In the Pursuit of Health:
Blueprint for a Healthier Florida 2013
The corporate mission of Florida Blue, Florida’s Blue Cross and Blue Shield Company, is “To help people and communities achieve better health.”
Introduction and Executive Summary

The corporate mission of Florida Blue, Florida’s Blue Cross and Blue Shield Company, is “To help people and communities achieve better health.” The Blueprint for a Healthier Florida is a high-level plan to transform our health care system comprehensively to deliver better quality care and value to patients and improve the health status of Florida residents. Five pillars support this plan: health care quality; health care cost; access to health care; the private marketplace and innovation; and public health.

The “Discussion” section of this document presents these pillars in detail. Successful health care reform rests on the comprehensive and coordinated incorporation of all five pillars. Essential to driving this holistic approach are delivery system and payment reform; increased consumer engagement; and a culture of wellness and prevention. The Executive Summary describes the relevance of these drivers and illustrates how the five pillars support them.

The Patient Protection and Affordable Care Act (ACA), and its accompanying Health Care and Education Reconciliation Act, were signed into law in March 2010. These measures have, and will continue to, prompt sweeping reforms. The ACA’s primary focus is to expand access to care by increasing coverage through the expansion of Medicaid eligibility, subsidies to purchase health insurance and other provisions such as the elimination of pre-existing conditions and guaranteed issuance of health insurance, among other things. While some provisions that were immediately effective have expanded coverage, those listed above will be the most significant levers, and they will not be effective until 2014. There are also provisions that implement quality and public health initiatives. While implementation of the ACA will go forward, litigation, the economy, debates regarding the national deficit and debt along with politics have made it difficult to predict the precise path of implementation. Furthermore, legislation of this magnitude will most certainly undergo perpetual tweaking.

Key Facts

- National health expenditures of the United States, estimated at $2.8 trillion, are 60 percent more per person than Norway, the second highest country in this category. According to national research, health care costs could be reduced by 30 percent while improving quality. Furthermore, the delivery system only provides evidence-based care 55 percent of the time.
- Providing better coordinated care to patients and paying for it in a way that emphasizes quality offers great opportunities to control health care spending.
- Florida Blue supports a universal coverage plan that is fiscally responsible, rests on personal responsibility and provides assistance to those who cannot afford coverage. Nearly four million Florida residents are uninsured, and the health care workforce, especially in primary care, is inadequate to serve the state. Provisions of the ACA slated to become effective in 2014 may result in substantially reducing the number of uninsured. However, the extent of the impact remains unclear due to a polarized political environment and negotiations regarding the national debt that could impact implementation of the ACA.
- Although Florida is better than national rates on some public health measures, there are significant opportunities for improvement in others. Approximately 65 percent of adults are obese or overweight, and approximately one-third of children are obese or overweight in Florida. AIDS and HIV incidence rates in Florida are higher than the national average. The data show significant health disparities among minority and low-income populations.

Delivery System and Payment Reform

Changing how care is provided, coordinated and financed is necessary to improve quality, increase access and control costs. Key policy proposals related to successful delivery system and payment reform focus on improving the quality and portability of information and using that information to align the incentives of patients, providers, and payers to focus to improve quality and control cost. Furthermore, a regulatory environment that facilitates a private market and strikes a balance between responsible innovation and consumer protection is essential to effectively reforming the delivery system and how we pay for care.
Improving the Quality and Portability of Information

Comparative effectiveness research (CER) and a viable health information network (HIN) are critical to improving the quality and portability of information. CER compares the effectiveness of new health care products to those already on the market. These efforts should define a set of standardized and manageable metrics to provide greater quality and cost transparency. Furthermore, it is essential to fund adequately the establishment of a viable HIN. This will allow for better utilization of data from CER efforts and facilitate better coordinated and safer provision of health care, all of which will result in better quality for patients.

Alignment of Patients, Providers, and Payers

Patients, providers, and payers must collaboratively focus on improving population health status. Implementation of accountable care organizations (ACOs) and other care models that focus on improved coordination will be crucial. Payment methods must incentivize the achievement of clear quality metrics and improved health outcomes in an efficient manner. This will require basing the compensation of providers on the quality, instead of the volume, of the service provided. Finally, while consumers also carry responsibility in achieving better health, providers and payers must engage them through the provision of education, tools, and resources to enable consumers more effectively.

Promoting Responsible Innovation and Protecting Consumers

Well-balanced regulation protects consumers while stimulating innovation. Regulations must allow the private market the flexibility to deliver health care product innovation iteratively and creative approaches to the coordination and delivery of services and health care financing. This will allow health care systems to evolve to the best solutions for their respective communities. Maintaining healthy competition within the delivery system so that consumers have choice, receive quality at a fair price, and have access to value added innovation is also essential. However, responsible innovation requires weighing potential risks and benefits and educating consumers about each. Furthermore, strategic and adequate regulation is required to eliminate unnecessary spending such as fraud, waste, and abuse that costs the health care system hundreds of billions of dollars annually.

