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The 2009 Health Care Leader Forum—A conference summary

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On March 30–31, 2009, the Federal Reserve Bank of Chicago and the Detroit Regional Chamber co-sponsored the third annual forum on health care. This year's program focused on the role of employers in improving the health care system in terms of cost, quality, and accessibility.

Materials presented at the conference are available at www.chicagofed.org/news_and_conferences/conferences_and_events/2009_detroit_health_care_forum.cfm.

In the United States, most people get their health insurance through their employers. In 2007, approximately 177 million people, nearly 60% of the population, were covered by employment-based health insurance.[1] The cost of providing health care coverage when viewed from the perspective of business is sizable, and it has been increasing. The U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) estimates that businesses paid approximately $518 billion for health services and supplies in 2007 (approximately 25% of total health care expenditures), as compared with $390 billion spent in 2002.[2] Health insurance premiums rose a cumulative 78% between 2001 and 2007—far faster than cumulative wage growth of nearly 20% over the same period; also, in 1999, the median employer cost for health insurance was 8.2% of payroll, whereas in 2005 it was 11.0%.[3]

To cut down on health care costs, employers have been increasing the portion paid by employees (e.g., deductibles and copayments, as well as insurance premiums), reducing benefits, and even dropping coverage altogether. But the pressure on firms to reduce these costs is still growing.

Many factors cause sizable variation in the costs of health insurance among firms, including differences in the age and health of employees, plan participation rates, and the costs of plans. This variation does not make the implementation of fair and equitable policy measures easy. Most policymakers and other observers agree that there is no "silver bullet" that will solve the U.S. health care problem. The emphasis is thus likely to be on incremental rather than comprehensive changes. The 2009 Health Care Leader Forum analyzed the role of employers in creating value in the health care system; this year's program also looked at prospective health-care-related programs likely to be enacted in Washington and health care initiatives of states and localities.

Employer initiatives in redefining health care

Scott Wallace, Batten Fellow, University of Virginia, presented the value-based approach to health care.[4] To Wallace, a successful health care system is one driven chiefly by results, not process (e.g., it is more concerned with whether a patient is cured or having less pain rather than with how many injections were administered). Such a system is also based on values that improve the health outcome of the patient relative to the cost of achieving this goal. In order to achieve this properly, it measures health care outcomes over the *full* care cycle of a disease, rather than by just a specific procedure, and it calculates the costs of the specific procedures over the full care cycle as well.[5]

Wallace argued that firms need to shift their thinking and create a new role for themselves with regard to managing health care costs. He noted that the cost of treating the poor health of firms' employees is three times greater than the cost of their baseline benefits. According to Wallace, our current health care system does not encourage changes in patients' (i.e., employees') health-related behavior; rather, it often cares for their health problems without looking at the root causes. So, Wallace contended that employers should focus on making their labor force healthier by promoting preventive health measures. He noted how challenging this can be, since many of the health and lifestyle decisions of employees are made outside the work environment—and even outside the doctor's office and family settings.

Wallace argued that wellness programs are one type of employer initiative that should be pursued. Programs such as smoking cessation, weight monitoring, exercise, and diabetes control should be encouraged—and, whenever possible, in a group setting. Group intervention is more effective than one-on-one sessions, he said, and it is also more cost-efficient.

Wallace saw room for a more activist role in the health care arena for employers, in part because firms have more leverage than individual workers. For example, health plans are currently designed to limit costs and *not* maximize value. So if the best procedure is located in a hospital that happens to be "out of plan," the treatment may not be covered. Wallace advocated that firms, using their negotiating power, should change this rule (or fight for an exception) and focus on results (i.e., the best health outcome for their employees) rather than costs.

In general, the return on investment, Wallace argued, should not be the first priority in delivering health care. Because of cost shifting among health care providers, firms usually do not have good measures to account for health care costs in any case. Rather than focus on return on investment, firms should do what employees want and need, Wallace suggested. If firms did this, their health insurance programs' success would be measured by employees' satisfaction and sustained participation, as well as other factors. This is not to say that standard business measures should not be employed; rather, they should not take the front seat in the process.

