

Health Care Reform 2008

Will Something Finally Give?

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The Problem Defined

“The problem of providing satisfactory medical care to all the people of the United States at costs which they can meet is a pressing one. At the present time, many persons do not receive service which is adequate either in quantity or quality, and the costs of service are inequitably distributed.

The Problem Defined (cont.)

“The result is a tremendous amount of preventable physical pain and mental waste. Furthermore, these conditions are...largely unnecessary. The United States has the economic resources, the organizing ability, and the technical experience to solve this problem.”

Jordanians Live Longer than Americans

- U.S. ranks 42nd among developed countries in life expectancy (77.9 years if born in 2004)
- U.S. ranked 11th in 1984
- Other countries have improved health care, nutrition, and lifestyles
- U.S. has uninsured people, high rates of obesity, racial disparities, and high infant mortality rates
- Jordan's per capita income is 128th (\$4,290/year)

Health Insurance

- Nearly 47 million Americans are uninsured
- Uninsured Americans exhibit consistently worse clinical outcomes than the insured, and are at risk of dying prematurely
- 30% of uninsured children have no usual source of care, compared to 2% of children with private insurance
- More than half of uninsured adults have no usual source of care, compared to 10% of adults with private insurance

Health Insurance (cont.)

- Fewer employers are offering coverage:
 - In 2000, 69% of all firms offered health benefits
 - In 2007, 60% of all firms offered health benefits
- The drop is more pronounced among small firms:
 - In 2000, 57% of firms with 3–9 workers offered health benefits
 - In 2007, 45% of these firms offered benefits

Health Savings Accounts

- 10 % of employers offer high-deductible plans
- 5 % of employees with insurance have HSAs; 57% have PPOs, 21% HMOs, 13% POS plans, 3% conventional plans
- “Enrollment is not growing at the rate one might expect given the public attention [HSAs] receive.”
- Mobilizes patients as consumers
- Market makes it hard to identify high-quality care
- High deductibles may discourage people from seeking necessary preventive/chronic care

Medical Errors

- 44,000–98,000 Americans die from medical errors annually
- Medication-related errors for hospitalized patients cost roughly \$2 billion annually
- Medical errors kill more people per year than breast cancer, AIDS, or motor vehicle accidents

U.S. Averages 66 on Five Dimensions of Health and Health Care

- 69: Long, healthy, and productive lives
 - **Best:** life expectancy at age 60
 - **Worst:** infant mortality
- 71: Quality of care (the right care and coordinated care)
 - **Best:** children's immunizations
 - **Worst:** controlling adult HBP
- 69: Quality of care (safe, patient-centered, timely care)
 - **Best:** hospital mortality rates
 - **Worst:** prescribing children antibiotics without strep test

U.S. Averages 66 on Five Dimensions of Health and Health Care (cont.)

- 67: Access to affordable care
 - 47 million uninsured people, 1.06M in Michigan
 - 600,000 more children uninsured
 - SCHIP reauthorization
- 51: Efficiency
 - **Best:** cost of care and mortality for AMI, hip fracture, colon cancer
 - **Worst:** physicians using EMR, inappropriate ER use, administrative costs

Where You Live Profoundly Affects the Health Care You Receive

- If you want a lumbar fusion , go to Idaho Falls—5x national average
- But evidence is mixed: typical bill \$50,000
- Dartmouth Atlas of Health Care: under-use of effective care (beta blockers after heart attacks, eye exams for potential diabetics) and over-use of care (lumbar fusions?)
- Michigan (late 1990s): C-section rate varies from 15% to 33%
- More health care isn't necessarily better care

National Health Spending

- Health care accounted for \$2.1 trillion of national health expenditures in 2006
 - \$7,026 per capita
 - 16% of GDP
- Spending on health care in 2006 increased 6.7% over 2005 spending
- U.S. health care spending expected to reach \$4 trillion in 2015 (20% GDP)

Personal Health Care Spending

- The average annual total premium cost is \$4,479 for single coverage; \$12,106 for family coverage
- Workers contribute, on average, 16% of the cost of premiums for single coverage; 28% of the costs for family coverage
- Premium increases are rising faster than overall inflation and earnings

Who Pays: Another View

- **Government: 33%** (with employer contributions to government counted as part of business's share)
- **Business: 32%**
- **Households: 31%**
- **Other private: 3%**
- Over 20 years, government share rising, business share steady, household share declining, but...
- Everyone's real costs are rising rapidly

Pay for Performance Shows Limited Effect So Far

- CMS has rewarded hospitals for 5 inpatient conditions since 2003
- Premise: Medical care can be improved by paying more for better treatment.
- New study of heart attack treatment in 500 hospitals suggests financially rewarded (54) didn't improve care significantly more than those that weren't rewarded (446)
- Perhaps incentives/penalties not high enough—the carrot may need to be bigger

Medicare Announces It Won't Pay for Hospital Errors

- Medicare won't pay for conditions that “could reasonably have been prevented”: bedsores/pressure ulcers, infections from catheters, leaving objects in a patient during surgery
- Private payers may follow suit (National Quality Forum's 27 “never” events)
- Leape: Need to disclose mistakes—full disclosure and early compensation have led to substantial reductions in suits filed and total payouts.