Consumer Engagement

Better quality care and improvement of the health status of Florida residents requires active involvement of consumers. The ACA will bring more change to an
already complex health care system. Thus, it is critical that providers, payers, and public health professionals provide education, tools, and resources to help consumers engage the health care system and adopt healthier behaviors.

**Consumer Engagement and the Health Care System**

There are several things providers and payers can do to promote increased consumer engagement of the health care system. First, providers must share data in a way that protects the privacy of individuals but benefits the populations they serve. Providers and payers have data the other does not have. Sharing and analyzing these data will enable better understanding of the population they serve by identifying opportunities to improve their overall health. The identification of these opportunities will provide insight about education, tools, and resources that would be most helpful to consumers to enable them to become true partners with providers in making better informed health care decisions. This includes decisions regarding the delivery and financing of care.

**Consumer Engagement, Prevention and Wellness**

Adopting healthier habits offers the largest opportunity to improve the health status of Florida residents and Americans. While individuals must assume personal responsibility for living a healthier lifestyle, their environments must facilitate these healthier habits. Worksite wellness programs should be encouraged as they improve the health of employees and save employers money with respect to medical costs and improved productivity. Children must have healthy meals at school and opportunities to be physically active. Our communities need to be physically and environmentally safe to encourage physical activity. Consumers should be engaged through the provision of education, tools, and incentives to adopt healthier behaviors.

**Public Health, Wellness and Prevention**

Public health utilizes clinical, social and environmental levers to improve the health status of populations. The public and private sectors, along with community-based organizations, have a role in utilizing public health principles to impact positively the health of our communities. This includes clinical interventions and wellness initiatives.

**Public Health and the Safety Net**

The safety net includes clinics that provide free care to targeted populations, requirements for emergency rooms to provide care regardless of the ability to pay, and Medicaid and Medicare that provide insurance for low-income populations and seniors. Efforts to expand access to our most vulnerable populations are essential to achieving universal coverage. However, these programs must be designed to offer coordinated, quality care. Furthermore, these programs must improve the health of vulnerable populations while becoming more fiscally sustainable.

**Wellness and Prevention**

There are opportunities to improve the health status of Florida residents through wellness and prevention efforts. The proportion of people in Florida suffering from AIDS, HIV, overweight, and obesity are above national rates. These rates are higher among racial and ethnic minorities, and these populations also tend to have higher death rates from cancer, stroke, and heart disease. Furthermore, unintentional injuries are the third-leading cause of death in Florida, and the per capita rate of violent crimes is higher in Florida compared to the national average. It is essential that policy makers focus efforts on ailments that adversely impact residents of Florida the most, and focus on racial and ethnic minorities when they are impacted at an even higher rate than the general population. While some public health efforts have been clearly successful, the field must design and implement efforts to measure the impact of public health initiatives on outcomes.
Discussion

Health Care Quality

Background

We do not receive optimal value for our health care dollar. Overall, Americans receive evidence-based care only 55 percent of the time. The health care system subjects too many patients to substandard, unnecessary, and discordant services, along with an unacceptable level of medical errors. Nationally, measurable medical errors that harm patients cost an estimated $17.1 billion annually. Disparities in health and health care among populations based on race, income, education, and geography present an additional layer of complexity. Comparisons between Florida and national quality indicators are mixed. While the mortality rates of Florida adults for many chronic diseases are favorable to national averages, health indicators for Florida’s children are not. Most experts agree improvement of health care quality is attainable and necessary. Widely accepted research shows we could lower the cost of care significantly and improve quality. However, it is difficult to agree on who should measure quality, how it should be measured, and what decisions should be driven by those results.

The delivery of quality health care rests on a delicate balance of efficient allocation of limited resources among a population and patient-centered care. Quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Attributes of quality health care are: safety; effectiveness; patient-centered; timely; efficient; and equitable. These attributes incorporate subjective and objective criteria. All but the patient-centered criteria lean toward objective analysis to aid in efficient allocation of limited resources. Conversely, patient-centeredness and the advancement of knowledge over time are more subjective concepts due to inherent variability. Differences in the preferences, resources, education, health status, and environments of patients make it difficult to measure quality and establish a baseline.

Given the importance of its role, primary care offers a significant opportunity to improve health care quality. The Institute of Medicine defines primary care as “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.” This definition suggests that this is the most important component of the health care delivery system, and thus, an essential driver of quality health care. However, in the United States, it is the most neglected. Private purchasers, government, consumers, and clinicians all agree that the primary care system must be reformed.

