT coalition.

Although general in nature, my comments most directly address Proposed SB No. 1, An Act Increasing Access To Affordable, Quality Care, and Proposed HB 6332, An Act Increasing Access to Health Care. The Connecticut Public Health Association believes that all Connecticut residents should be covered by health insurance that provides equitable access to all effective care based on need alone and that society can reasonably afford. We believe that the moral, economic, and public health rationale for guaranteeing health insurance coverage to be compelling, and we urge the General Assembly to set in motion a process that will establish a health care system that is sufficiently integrated to ensure that all residents are covered by health insurance that meets these standards.

Allow me to comment on the implications of a few well-evidenced characteristics of the current health care system that can and should guide your efforts to ensure universal health insurance coverage.

The lack of health insurance coverage significantly increases the risk of death.¹ Uninsured adults receive less appropriate care than those who have health insurance. Several studies indicate that the lack of health insurance is associated with a 25 percent higher risk of death. Excess deaths among uninsured adults age 25 to 64 years are estimated to be in the range of 18,000 per year. Higher death rates are accompanied by higher rates of high cost chronic illnesses. The clear implication of this finding is that improving the health status of Connecticut residents is dependent on all residents having adequate health insurance coverage.

The majority of health care costs are incurred by a small minority of the population suffering from one or more chronic illness.² Forty-nine percent of health care costs are incurred by just five percent of the population, and 80 percent of health care costs are incurred by just 20 percent of the population. Furthermore, the minority of the population that is responsible for the bulk of health care spending is elderly and has one or more high cost chronic illnesses. The five most costly conditions (heart disease, cancer, trauma, mental disorders, and lung disease) account for nearly a third of all health care spending, and the 15 most costly conditions account for 44 percent of spending. Importantly, high health care spending is not attributable to inappropriate utilization at the point of entry into the health care system.

The concentration of health care costs in a relatively small portion of the population suggests that efforts to control health care costs should be focused on the prevention, early detection, and aggressive management of high cost chronic illnesses. The prevention of high cost chronic illnesses can best be achieved through community-based prevention services, which, in turn, requires a substantial investment in our public health infrastructure, which has been woefully under-resourced for decades. Numerous health care studies have demonstrated a direct link between better health and cost savings. The evidence suggests up to \$3 can be saved for every \$1 invested in prevention. The long-run savings achieved through universal access to preventive services can be used to finance the coverage of those currently

¹ Institute of Medicine, *Coverage Matters: Insurance and Health Care* (Washington: National Academies Press, 2001); IOM, *Care without Coverage: Too Little, Too Late* (Washington: National Academies Press, 2002); J.Z. Ayanian et al., "Unmet Health Needs of Uninsured Adults in the United States," *Journal of the American Medical Association* 284, no. 16 (2000): 2061–2069; and J. Hadley, "Sicker and Poorer—The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income," *Medical Care Research and Review* 60, Suppl. 2 (2003): 3S–75S.

² Stanton MW, Rutherford MD. The high concentration of U.S. health care expenditures. Rockville (MD): Agency for Healthcare Research and Quality; 2005. Research in Action Issue 19. AHRQ Pub. No. 06-0060.

without health insurance. Employers, school systems, and medical providers also have important prevention roles. Early detection is a shared responsibility of local public health, employers, school systems, and medical care providers. Finally, aggressive case management, which was the promise of managed care in its early incarnations, can reduce hospitalizations and the development of costly complications.

Achieving the promise of preventive services can only occur by addressing the fragmentation of the current health care delivery system. The existing hodgepodge of private and public programs constitutes a non-system in which the savings achieved in one area are either lost or accrue only to one sector. Such a non-system cannot take advantage of savings in one area in order to apply them to another. This creates an actual disincentive for prevention services, since there is no way to achieve savings through an upfront investment in prevention. Hence, establishing universal health insurance coverage requires the creation of a health care system with sufficient uniformity to allow the savings achieved through prevention to be captured and used to offset the cost of improved access and quality.