Medicare Announces It Won't Pay for Hospital Errors (cont.)

- Biggest disappointment: getting health system CEOs to make safety a priority; culture of safety not possible without leadership at the top
- Federal and state government: too little done on incentives for improving safety; some reporting requirements only.
- Michigan's Keystone ICU project: reduced infection rates

Pennsylvania Hospital Offers Surgery with a Warranty

- Geisinger Health System charges flat fee that includes 90 days of follow-up care; if patient has complications and must return, GHS will not send a bill to insurer
- Started with elective heart bypass surgery—patients now less likely to return to ICU, spend fewer days in the hospital, and are more likely to return to their homes than to nursing homes
- Payment for quality, not quantity, of care
- GHS doctors identified 40 essential steps—and make sure all doctors follow them all the time. At start, they completed all 40 steps 59% of the time. Now operation cancelled if any pre-op measures forgotten

Payment Reform: Why Not Soon?

- No incentives for hospitals to limit readmissions
- Few incentives to avoid hospitalization through preventive care and high-quality chronic care
- Chronic management, in which nurses check patients' symptoms and adhere to recommended treatments—effective, but rarely covered
- If all states were at admission and readmission rates of the 5 best-performing states, Medicare would save \$2–5 billion/year
- Problem: Savings don't accrue to providers that implement programs

Medicare Physician Group Practice Demonstration

- Effort to control costs and improve quality of care
- Preliminary results: evidence that paying for quality rather than volume of services helps Medicare, physicians, and patients.
- 10 physician groups, including U-M Faculty Group Practice, paid fee-for-service and then share in savings from enhancements in care management

Medicare Physician Group Practice Demonstration (cont.)

- All groups met targets on 7 or more of 10 diabetes quality measures
- Gives physician groups flexibility to redesign care processes for chronically ill patients—if these result in savings to Medicare, groups share in those savings.
- U-M shared in millions of \$\$ in savings
- Shared learning collaborative

Reform in the States

- In last few years, more than half the states have proposed or passed major reforms
- Key features:
 - Expanding Medicaid and SCHIP
 - Employer mandate
 - Individual mandate
 - Insurance pools or “connectors” to help individuals and small businesses by insurance
 - Subsidies and sliding scale premiums

Illinois

- All Kids—universal coverage for children
- Builds on Medicaid and SCHIP, but funded exclusively with state money
- Families can purchase coverage on sliding scale
- Enrollment surpassed state targets: 160,000 total, 60,000 in state-only component
- Financing from projected savings from primary care case management and disease management (\$57M/year)
- Issues: whether PCCM and DM programs save money; high AK premiums for higher-income kids

California

- Schwarzenegger's shared responsibility approach: meaningful employer contribution minimums and individual mandate
- Passed state assembly, but didn't get out of senate
- State subsidies/tax credits for pool coverage, measures to improve insurance access would have covered 70% (3.6M of California's 5.1M uninsured—2/3 of remaining uninsured are undocumented adults)

California (cont.)

■ Lessons (Rick Curtis):

- Fed funding formulas must respond more quickly to rapid downturns in state revenues
- Without some employer responsibilities, most states could not finance major expansions in subsidized coverage for those who cannot afford individual coverage, especially given the crowd-out of employer coverage that would ensue
- Safeway led employers supporting CA legislation because of cost shifting, but multistate employers worry about 50 different standards

Massachusetts

- April 2006: Nearly universal coverage passed
- 176,000 enrollees as of March 2008
- Individual mandate: All adults purchase coverage or pay penalty of 50% of insurance plan
- Employer requirement: Those with 11 or more employees required to provide coverage or pay “Fair Share” contribution of \$295 annually per employee

Massachusetts (cont.)

- Commonwealth HI Connector: connects small businesses and individuals to affordable, quality HI products. CHIC approved plans from 7 insurers
- Government-funded subsidies to low-income individuals to assist with HI—sliding scale subsidies up to 300% FPL. No premium at all if income is 150% FPL or less
- Medicaid expansion to children up to 300% FPL

Massachusetts (cont.)

