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Honeywell is a multinational corporation based in the United States with approximately \$30 billion in revenue and 120,000 employees worldwide. We have 65,000 employees in the U.S. and 55,000 of them participate in Honeywell medical plans. The remaining 10,000 workers – usually younger and single people – have opted out generally because of the cost, or because they have coverage through a spouse's plan. In addition, Honeywell covers 45,000 retirees through a variety of plans. In all, Honeywell covers over 230,000 employees, their families and retirees.

This year Honeywell and its employees will spend a total of \$728 million on health care. \$517 million will be spent on our active employee population for medical care, with the company bearing \$331 million of those costs. We don't cover 100% so employees will spend an additional \$186 million (\$96 million through premium contributions and \$90 million through out-of-pocket expenses such as coinsurance and copays). Employees pay 23% of the medical premium, however, when you include out-of-pocket expenses, employees pay on average 36% of the cost. In the last 5 years (using 2000 as a base year), the total employee per capita spend has almost doubled (up 80% or 16% per year). The employee portion of that has grown even faster as their proportion has grown from 24% to 36% as we tried to increase employee activism in choosing care wisely. Factoring in dental care (\$46 million) and retiree medical (\$165 million) makes the \$728 million Honeywell spends on health care one of the largest corporate expenditures second only to payroll.

With that preamble, it's clear this is a big deal for Honeywell and our employees. I applaud CNBC, Governors, and Senators here today for having this Forum.

As you might expect, we support those efforts focused on reducing paperwork, improving patient records and safety, and of course reforming medical malpractice. These issues clearly need to be addressed.

Today, I'd like to advance an additional priority. It's based on the idea that better outcomes for patients yield lower costs. Process work in a number of areas over the last two or three decades has repeatedly demonstrated that quality isn't costly, in fact it saves money. Quality doesn't mean more and more tests. It means the right care at the right time at the right place. We should look at the entire process - from diagnosis to recovery - that impacts a patient's outcome. Better outcomes, lower costs.

We have a good health care system but we also have a lot of potential to be better. The healthcare industry is huge and in many areas it is very fragmented, almost a cottage industry. High fragmentation yields high variability in results... not just in costs but especially in outcomes.

Like other private and public employers, Honeywell has asked employees to pay a greater share of their total healthcare costs in an attempt to encourage more consumer focus. We are incentivizing employees to become even more involved in care selection. You would think people would already be intimately involved in their own healthcare, but in practice, they are not. One of the reasons is a lack of available and understandable information. We believe by making employees more financially impacted by their healthcare decisions, they will make more informed decisions. But they need access to accurate information.

Honeywell is trying to address this issue in three ways. The government could be instrumental in each of them resulting in better patient outcomes and lower costs. Everybody wins.

The three areas of focus are:

- 1 – Is the recommended remedy the right one for the patient?
- 2 – What’s the historical quality of patient outcomes for hospitals and physicians?
- 3 – How do we address chronic care conditions?

I. Starting with the first... is the recommended remedy the right one for the patient?

Studies have shown that despite the high technical proficiency in health care, best practices travel very slowly. As well intentioned as physicians are, a 1997 study in the New England Journal of Medicine concluded it takes physicians on average three years to learn of a best practice and seven years to adopt it. A 2003 New England Journal of Medicine study stated that 30% of conditions have a known best practice, yet they are only followed half the time. Additionally, the remaining 70% of conditions have more than one treatment option but most patients are presented only one.

An example is prescribing Beta Blockers for heart attack patients following their discharge from the hospital. It reduces the chance of a second attack significantly. In a 1995 analysis of Medicare regions, even though the best practice had existed for years, the prescription rate only averaged 50% and ranged from 5 to 95% throughout the regions. Although there has not been specific follow-up to this study, a 2002 update on general variation patterns conducted by Dartmouth indicates little has changed.

Additionally, recommended treatment varies significantly across the country. Doctor John Wennberg at Dartmouth has done some insightful work in this area. He demonstrated that there are wide variations in utilization of health care services that are unrelated to the quality of health outcomes and are largely driven by the supply of hospitals and/or physicians. For example, you are six times more likely to have back surgery if you live in Santa Barbara, CA than if you live in Bronx, NY. In Elyria, OH a patient is seven times more likely to have an angioplasty than in York, PA. The likelihood of a patient undergoing an expensive treatment often varies based on the supply of health care providers in the area and doesn't always improve the health care outcome.