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Employers, employees, and value in health care

Carl Camden, president and CEO, Kelly Services (a large temporary staffing agency), argued that the current employer-based health care system depletes rather than creates value. This framework hurts wages, inhibits job creation, restricts employee mobility, and hampers global competitiveness. Worker productivity, motivation, and creativity are suffering because many employment decisions are being driven largely by concerns about health care access. The term "job lock" has been coined to reflect this phenomenon.

Camden contended that the current U.S. health care system harms the nation's global competitive position. Health care benefits represent about 11% of U.S. payrolls—more than double the average share of payrolls for foreign companies, according to Camden. Looking specifically at U.S. manufacturing, it is estimated that this industry's health care costs equaled $2.38 per worker per hour in 2005, as compared with $0.96 for foreign manufacturers.[6] For Kelly Services, U.S. health care costs actually exceed the profits generated from its U.S. operations; and Kelly Services' experience is not that rare. Partly because of the high costs of health care, firms are increasingly looking outside the United States to start their new operations.

Camden stated that most economists are of the opinion that in the United States higher health care payments are offset by lower wages. Consequently, health care should not be a hindrance in the competitive marketplace. While such a proposition may be true in the long run, employers are still negatively affected by rising health care costs. As a recent New America Foundation report shows, employers are dropping health insurance plans because they cannot shift rising health care costs to workers fast enough.[7] Only 60% of U.S. firms offered coverage in 2007, compared with 67% in 2000, according to Camden.

To Camden, so-called free agents, which include freelancers, temporary or contract workers, and independent consultants, as well as entrepreneurs, are the driving force providing the impetus for innovation, growth, and flexibility in the U.S. economy. Consequently, the lack of adequate health insurance coverage depletes the available pool of free agents (a large and growing segment of the U.S. working population), potentially hampering U.S. economic growth and well-being.

According to Camden, employers should work toward revamping the whole system rather than just making piecemeal reforms. Indeed, Camden advocated a partnership between business and government to develop a workable large-scale solution.

Shaping the future of health care: Political prospects

Gilbert S. Omenn, professor of internal medicine, human genetics, and public health, University of Michigan, presented an assessment of the prospects for health care reform by the Obama administration. According to Omenn, 2009 should be the best chance for achieving substantial health care reform. Currently, there is a strong consensus by members of Congress and the public that something must be done. However, the political process to reform the health care system will not be easy. Health care reform is one among many pressing political issues vying for lawmakers' attention. Also, health care reform is very complex, and its intricacies will not be easily digested and discussed by Congress. What's encouraging is that the Obama administration will not develop its plan in secret and present it to Congress as a *fait accompli*—as was done

in the early days of the Clinton administration. Ahead of presenting detailed proposals, the Obama administration has laid out some principles for health care reform, including those that focus on costs and affordability.

According to Omenn, the issues that are likely to determine the fate of health care reform include the following.

- Should the reform be incremental or comprehensive?
- When will health information technology, health promotion, chronic disease management, malpractice reform, and payments incentives generate savings?
- Should there be a public health care option?
- Will physicians, hospitals, employers, and insurers accommodate or oppose reform in the end?
- Will Republicans "just say no"? What will be the price for President Obama to claim bipartisan support?
- How much momentum can President Obama generate?

Omenn argued that a new comprehensive health care program is likely to be enacted. Furthermore, he estimated that approximately 25% to 50% of the purported savings will be realized. He cautioned that many constituencies who have a stake in the process may still look at only their own particular interests, and others might paint the worst-case scenario. Still, he expressed optimism that these stakeholders will ultimately focus on the greater good with respect to health care reform.

Challenges and opportunities in health care

Joseph M. Heyman, chairperson of the board of trustees, American Medical Association, spoke not just as a doctor, but as a small business operator and one who was closely involved in the implementation of the Massachusetts health care program. He described the challenges and opportunities that the Massachusetts and U.S. health care systems present to the medical profession and other segments of society.