Research suggests patient-centered models, instead of our current physician-centered model, is the best environment in which to deliver high quality and efficient primary care. The key functions of primary care are: first-contact care; comprehensiveness or concern for the entire patient; long-term person-focused care, including follow-up and compliance; and coordination among providers. Research suggests that practices in alignment with these functions results in higher quality and lower costs. Patients reporting a usual source of care receive higher quality care and are associated with lower utilization and lower costs. The Community Care of North Carolina serves as an example of successful implementation of the patient-centered model. This program links Medicaid and CHIP enrollees to community-based primary care medical homes; provides technical assistance to improve chronic care; and employs nurses, mental health workers, pharmacists, and other professionals to collaborate on high-risk cases. A 2011 analysis determined the program saved the state $1 billion in health care costs over the four-year period from fiscal year 2007 through fiscal year 2010.

The health care system must foster an environment to facilitate transformation and allow patient-centered models to evolve and thrive. First, there must be a set of standardized, meaningful, and manageable quality standards for providers. Second, measurement tools must consider the relationship between practice systems and quality of care. Third, payment models and regulations must allow evidence to inform the evolution of patient-centered models and create incentives to allow providers and payers to share the rewards of increased efficiency and the delivery of better quality care. Maintaining such an environment necessitates ensuring that there is adequate competition among providers, including vertically integrated provider systems, which facilitate innovation and the delivery of optimal value to patients. Fourth, patients should be educated about the essential functions of a primary care practice and the impact primary care has on health care quality and costs. Patient buy-in is crucial to improving quality.
of care. There must be effective efforts to educate consumers and facilitate better communication and engagement between them and their health care providers. Finally, the pipeline of primary care physicians and non-physician primary care clinicians must be bolstered to support a transformed primary care delivery model and provide adequate service to patients.

Greater health care expenditures do not translate into better quality care. Health care is supply-sensitive. This means that where there is greater capacity, more care is delivered, regardless of need. Research shows that Medicare spending varies more than three-fold across hospital referral regions, and this variation is almost entirely driven by volume, not price differences or severity of illness. Ironically, clinical and service quality tends to be inferior in higher-spending regions. As we continue to see a proliferation of medical technology, it is not only important to manage it because of cost. New technology that creates new procedures creates an opportunity to improve care. However, if we do not understand the marginal value that new technology brings to the health care system, it introduces the possibility of needlessly increasing cost, causing harm, or both.

The ACA provides for initiatives regarding improving the quality of care, however more efforts are needed. It mandated the establishment of a national strategy and priorities to improve the delivery of health care services, patient health outcomes, and population health. The latest progress report lists six priorities of the national quality strategy:

1. Reducing harm in care delivery;
2. Patient and family engagement as partners in their care;
3. Effective communication and coordination of care;
4. Promoting effective prevention and treatment practices of leading causes of death;
5. Promotion of healthy living in communities; and
6. Making care more affordable through alternative care models.

The ACA also requires the strategic plan to align public and private payers with regard to quality and patient safety efforts. There are also provisions that promote comparative effectiveness research, patient engagement, care and reimbursement models that pay for quality instead of quantity, quality indicators in the Medicare and Medicaid programs, and other topics to address quality of care. The concepts behind these initiatives offer promise for improved quality, however the health care system must continue to learn from these types of initiatives and evolve.

**Proposed Solutions**

**Compare the effectiveness of new health care products and services to those already on the market.** This effort should seek to define a set of standardized and manageable metrics to provide greater quality transparency with respect to health care delivery. Furthermore, there should be an effort to translate and package this research so that patients can utilize it to make informed decisions. The ACA creates the Patient Centered Outcomes Research Institute (PCORI) for the purpose of comparing clinical effectiveness. However, there must be efforts to

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provide consumers with comparative information regarding cost and quality so they can make value-based and informed decisions.

**Provide sufficient funding for the establishment of a viable health information network.** To transform the health care system, it is important that providers adopt interoperable health information technology to allow information to flow seamlessly and securely. This is essential to improving quality and coordination and lowering costs by eliminating unnecessary or even harmful provision of care. Successful implementation of a viable health information network requires measures to protect privacy and public education regarding those measures.

**Continue efforts to explore alternatives to fee-for-service payment models that will emphasize quality over quantity.** These include pay-for-performance and other models that emphasize the quality of care delivered and sharing of medical savings, and risk, between purchasers and providers. These innovations must be coordinated with efforts to leverage patient behavior and preferences to align the incentives of patients and providers. Health insurers, through their experiences with value-based benefit design and insurance design are well-positioned to provide data to aid these coordination efforts.

**Promote the implementation of primary care models that evidence has shown to improve quality and lower costs.** This includes models where patients have a “usual source of care” and where primary care providers provide first-contact care; comprehensive care; long-term person-focused care; and coordination across providers. Governments and private purchasers should look to successful models to provide care to their customers.