■ Implementation issues:

- Balancing minimum coverage and cost: What constitutes affordability, for individuals, families, and the state?
- No effective cost containment
- March 2008: Connector increases sliding premiums by 10%
- Gov. Patrick considering raising employee fee for non-participating employers—\$869M in budget, likely to be \$150M short

Michigan First

- Would cover 550,000 uninsured
- Requires federal approval of \$600M; still pending
- Subsidies to individuals and businesses to purchase coverage; sliding scale between 100% and 200% FPL
- “The Exchange”: recruits HI plans to offer affordable coverage to individuals and small businesses
- Benefits plan under discussion

Lessons Learned from the States

- Medicaid is important foundation for expanding coverage—if you can access more federal funds
- Early demand may be higher—and costlier—than expected
- It is a challenge to offer affordable and comprehensive coverage
- Must mix strategies from across political spectrum
- Need to control unpredictable costs intensifies as years go by

Major National Reform Proposals

- Single-payer, national insurance system
 - No current candidates (proposed by Kucinich)
- Expansion of access through current mixed private and public insurance system
 - Clinton and Obama
- Market-based strategies/Consumer-directed health care
 - McCain

Single-Payer Principles

- Universal coverage
 - Creates one large risk pool
- Provides minimum benefit floor
- Affordable (no out-of-pocket expenses)
- Administratively simple
 - One entity responsible for payment and quality measurement
- Severs the link between employment and health insurance—creates true portability

Hillary Clinton's Health Care Plan

- New group insurance option—Health Choices Menu—with benefits equivalent to FEHBP
 - Participating plans required to adopt practices to improve quality and efficiency
- Expansion of Medicaid and SCHIP eligibility
- Individual mandate with refundable tax credit
- Employer mandate with tax incentives
- Regulation of private insurance companies: guaranteed issue, automatic renewal, modified community rating, minimum stop-loss ratios

Barack Obama's Health Care Plan

- Creation of new public insurance plan and a National Health Insurance Exchange for individuals and small businesses
 - Participating plans required to provide benefits at least equivalent to new public plan
 - Exchange would evaluate plans and make differences transparent
- Expansion of Medicaid and SCHIP eligibility

Barack Obama's Health Care Plan (cont.)

- Government subsidies for individuals and some employers
- Requires children to have insurance
- Employers: offer “meaningful” coverage or contribute % of payroll toward cost of public plan; reinsurance for catastrophic costs
- Regulation of private insurance companies: Guaranteed issue, modified community rating, minimum stop-loss ratio

Basic Principles of Clinton & Obama Plans

- Build on what's already in place
- Create broad health care risk pools through expansion of group insurance options
- Implement regulations to prevent insurers from selecting against individuals with serious health risks
- Shared responsibility for health care coverage
- Control costs through strategies for improving quality and efficiency

John McCain's Health Care Plan

- Tax credits for individuals with insurance
 - \$2,500 for individuals; \$5,000 for families
- Eliminate bias toward employer-sponsored health insurance
- Deregulation of insurance markets
 - Individuals could purchase insurance from any state

John McCain's Health Care Plan (cont.)

- Special focus on provider payment reform
 - Expand pay-for-performance
 - Medicare could pay single bill for high-quality coordinated care
- Expansion of health savings accounts (HSAs)

Basic Principles of McCain's Plan

- Bring costs under control by:
 - Increasing competition in the individual insurance market and decreasing reliance on employer-sponsored insurance
 - Increasing patient responsibility for health care decisions
 - Promoting competition among providers
 - Increasing quality and care coordination
- Primary responsibility for health care coverage lies with individuals

What Is To Be Done?

- Too many uninsured
 - Number even rose during good economic times of 2004–2006
 - State budgets could prevent expansion
- Quality has room for improvement
- Costs expected to double by 2017
 - 19.5% of GDP—16% now
 - Aging of baby boomers—yikes

What Is To Be Done? (cont.)

- Single payer is out for the near future
- Choices will include:
 - Tax incentives to expand coverage in the individual market
 - Expansion of group insurance through mixed private-public system
- The public want to reduce the number of uninsured and reduce costs, and they agree with shared responsibility for obtaining coverage

What Is To Be Done? (cont.)

- Dueling cost containment—the targeted, based on lessons learned and proven practices, and the arbitrary, based on across-the-board cuts
- The ascension, communication, and rewarding of quality is our best hope

Thank You

Questions?