Higher health care costs in the United States are primarily attributable to higher prices and not higher utilization of health care services.³ Per capita health care spending in the U.S. is 140 percent above the median in other developed countries. However, higher costs in the U.S. cannot be attributed to higher utilization of health care services, a greater supply of health care resources, or higher litigation expenses. The majority of the higher spending in the U.S. is attributable to higher prices for the same services.

The implication of this finding is that efforts to constrain spending that focus solely on health care utilization are not likely to have a significant impact. Controlling spending can only be achieved by addressing prices, which necessarily means achieving a careful balance between price and access and quality. Getting a handle on prices requires the creation of a health care system that is sufficiently integrated to leverage a degree of regulatory control.

³ Anderson GF, Reinhardt UE, Hussey PS, Petrosyan V. It's The Prices, Stupid: Why The United States Is So Different From Other Countries. *Health Affairs*, May, and /June 2003; 22(3): 89-105

Higher health care quality and lower health costs are directly related to the availability of primary care services.⁴ A robust body of research assessing both international and domestic U.S. variations in cost and quality has consistently associated higher quality care, improved health status, and lower health care costs with the availability of primary care.

The implications of this finding are that the benefits package under universal health insurance must ensure ready and universal access to primary care services, something that will not occur by simply providing an insurance card. In contrast to the current system, primary care providers must be adequately compensated for their services, and barriers faced by patients in accessing primary care must be lowered. Patient barriers include financial (co-payments and deductibles), geographic, and cultural and linguistic.

At its most fundamental level ensuring universal health insurance coverage means confronting our disjointed, fragmented health care system. Proposals to expand eligibility for current programs and provide tax breaks for health insurance premiums are all laudable. However, they amount to throwing significant amounts of additional money into a system that is already too expensive. Tinkering around the edges of the current system is not a sustainable strategy. The system itself must be confronted. While the creation of a health care system in Connecticut cannot be achieved in a single legislative session, you can be set in motion a process with clear goals, parameters, and timelines.

The decisions before you are monumental and difficult. No health care system can be created without some dislocations to revenue flows and employment. However, every evidence-based projection indicates that the net effect for Connecticut will be overwhelmingly positive. A deliberate transition to universal health insurance coverage that builds on the existing pluralistic system can moderate the dislocations and make them reasonably predictable.

⁴ Starfield B, Shi L, Grover A, Macinko J. The effects of specialist supply on populations' health: assessing the evidence. *Health Aff (Millwood)*. 2005 Jan-Jun;Suppl Web Exclusives:W5-97-W5-107. Fisher ES, Wennberg DE, Stukel TA, Gottlieb DJ, Lucas FL, Pinder EL. The implications of regional variations in Medicare spending. Part 1: the content, quality, and accessibility of care. *Ann Intern Med*. 2003 Feb 18;138(4):273-87. Fisher ES, Wennberg DE, Stukel TA, Gottlieb DJ, Lucas FL, Pinder EL. The implications of regional variations in Medicare spending. Part 2: health outcomes and satisfaction with care. *Ann Intern Med*. 2003 Feb 18;138(4):288-98.

The difficult decision to ensure universal health insurance will be only the first of many ongoing difficult decisions. No health care system is perfect or without controversy. A key element of a universal system is a sanctioned agency with the appropriate authority to make the ongoing decisions related to coverage, benefits, and costs. Such an authority will require access to a comprehensive set of evaluation data and the analytic capacity to turn those data into useful policy guidance. We strongly urge you to put data and evaluation high on the list of design elements for a universal health insurance system.

I greatly appreciate the opportunity to address the committee today and am happy to respond to any questions now or in the days ahead.

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The Connecticut Public Health Association is an organization of public health professionals affiliated with the American Public Health Association. CPHA has a diverse membership including local health directors, health care providers, educators, researchers, state Department of Public Health employees, and others.