**Initiate robust efforts to address health care disparities and health literacy.** The health care system must seek to eliminate variations in the quality of health care delivered to different populations ... Furthermore the public and private sectors can develop and encourage health literacy outreach programs so consumers have opportunities to comprehend information they receive from the health care system.
Cost of Health Care

Background

Health care cost trends are unsustainable. National health expenditures for 2012 are estimated to be $2.8 trillion and are projected to rise to $4 trillion by 2018.\(^8\) Health care costs consistently outpace inflation; thus, health care consumes more and more of national gross domestic product each year. American health care spending per capita is more than two-and-a-half times than that of most developed nations in the world, including relatively rich European countries like France, Sweden and the United Kingdom.\(^9\) Furthermore, health care costs are concentrated. Just one percent of the population accounted for approximately 22 percent of total health care expenditures in 2009, and half of the population accounted for nearly 93 percent the costs.\(^10\)

Florida personal health care expenditure trends mirror those of nation. Between 1991 and 2009, annual Florida personal health care expenditures rose at an average rate of 6.9 percent, compared to the national average of 6.5 percent. In 2009, Florida personal health care expenditures totaled $132.5 billion. While the average rate of growth of expenditures for hospital and physician care coincides with national averages for those two categories between 1991 and 2009, the average growth rates for prescription drug expenditures outpaced the national average by nearly two percent.\(^11\) Also, for state fiscal year 2011-2012, approximately 32 percent of Florida’s $69 billion budget was tied to Medicaid.\(^12\) Furthermore, overall average Medicare reimbursements per enrollee in Florida are more than 15 percent higher than the national average and far beyond the 90th percentile.\(^13\)

Fraud and waste also inflate the cost of care. For obvious reasons, it is difficult to measure fraud or waste precisely. The Federal Bureau of Investigation estimates that fraudulent billings to public and private health care payments comprised three to 10 percent of total health spending in fiscal year 2009, or $75 to $250 billion.\(^14\) A number of situations can encourage waste. However, defensive medicine is one of the largest drivers. Fear of litigation prompts physicians to perform diagnostic or therapeutic procedures that are not medically necessary but may serve as protection if a medical malpractice claim is made against them. Estimates regarding the overall annual medical liability system costs, including defensive medicine, range from $56 billion to $210 billion. Although difficult to measure, approximately 80 percent of this amount is attributable to defensive medicine.\(^15\) Furthermore, the cost of medical malpractice insurance has caused some doctors to eliminate certain services, flee certain states, or cease practicing medicine entirely.

Another factor that will have a larger impact on health care costs is lifestyle and healthy behaviors. One study asserts that 87.5 percent of health care claims are due to an individual’s lifestyle.\(^16\) Due to rising overweight and obesity rates, today’s youth are experiencing early onset of type-2 diabetes and other chronic conditions. Unless adults and children adopt healthier behaviors, more people will have expensive chronic conditions for a longer period of time.

Consumers must have information and tools to help them make decisions that lead them to the best care. Research shows that presenting cost data to consumers along with understandable quality information and highlighting high-value options help them understand that high cost does not always equate to high quality.\(^17\) Furthermore, there is great need to improve the understanding of consumers with respect to the concepts of “medical evidence” and “quality guidelines.”\(^18\)

There is convincing evidence that wellness programs lower medical costs and improve health. A review of studies on the impact of wellness programs on medical costs found that medical costs decrease $3.27 for every dollar spent on wellness programs and that absenteeism costs decreased $2.73 for every dollar spent.\(^19\) Large employers, however, are more likely to have wellness programs than small employers.\(^20\) This is important because Florida has a high concentration of small businesses.

We can bend the health care cost growth curve and improve the quality of care. Achieving this objective is predicated on realizing the potential impact of the expansion and improvement of primary care. While researchers have pointed to the emergence and widespread adoption of new medical technology and services as a significant driver behind real growth in health care spending,\(^21\) recently, consolidation in the delivery system has come to play a significant role in cost growth as providers position themselves to engage alternative reimbursement models, particularly Medicare ACOs. Other factors contribute to unnecessary cost such as provider incentives focused on producing more care instead of better care, lack of standardized and manageable quality standards, lack of care coordination, excessive fraud, waste, and abuse, and a flawed tort law system that encourages overutilization.
Proposed Solutions

Provide education, tools and resources to consumers to drive quality improvement and healthier behaviors. Currently, price is the primary cue for quality for many consumers. Tools and education along with the guidance of providers motivated to provide quality care are essential to assisting consumers in making informed health care decisions. There should also be incentives and penalties to stress personal responsibility in leading a healthy lifestyle. However, economic and other societal barriers should be mitigated to allow those who are disadvantaged an opportunity to engage a healthier lifestyle.