At Honeywell, to provide employees with more data and information, we've implemented a suite of health care decision support tools and resources through a program we call HealthResource which includes online health content through the Mayo Clinic, an online hospital selection guide, and a Medical Decision Support service called MDS. In 2004, our HealthResource web site had over 100,000 visits from employees and their families.

The cornerstone of this program is MDS, a phone based service that puts our employees in touch with a top-5 medical school physician (Harvard, Duke, Johns Hopkins, University of Pennsylvania) and a researcher who has access to established best practice information from peer review medical journals (e.g., New England Journal of Medicine, AMA, etc.), professional organizations (e.g., American College of Cardiologists, etc.), respected not-for-profit organizations (e.g., American Diabetic Association, American Lung Association), and government organizations (e.g., Centers for Disease Control) for employees faced with any one of 60 serious and acute diseases such as cancers, neurological disorders, and heart disease. Based on the employee's diagnosis, MDS customizes best practice information, questions, and treatment options.

The Medical Decision Support system has delivered some eye-opening results. In 2004, about 500 employees with critical conditions used MDS with 31% changing the recommended treatment to a best practice and 17% changing doctors.

We have some great examples of successes. Consider the 58 year old employee's spouse diagnosed with Parkinson's disease. The couple sold their home and moved closer to their children in anticipation of future problems. After going through MDS, the patient learned that there is a test for Parkinson's that he was not given. He sought a second opinion, had the test and learned he did not have Parkinson's but rather a benign tremor of the hand. You can imagine the emotional weight lifted from the patient and family. And it saved a minimum of \$84,000 by avoiding \$12,000 a year in medication and ongoing treatment for Parkinson's.

Or the 64 year old employee diagnosed with stomach cancer after an earlier bout with breast cancer. After going through MDS, she sought a second opinion and learned she had breast cancer that had metastasized to her stomach. The employee obviously changed doctors and treatment. In addition to a better result, it saved a minimum of \$250,000 in direct savings and cost avoidance through an effective therapy.

- Or the parents of a three year old boy who were told in 2000 that their son would need a heart transplant. After calling MDS and learning more about treatment options, including the failure rates of heart transplants, they sought a second opinion. They chose a less radical surgery to replace a valve in the boy's heart and monitoring for 6 months. The family knew upfront that as the boy grew, the valve would have to be replaced a couple of times. He recently had another surgery to replace the valve and he will have to have it replaced one more time in the future. Five years later, the boy is doing great and the parents feel they made a good decision. The savings

associated with avoiding the heart transplant and choosing a less radical surgery were over \$1 million.

We estimate that we saved \$6 million in 2004 while improving the outcomes for our employees and their families. Savings have ranged from zero for employees who were able to determine that they were on the right course of treatment, to \$40,000 for avoided back surgery, or in the case of the child who avoided a heart transplant... as much as \$1 million. And it's all based on having better information available to the consumer.

One of the most valuable returns is the ongoing behavior change in employees. You can't measure the value of someone becoming a better health care consumer. Once someone goes through the MDS process they will always approach health care differently from that point forward. Survey results show time after time that people feel empowered, learned they had the right to ask questions, and that their values and preferences were just as important as the physician's when making decisions about their care.

The US government can support the dissemination of health care information by establishing national standards for measurement, reporting and the application of best practices. The government can also accelerate the implementation of these standards by providing reimbursement incentives to providers who purchase and use compatible health care information systems that support national standards. The implementation of these health care information systems is a critical step to integrating the health care delivery system and facilitating the sharing of information across providers of care and consumers. We need to work together in bringing the proper technology to physicians enabling them to perform at their best and rapidly adopt best practices.

II. Turning to the Second area of Honeywell focus: determining the historical quality of patient outcomes for hospitals and physicians.

In any highly fragmented system there are highly varied outcomes. A consumer today can get more data on the quality of a new car or a Honeywell thermostat than they can on hospitals or physicians.

According to the Institute of Medicine's report, "To Err is Human" published in 2000, there are about 100,000 deaths annually caused by preventable medical errors in hospitals. That's about the same number of deaths caused annually by vehicle accidents (43,000), breast cancer (42,000), and AIDS (17,000) combined.

For example, a successful back surgery today costs \$40,000 on average. With post-operation complications like infections, that can rise significantly. If complications such as infections, blood loss, or stroke occur, the cost of surgery can increase by over 500%. Post-operative complication rates for some conditions can be 3 to 4 times higher in poor quality hospitals than high quality hospitals. Today the consumer generally relies on word-of-mouth. If hospital quality care information were available to consumers, most people would choose the better facilities that do a high volume of procedures and have lower complication rates.

