Anthony Keck, Director, South Carolina Health and Human Services
Summary of Testimony to the Subcommittee on Health, Committee on Energy and Commerce
Wednesday, June 12, 2013

- The Institute of Medicine estimates up to 30 percent of health care spending is waste while we fall further behind on health status compared to the rest of the world.
- Years of public health research concludes the primary drivers of health and well-being are income, education, community and family support, personal choices, environment, race, and genetics. Health care services contribute to a much lesser extent.
- Despite this evidence, our health system is built on the tenuous logic model that health insurance leads to access to effective health care services, which leads to health. Health care spending crowds out other important personal, business, and government spending.
- We need to pursue strategies that according to David Kindig, et al. "include redirecting savings from reductions in health care inefficiency and increasing the health promoting impact of policies in other sectors such as housing and education," and promote local examination of "outcomes and determinants of health to determine what cross-sectoral policies would address its own situation most effectively and quickly."
- Medicaid currently treats states more like sub-contractors operating at a discount than partners contributing over 40 percent of the bill. Deviations from the norm require state plan amendments and special waivers, which may give the illusion of accountability, but promote neither quick and effective local solutions nor cross-sectoral solutions.
- Currently there are few, if any, long-term population health goals negotiated between states and the federal government. Despite federal efforts to manage expenditures through maintenance of effort requirements, limiting state revenue maximizing strategies, and focusing on fraud and abuse, Medicaid spending grows as access to health services suffers.
- There is developing interest among states for flexibility to manage programs locally in exchange for more accountability for improved health and more predictability in expenditures at the state and federal level.

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Good morning Mr. Chairman and members of the subcommittee. My name is Anthony Keck, and I am the South Carolina Director of Health and Human Services, the state Medicaid agency. I appreciate the invitation to discuss my thoughts on improving health through Medicaid.

While we don't run a $6 billion agency on anecdote, I'd like share a simple story with you that sums up our challenge.

I once ran a community clinic in a poor but vibrant and politically active New Orleans neighborhood known as the St. Thomas/Irish Channel. During that time, I took part in a focus group of pregnant teenage girls enrolled in Medicaid who were participants in a separate citywide program that matched each girl with a doula – a birthing coach – to help her better connect to the health care system and prepare for motherhood.

One conversation still stands out. Paraphrasing her almost 20 years later, one of the participants said with exasperation near the end of our time together "Look, I love my doula and my doctor and I appreciate all the help they give me, but I've slept on a different couch almost every night for the past three weeks, and that's why I'm really having a hard time."

The limits of our programs, expressed in the statement of that teenager, are clear. She needed stable housing, what we had were doulas. Her personal struggle captures the truth that years of public health research on social determinants of health has revealed: the primary drivers of health and well-being are income, education, community and family support, personal choices, environment, race, and genetics, while health care services contribute to a much lesser extent.[i]

Yet our health system is built on the tenuous logic model that health insurance leads to access to effective health care services, which leads to health. We are so beholden to this common wisdom that even though the Institute of Medicine estimates up to 30 percent of all health care spending is waste[ii], we now spend almost 18 percent of our paycheck, payrolls, and government budget on health care services[iii] while we fall further and further behind on health status compared to the rest of the world.[iv]

David Kindig, one of the country's leading public health researchers, recently wrote that for all of our health spending, mortality increased for women in 43 percent of US counties between 1992 and 2006 – with no correlation to medical care factors such as health insurance status or primary care capacity. He calls for a robust strategy to address this appalling trend:

> "Such a strategy would include redirecting savings from reductions in health care inefficiency and increasing the health promoting impact of policies in other sectors such as housing and education."

He goes on to say that:

> "Each county…needs to examine its outcomes and determinants of health to determine what cross-sectoral policies would address its own situation most effectively and quickly."[v]

Yet Medicaid today operates under the default position that different populations and geographies face similar challenges and equity in health insurance benefits is the goal of the program rather than improvement in population health. Medicaid currently treats states more like sub-contractors operating at a discount than partners contributing over 40 percent of the bill. Deviations from the norm require state plan amendments and special waivers, which may give the illusion of accountability, but promote neither quick nor effective local solutions nor cross-sectoral solutions, which consider public health, education, housing, employment, food security, personal responsibility, and community action as important contributors to achieving better health and well-being.

The truth is there are few, if any, long-term population health goals currently negotiated between states and the federal government so it is no wonder that we cannot agree on

Medicaid's value. In addition, for all the federal efforts to manage expenditures through maintenance of effort requirements, limiting state revenue maximizing strategies, and focusing on fraud and abuse, the program continues to grow while access to health services suffers.

I believe there is a developing bi-partisan interest among states for flexibility to manage programs locally in exchange for more accountability for improved health and more predictability in expenditures at the state and federal level. I ask you to consider the proposals both before you and in development that would accomplish this goal.

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[i] Centers for Disease Control and Prevention. *Social Determinants: Frequently Asked Questions.* Retrieved online: http://www.cdc.gov/socialdeterminants/FAQ.html

[ii] Institute of Medicine. 2010. *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary*. Washington, DC: The National Academies Press.

[iii] Center for Medicare and Medicaid Services. *National Health Expenditure Projections 2011-2020.* Retrieved online: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf

[iv] National Research Council. (2011). *Explaining Divergent Levels of Longevity in High-Income Countries.* E.M. Crimmins, S.H. Preston, and B. Cohen, Eds. Panel on Understanding Divergent Trends in Longevity in High-Income Countries. Committee on

Population, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press.

[v] Kindig, David, A., Cheng, Erika, R. (2013). *Even As Mortality Fell In Most US Counties, Female Mortality Nonetheless Rose In 42.8 Percent Of Counties From 1992 To 2006.* *Health Affairs*. March 2013 32:3451-458.