Maximize efforts to drive fraud, waste and abuse out of the system through aggressive law enforcement, tort reform and engaged consumers. The FBI estimates that fraud is responsible for three to 10 percent of health expenditures. National estimates for expenditures on defensive medicine (unnecessary procedures in response to fear of medical malpractice claims) range from $56 billion to $210 billion. The ACA allows for the provision of grants to states for development, implementation, and evaluation of alternatives to current tort litigation, and it extends federal malpractice protections to a free clinic’s nonmedical personnel, but more effort is needed to address this issue.

Incentivize investment in wellness programs through grants and tax credits. Research clearly shows that worksite wellness programs improve employee health, lower medical costs, and increase worker productivity. Public policy should motivate employers, especially small employers, to implement these types of programs.

Maintain competitiveness in the delivery system. It is important to maintain an environment that invites healthy competition within a market so that consumers have choice, receive quality at a fair price, and are privy to value-added innovation. This is especially important as the health care system experiments with alternate care and reimbursement models.

Access to Health Care

Background

The two essential components to access to care are: 1) the ability to pay; and 2) the availability of health care services. As of 2010 approximately 50 million Americans, or 16.3 percent of the population, were uninsured. In Florida, this number is approximately 3.9 million, or 21 percent of the population. Small business has had difficulty maintaining health insurance, and the overall proportion of health insurance provided by employers has declined.

The uninsured population consists of four groups: 1) those who are eligible for government programs, but are not enrolled; 2) those not eligible for public assistance but cannot afford private coverage; 3) those who cannot obtain insurance due to pre-existing conditions and do not have access to insurance through an employer; and 4) those who can afford coverage but choose not to purchase it.

Those who do not have insurance often delay getting care until their ailments become more acute. Consequently, they consume more expensive services in more expensive settings than if they were to get appropriate care earlier in the appropriate setting. Ultimately, taxpayers and those who purchase private insurance pay the cost for care provided to the uninsured, and that care is often inefficiently delivered.

Greater access to care depends, in part, on expansion of access to adequate coverage. Expansion of coverage, however, must be done strategically. Those who cannot afford coverage should have adequate and appropriate assistance. Those who can afford coverage must choose participation or pay an adequate financial penalty. The most efficient method of distributing access to coverage is through employers. Administrative economies of scale are realized when people are insured in larger blocks. Nearly 70 percent of the uninsured in Florida are full-time employees of firms with fewer than 50 employees. More than 40 percent of the uninsured in Florida are employees of firms with fewer than 10 employees. Nationwide, the health insurance premiums of those in small businesses more than doubled between 1999 and 2009.

The ACA has many provisions to expand access, and most are based on the ability to pay through expansion of coverage, premium assistance, guaranteed issue, and the individual mandate. The legislation provides for a high-risk pool through December 31, 2013, and then, in 2014, it requires everyone to purchase insurance or pay a penalty. This along with subsidies for health insurance...
premiums for those up to 400 percent of the Federal Poverty Level (FPL) and the ability to expand Medicaid eligibility provide a broader pool of insured people which will absorb the cost of those with pre-existing conditions. The ACA will eliminate the ability to exclude individuals from coverage due to pre-existing conditions in 2014.

The value of health insurance, however, is predicated on the availability of health care services. Current trends regarding primary care physician supply portend a crisis. In 2007, a survey of fourth-year medical students indicated that only seven percent planned careers in adult primary care. Florida statistics are slightly worse than the national numbers. Florida has 78.1 active primary care physicians per 100,000 people, giving it a national rank of 29. Health care workforce experts estimate 11.2 percent of the population in the United States is underserved regarding primary care, compared to 15.1 percent in Florida. A widening income gap between primary care physicians and specialists, in favor of specialists, in the face of increasing educational debt drives these trends. The ACA has provisions that seek to address these issues. This includes increased reimbursements for primary care physicians, grants for workforce planning, as well as provisions for increasing the supply of the workforce among advanced non-physician practitioners, public health professionals, and pediatricians.

We cannot rely on the current supply and pipeline of non-physician primary care clinicians to address this shortage. Current projected graduation rates of nurse practitioners and physician assistants entering primary care are not sufficient to close the projected gap between demand and supply of primary care services.

**Proposed Solutions**

Aggressive outreach to those who are eligible for public programs but are not enrolled. This population is primarily composed of low-income children and their parents. It was estimated that approximately 72 percent of uninsured children in Florida were eligible in 2007 for free or subsidized KidCare coverage. Emphasis should be placed on children between 12 and 18 as they represent more than 50 percent of the uninsured children in Florida. Consideration must be given to organizations that possess the cultural competence and other capabilities necessary to reach these populations.

Increase income eligibility limit for Medicaid for the entire adult population. In Florida, more than 27 percent of the uninsured have incomes less than 100 percent of FPL. Another 22.7 percent of the uninsured have incomes between 100 and 150 percent of FPL.

