



Testimony on behalf of HB660

**Contact: Lesley Mills, Director/Owner
203 882-0831**

I am here to support Sustinet as a health insurance model because I own a homecare company with up to 500 employees who often float between the needs of elderly clients who contract with different employers. As such, it is impossible for one employer to cover them. I attach for you a diagram of where the money goes in our company. In order to offer the best caregivers, we spend 73% of our fees on the caregiver as opposed to the industry standard. By looking at our mission of a 1% profit margin, you will see that there is no where for health insurance premiums to go other than directly to the elders receiving care. Sustinet offers a method that is outside the traditional employer model.

But perhaps **my value today is to offer some history that puts Sustinet in good company.** Once upon a time, long, long ago (that would be 1970) in a foreign land far, far away (that would be in the bowels of Yale research) an unlikely cast of odd characters came together. There was the wizened male nurse, a professor at the School of Epidemiology and Public Health (John D. Thompson); There was the tenured professor of Administrative Sciences – the forerunner of Organization and Management - (Bob Fetter). Enter the young Ph.D. student who possessed the talent to create computer languages that would allow statisticians AND doctors to study millions of patient records, the first “on-line” interactive analysis. (Ron Mills).

And his English wife who knew enough about medicine, statistics and computer science to be dangerous but her sole talent was the ability to translate their findings into her native tongue so that others could grok it. (That would be me) To grok is to share the same reality or line of thinking with another, from Robert Heinlein’s best-selling 1961 book, Stranger in a Strange Land. I’m here today for you to grok this concept of Sustinet.

We worked for 3 years before coining the phrase Diagnosis Related Groups (DRGs) to describe what we thought would be a more rational way to predict the costs of, and reimburse hospitals for, treating Medicare patients. It took another seven years before the methodology went nationwide in 1981, determining the way in which hospitals have been reimbursed for Medicare patients for 28 years.

At a time when hospitals had always been reimbursed based primarily on the length of stay of each patient, the concept of defining different classes of patients for different reimbursement was revolutionary. It was also, to some, heresy.

There are many similarities between DRGs and Sustinet: both have overcome similar challenges in the complexity and scale of the problem; both have relied on the union of comprehensive economic and medical analysis; both offer opportunities in the improvement of quality beyond the presented problems of economy and fairness.

First, with Sustinet, there is the thoroughness of defining the problem. Over the last several years, the Universal Health Care Foundation has done a magnificent job of coordinating research by slicing through all the strata of every

sphere that had vested interest in health care. Employers of all sizes, industry types and seasonality were considered. Employees were included if they were on payroll or independent contractors, if they were full time, part time or unemployed, if they were native born or immigrant, English speakers or not. The needs of societal tribes were considered if they were heads of households, stay-at-home parents, dependent children, youths on college campuses or on the streets, our financially and physically independent elders or our frail and institutionalized elderly poor. And the health of the market players was taken into account whether they were providers, insurers or sales people.

Second, the presented solution was not developed by a political committee looking to solve some problems while protecting vested interests. Instead, the Foundation conducted its own research on advisors and selected two with deep working knowledge of the field: Stan Dorn, J.D., of the Urban Institute, and Jonathan Gruber, Ph.D., of MIT. The expertise of these men represents all the constituents, from government payors to self-payors, from the high tax bracket citizen to the uninsured child.

Third, Sustinet becomes economically viable as other vital changes to the health care delivery system are developed. Just as the advent of DRGs drove the improvement in the collection of medical records, so Sustinet requires a “medical home” for each person. This ‘medical home’ aggregates patient data across providers and payors providing rich opportunity to eliminate wasteful duplicative diagnostic testing while simultaneously providing opportunity for enhanced diagnosis. The scale of the ‘medical home’ for all patients allows Sustinet to take advantage of current and advancing technologies in data storage and manipulation. By comparison, the present state of dispersed medical data is woefully inadequate and more expensive.

Fourth, Diagnosis Related Groups offered many opportunities for analysis that resulted in better cost management and improved quality of care. For example, prior to 1981, the DRG for Acute Myocardial Infarction – heart attack – showed a highly consistent 21 day length of stay. Analysis of that DRG soon showed that there was little to no difference in outcomes for those patients who stayed 10 days or 30 days. Additionally, it was soon shown that those hospitals providing the greatest number of bypass surgeries had the most positive outcomes. A significant component of Sustinet is the requirement that all public and private insurers provide patient based anonymous data showing services, outcomes, quality of care and satisfaction. I look forward to the wealth of systemic improvement that this opportunity provides.

Finally, just as it made sense that there should be more than simply surgical or non-surgical patients for reimbursement, so it makes economic and ethical sense that all people should be afforded healthcare. And it makes sense that this care should be monitored from a central “medical home” that does not change due to age, or job change or insurer. Research has shown that the advent of DRGs has extended the Medicare Trust Fund by 18 years. I have confidence that a national Sustinet model with its underlying economics will yield an equally successful outcome if we provide the mandate. The DRGs were developed here but first tested in New Jersey. Let us be able to say, 28 years from now, that Sustinet was developed *and* tested in Connecticut.