In a recent example, we had a 47 years old employee diagnosed with mitral stenosis (a leaky heart valve) and valve replacement surgery was recommended. After going through MDS, the employee learned the local hospital he had chosen had only done this once before. The employee switched to a hospital with a long and successful track record for this surgery. She also learned the medication previously prescribed was potentially damaging. A better outcome and an estimated \$32,000 savings.

While hospital quality data exists today, it is limited to a few measures (e.g., complication rates, mortality rates, length of stay, safety standards, volume, etc) and is heavily reliant on Medicare data. Additionally, there is scant quality data on physicians available and there are no national standards to measure physician or hospital quality. Honeywell, other employers, and managed care organizations are all attempting to measure physician quality but splintered efforts to measure quality on a voluntary basis have resulted in incomplete data and only confuse the provider community and consumers. We are now collectively working on joint public and private sector initiatives (the national coalition Ambulatory Quality Alliance) in an attempt to standardize how quality is measured and reported.

The US government can be a big help here by partnering with employers to establish a clear definition of what should be measured to determine physician and hospital quality. Even with standards, however, it is essential to measure what's important and not just what's available. The government could tie reimbursement to data reporting on physician and hospital measures to ensure that the effectiveness of care and performance of providers is adequately measured and reported.

The government is in the best position to:

- First – establish national quality standards for the measurement and reporting of quality data
- Second – tie reimbursement to data reporting and ultimately the achievement of these quality standards
- Third – make the data publicly available.

III. The third area of Honeywell focus is addressing Chronic Care conditions.

At Honeywell, chronic conditions account for 57% of our active employees health care costs. The top eight chronic conditions (heart disease, cancer, pulmonary, mental health, hypertension, diabetes, arthritis, back) represent 23%. Chronic illness affects more than 100 million American and accounts for 70% of the nation's annual health care costs. Diabetes alone costs the country \$123 billion annually.

We have implemented a number of disease management programs (diabetes, asthma, heart and back) and care management programs to help and in some cases incentivize our employees to better manage their condition. These programs helped Honeywell save over \$7 million in 2004.

Disease management requires the coordination of care with the physician, lifestyle changes by the patient, and the ability to monitor key biometric indicators of the disease. Weight gain for example is a key indicator for developing problems in congestive heart failure patients and if caught early has been proven to prevent hospital admissions and emergency room visits. But monitoring is not always easy to do, frequency is important and lapses are easy, and it uses valuable physician time or - in the case of home health care – the time of the visiting nurse.

Technology exists today to allow accurate in-home monitoring of key indicators like blood pressure, cholesterol, heart rate, weight, blood sugar levels, etc., for such conditions as diabetes, congestive heart failure, coronary artery disease, bronchitis and emphysema. Measurements can be taken daily and electronically transmitted to medical professionals in a central office where they can be analyzed by experts. If results fall outside established parameters, a call can be placed to the patient or a nurse can be dispatched to the home. The British government is now reviewing it for wider application. For full disclosure, I'm proud to add that Honeywell is in this business and we're determining now how to best use it with our employees to improve their lives and reduce chronic care costs.

The US government can help by shifting reimbursement practices to pay for disease management programs that *prevent* or *manage* the highly expensive and debilitating effects of chronic disease... not just the *treatment* of chronic disease. Today there is no incentive to manage chronic conditions. If home health care agencies, for example, elect to use this technology in the monitoring of congestive heart failure patients, they need to absorb the cost in their current Medicare reimbursement. By supporting proven technologies through reimbursement practices, the government can accelerate the use of this technology and the opportunity to improve the lives of chronic care patients and reduce costs simultaneously.

While these three recommendations are a lot to consider, they come down to one principle: improving the quality of outcomes for patients will lead to lower costs. By examining the process from diagnosis to recovery, identifying and spreading best practices, and making data available to patients so they can make informed decisions, we can significantly reduce the variability of outcomes resulting in higher quality care and lower costs.

The US government needs to play a major role in advancing the cause of higher quality patient outcomes and improving the lives of our employees and their families. Our combined efforts would not only make US business more cost competitive but also result in a more able and healthy workplace.

I've raised many questions here today and tried to propose some answers. My goal is to begin the dialog so together we can pursue the innovative solutions needed by the health care marketplace and the American people. As in business, an informed consumer always makes a better decision.

Thanks for listening.