Establish appropriate reimbursement levels in the Medicaid program. Although health care reform has provided temporary parity in Medicaid and Medicare fees for primary care physicians in 2013 and 2014, Medicaid historically has reimbursed providers less
than Medicare, leading to reduced access among the Medicaid population, because fewer providers will accept Medicaid’s lower reimbursement.\textsuperscript{47}

**Guaranteed issue and the elimination of pre-existing conditions combined with an adequate individual mandate are essential to sustainable universal coverage.** Universal coverage requires protection for people with pre-existing conditions, and program sustainability requires inclusion of healthy people in the health insurance pool. As such, an individual mandate should be enacted at the state level.

**Provide incentives to small employers to offer employer-sponsored coverage.** Price sensitivity to health insurance premiums decreases as employer size increases. The majority of the uninsured are employed by firms with fewer than 50 employees. Provide assistance to these firms through refundable tax credits to provide incentives that offer and subsidize coverage for their employees.

**Provide incentives to expand the capacity of the primary care workforce and bolster the pipeline of primary care physicians and advanced non-physician practitioners.** This includes loan forgiveness programs and adequate reimbursements for cognitive tasks, care coordination provided outside of the office visit and providing access to patients either during the day or after hours. Reimbursements for consultation via phone or email would enable this capability. Payment models, however, should focus on the quality of care provided to each patient, not the quantity. Also, geographical areas that suffer most from shortages of primary care are those containing under-represented minorities and rural communities. We must increase the number of providers who have strong connections to these communities as they are likely to practice there. Increasing Title VII funding under the Public Health Service Act for federal grants for primary care training would be effective as physicians exposed to underserved areas are more likely to practice in those areas. Finally, access to primary care must be expanded in rural communities through incentives and the use of health information technology.

### The Private Market and Innovation

**Background**

Innovation is crucial to health care in the United States. Innovative care-process change occurs when: 1) consumers are actively engaged in behavior that mitigates disease or improves purchasing; 2) safer and more effective drugs or devices are developed and adopted; 3) clinicians deliver more rapid, appropriate, and reliable care; 4) unnecessary tests and therapies are eliminated; or 5) supply chain costs are systematically lowered.\textsuperscript{48} These advancements are needed to improve health care quality, expand access to care, and contain uncontrollable health care costs.

The private market, particularly venture capital, has a strong record for producing innovation. Studies suggest that a dollar of venture capital appears to be more than three times as potent in stimulating patents as a dollar of traditional research and development.\textsuperscript{49} This may explain why total venture capital investment averaged less than three percent of total corporate research and development dollars during the 1990s but contributed to more than 15 percent of patent filings.\textsuperscript{50} For the period between the third quarters of 2010 and 2011, however, the number of health care venture deals declined 22 percent. The reported driver of this decline was an unfriendly regulatory and uncertain exit environment.\textsuperscript{51}

Public policy must balance the need to protect consumers, facilitate price and quality transparency, and maintain an environment that encourages investment in the development of products and services that produces innovative care-process change. This requires the discovery of revolutionary products and services along with the flexibility to construct business models that allow those products and services to maximize their productivity. This does not happen when products and services that are less costly, and of the same or better quality, than their predecessors are required to be delivered in an unnecessarily complex and costly infrastructure.\textsuperscript{52} When productivity is not optimized, maximum value is not delivered to consumers. Furthermore, public policy must align the pecuniary interests of investors with the goals of improving health care quality and outcomes. One example of alignment between pecuniary and public health interests occurred in 1997 when the federal government granted six months of market exclusivity extensions to companies that conducted pediatric safety studies for certain products.\textsuperscript{53} The Pediatric Exclusivity Provision was renewed in 2007 and again in 2012.\textsuperscript{54}

A private health care financing system is crucial to innovation. First, private health insurance is the dominant health care financing mechanism among Americans and Florida residents. In 2010, approximately 196 million Americans and 10.6 million people in Florida were covered by private health insurance. This translates to 63 percent and
56 percent of Americans and Florida residents, respectively. Second, private payers have produced several innovative models aimed at improving quality of care while containing cost. A robust private financing system creates incentives for innovative products and services to add value to the health care system.

Various health insurers, including Florida Blue, have invested in and implemented innovative solutions that promote patient-centered care and emphasize quality and value over volume of care delivered. These efforts focus on outcomes and have resulted in the reduction of unnecessary medical and administrative costs while improving quality. Florida Blue has established ACO programs with providers. In 2009, Blue Cross and Blue Shield of Massachusetts implemented the Alternative Quality Contract which is a fixed payment contract with a payment and bonus structure connected to quality goals and defines the rate of increase for each contract group’s budget over a five-year period. This effort has received high-level praise for its creativity and early success. Continued investments are necessary to improve quality and bend the cost curve over the long term. The private market must be encouraged to continue to experiment to explore the full range of solutions.

Cost shifting from the public sector to the private sector should be minimized. Currently, the private marketplace inconspicuously subsidizes public programs. Between 2000 and 2006 Medicare and Medicaid failed to reimburse hospitals in amounts adequate to cover the cost of the care hospitals provide to those patients. In order to maintain viability, hospitals calculate these losses into their negotiations with private payers. This subsidy from private payers is estimated to be approximately $89 billion annually. Instead of ignoring this phenomenon, there must be efforts to make health care affordable through the relentless pursuit of innovative care and business models.

Proposed Solutions

Government at all levels should engage in sound policymaking that protects consumers and allows for responsible innovation in health care delivery and financing. Regulation should be maintained at the state level as state governments are best equipped to monitor the solvency and consumer practices of health insurers. Health insurers operating within a state should all be subject to the same solvency rules and mandates to maintain a level playing field and healthy competition. Laws and regulations must balance sufficient protection of consumers with the allowance of sufficient choice. It is essential that a greater number of younger, healthier people who can afford health insurance purchase it. It is essential that this population have acceptable price points to enter the health insurance pool.
The government should adequately finance public programs to prevent cost shifting to the private market. Under reimbursement of providers by Medicare and Medicaid result in tens of billions of dollars in medical expense shifted to those who purchase private insurance. This contributes to the inefficiency of the financing of health care and is unfair to consumers and employers who pay private health insurance premiums.

Legislators and regulators must align goals for improved health quality and cost containment with the pecuniary interests of investors who drive innovation. The regulatory environment must allow for flexible business models to allow innovative products and services to provide maximum productivity. CER and other tools must be utilized to increase price and quality transparency. Regulatory adjustments must be made to incent market behavior that results in improved health care quality and public health.

Design health insurance exchanges to offer a range of choices to fit the needs and preferences of consumers of health care. Exchanges should be state-based, regulated at the state level, and have low barriers to entry and exit to encourage participation among health insurance carriers. As exchanges develop, the preferences of health care consumers will evolve. Flexibility must be maintained to allow exchanges to adjust to these evolutionary preferences.

Public Health

Background

Discussions regarding the health status of a population lean heavily on three terms: 1) public health; 2) population health; and 3) social determinants of health. Public health relies heavily on prevention and focuses on impacting health status at the population level, versus the individual level, through a variety of clinical, environmental and social levers. Population health is the health outcomes of a group of individuals, including the distribution of such outcomes within the group. The social determinants of health are the conditions in which people are born, grow, live, work, and age, including the health system. In short, population health is the health status of a defined group of people; social determinants of health are the environmental and
social conditions that impact that group; and public health are the amalgamation of clinical, environmental and social levers used to improve population health through, in part, improving the social determinants of health.

Although Florida is favorable on some disease and mortality measures compared to other states, it does not fare well in others. Florida’s HIV rate is twice the national average. The teen and child death rates are also slightly above the national average. More than 10 percent of persons are diagnosed with AIDS and 12 percent diagnosed with HIV in the United States live in Florida. The hospitalization rates due to heart disease, stroke and heart failure are above national rates. Overweight and obesity rates for children and adults in Florida, 33 percent and 65 percent, respectively, are slightly above national levels. Smoking rates among adults are close to the national rate at 17.1 percent. Conversely, Florida tends to fare well when compared to national death and incidence rates for many types of cancer, including lung, colorectal, breast and prostate cancer. Cancer, however, is the leading cause of death in Florida. Furthermore, Florida has a lower death rate and higher life expectancy than the national rates.

A number of socioeconomic and societal indicators suggest there is significant opportunity for Florida to improve its health status. With 21 percent of its population uninsured, Florida ranks third in the country in this category. Sixteen percent of Florida’s children are uninsured, compared to 10 percent nationwide. Twenty-four percent of children under 200 percent of the poverty level are uninsured in Florida compared to 15 percent in the United States. As mentioned earlier, a greater percentage of Florida’s citizens live in primary care shortage areas compared to the nationwide average. Also, 542 violent crimes were committed in Florida per 100,000 residents, compared to 404 nationwide. Finally, unintentional injuries are the third-leading cause of death in Florida. Furthermore, Florida has a lower death rate and higher life expectancy than the national rates.

Health disparities, along with national trends, are stark in Florida. The infant mortality rate and diabetes death rate among blacks in Florida are double those of whites. Although whites in Florida have a higher incidence rate of cancer, blacks have a higher death rate. The death rate among black Florida residents from heart disease is also significantly higher than that of whites. There is also a higher rate of obesity and poverty among blacks and Hispanics in Florida.

Budget cuts to vital public health agencies and programs at both the federal and state levels have taken their toll. In 2011, Florida lawmakers cut $55.6 million from the state health department’s $2.9 billion budget, leading to hundreds of layoffs statewide. Three-fourths of those laid-off worked at county health departments. In 2010, Florida’s county health departments suffered a $30 million budget cut statewide. Children’s medical services, in particular, were cut by approximately $2.5 million. There was also a $5.4 million cut to Healthy Start Coalitions, community-based prenatal care centers for at-risk mothers and babies.

Through agencies such as the Centers for Disease Control and the Health Resources and Services Administration, the federal government plays a leading role in public health. The Centers for Medicare and Medicaid Services (CMS) plays a significant fiscal role through the administration of two public programs that finance care for low income groups and seniors, Medicaid and Medicare, respectively. Furthermore, there are many provisions throughout the ACA that address public health. These provisions focus on modernizing disease prevention and public health systems, increasing access to clinical services, creating healthier communities, and support for prevention and public health innovation. These provisions seek to utilize the clinical, social and environmental levers to improve public health and addresses child health, aging, oral disease prevention, and obesity, among other things. It also calls for a National Prevention, Health Promotion and Public Health Council Strategy.

Like other aspects of health care, return on investment regarding public health spending is unclear. Preventive care, while lowering the cost of care for some individuals, can often raise aggregate costs. These costs, however, are justifiable when the service results in better quality health care and a better quality of, and longer, life. A recent study analyzed spending by local public health agencies over a 13-year period and determined rates of community mortality from preventable causes of death (cardiovascular disease, diabetes, and cancer) fell between 1.1 percent and 6.9 percent for each 10 percent increase in local public health spending. These results suggest that increased public health investments can produce measurable improvements in health, especially in low-resource communities. However, more money alone is unlikely to generate significant and sustainable health gains. Improvements in public health practices such as the tracking of public health spending and the impact of those dollars are needed as well. Communities may vary considerably in how effectively and efficiently resources are used to address community health
Estimates consistently indicate that less than five percent of national health spending is devoted to public health activities. However, more data are essential to making informed decisions regarding the marginal benefit of additional dollars allocated to public health and where those dollars would have the most impact.

needs. Research documents disconnections between spending and outcomes in local medical care delivery. On balance, there is very little empirical evidence about the extent to which differences in public health spending levels contribute to differences in population health. Estimates consistently indicate that less than five percent of national health spending is devoted to public health activities. The United States spends more on administrative overhead for medical care and health insurance than it does on public health activities. However, more data are essential to making informed decisions regarding the marginal benefit of additional dollars allocated to public health and where those dollars would have the most impact.

Proposed Solutions

Design and implement efforts to measure the impact of public health initiatives on outcomes. This is imperative to understand the impact of public health initiatives and to make persuasive requests for funding of public health efforts. It would also allow for informed decision making about how to allocate funding regarding public health so that the impact of scarce investment dollars are maximized.

Assess and implement public health initiatives to educate and encourage healthier lifestyles to prevent early onset of expensive chronic diseases. Heart disease and cancer are the top two leading causes of death in Florida. Although obesity and smoking rates reflect national rates, there is significant opportunity for improvement. However, current efforts to address these issues should be assessed to determine the most effective methods to achieve additional improvement.

Assess opportunities to impact major causes of death and prioritize efforts and funding accordingly. The top five major causes of death in Florida are heart disease, cancer, chronic lower respiratory disease, unintentional injuries and stroke. Current public health efforts in these areas should be examined to determine if funds are allocated in a way that maximizes the marginal benefit of the last dollar spent on such programs.

Maximize efforts to address determinants of health, with a keen focus on children. Children must reside in a stable, safe, and healthy environment. This maximizes their ability to obtain a good education when it is available to them. This in turn increases their ability to obtain higher levels of education which is correlated with higher income and improved health status.
Endnotes


6 Committee on Quality of Health Care in America, Institute of Medicine, “Crossing the Quality Chasm: A New System for the 21st Century,” 2001, National Academy Press.


13 Ibid.


17 Patient Protection and Affordable Care Act, Section 6301, Public Law 111-148, 124 Stat. 609.


30 Ibid.


32 Patient Protection and Affordable Care Act, Section 10607, Public Law 111-148, 124 Stat. 891.

33 Patient Protection and Affordable Care Act, Section 10608, Public Law 111-148, 124 Stat. 896.


36 Ibid.

37 Patient Protection and Affordable Care Act, Section 1101, Public Law 111-148, 124 Stat. 23.


40 Patient Protection and Affordable Care Act, Section 1201, Public Law 111-148, 124 Stat. 36.


46 Ibid., p. 7.


55 U.S. Census Bureau, “Table HIA-4. Health Insurance Coverage Status and Type of Coverage by State – All People: 1999 to 2010.”


57 Will Fox and John Pickering, “Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers” Milliman, Inc. prepared for America’s Health Insurance Plans, the American Hospital Association, the Blue Cross Blue Shield Association, and Premera Blue Cross, December 2008, p. 6.

58 Ibid. p. 2.


The corporate mission of Florida Blue, Florida’s Blue Cross and Blue Shield Company, is “To help people and communities achieve better health.”