The Massachusetts Health Care Reform Act, enacted in 2006, required nearly all Massachusetts residents to obtain health insurance and imposed fines on those who did not. It also required employers with 11 or more workers to provide health care coverage or pay a "fair share" amount on an annual basis to the state government.[8] Subsidies, on an income-based sliding scale, were provided to assist the purchase of insurance by low-income residents. The "free care pool" was established to compensate health care providers for expenses. It was expected that uninsured costs would decline as the number of insured patients rose.

Heyman attributed the success of the act to bipartisan support in the initial phase and to a willingness of various groups to work together to find solutions as problems arose. The overall uninsured rate in Massachusetts dropped to 5.7% in 2007 from the previous year's 6.4%. By 2007, nearly three-quarters of Massachusetts' employers offered health insurance to their employees, up slightly from the 2001 level of 69%. Over the same period, the national rate of employers offering health insurance dropped from 68% to 60%. The financial performance of hospitals was positive in 2007, but Heyman expected that to deteriorate because of the effects of the recession.

Given current weak economic conditions, Heyman stated that achieving health care reform was imperative. Heyman expressed high hopes for successful implementation of national health care reform because of the widespread realization that changes in health care are needed and the belief that collaboration among various groups at the state level, as evidenced in Massachusetts, can also occur at the national level.

One of the potential pitfalls for national health care reform, Heyman warned, is exemplified by Medicare. Heyman noted that in the Medicare segment there is a widening negative gap between the cost of providing medical services and the level of Medicare reimbursements. This has discouraged physician participation. In Michigan, more than half the physicians indicated that they would discontinue or reduce the volume of Medicare patients they see unless reimbursement rates were raised. If payment rates to physicians are not set appropriately under federal health care reform, similar problems could develop.

Health care initiatives at state and local levels

Jennifer Tolbert, principal policy analyst, Kaiser Commission on Medicaid and the Uninsured, described state efforts to improve health care coverage. She noted that states have focused on expanding health care coverage for children and low-income earners, often using Medicaid as the medium. Some states have attempted to increase coverage further by granting tax incentives to employers (e.g., Maine and Montana) and by enabling employees to pay premiums on a pretax basis. To prevent employers from totally abandoning insurance for their workers, some states have required employers to either provide coverage or contribute toward state funding (e.g., Massachusetts and Vermont). Another pioneering effort was to place greater emphasis on preventive care (e.g., Maryland and Florida). Michigan is a leader in the collection of cost and quality of care information, which will help determine best practices as well as efficient resource allocation.

Tolbert argued that states can serve as test laboratories for different programs

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but that the ultimate solution must come from a national perspective because of the states' limited influence and resource constraints.

Tom Simmer, chief medical officer, Blue Cross Blue Shield of Michigan (BCBSM), described his company's program to improve health care in Michigan. The BCBSM program, called the Physician Group Incentive Program (PGIP), consists of 35 health groups, over 6,000 physicians, and 1.7 million members. It was designed to improve the health care process, reduce variation by sharing information, and lower the number of patient revisits. To encourage efficiencies, physicians in the PGIP are paid based on their performance, which includes patient outcome and the implementation of health care information technology and preventative measures such as weight control and diabetes care procedures.

The results of the PGIP were very favorable but preliminary in nature, since the period of measurement was only 15 months. The overall score in evidence-based care report measures, which included measures of treatment for coronary artery disease, diabetes, and asthma, among other diseases, rose from 68% at the end of 2006 to 76% at the start of 2008. The improvement was also evident at the individual organization level. At the beginning of the program, in 2006, most scores ranged between 60% to 70%; by 2008, the lowest score was 70%. Costs were also reduced. The cost per member per month of the PGIP group was $4.84 below that of a control group in 2006, and the differential had improved to $21.08 by 2008. Simmer concluded that a health care program can be designed that improves both patient care and cost efficiencies.

Conclusion

From the employers' perspective, the cost of providing health care coverage is sizable and increasing. Reforming health care is complex and requires attention to many details. Successful implementation of reforms will require active partnerships across industries and interest groups.

Employers can promote better health and thereby reduce health care costs by encouraging their employees' wellness. In addition, employers can take a more activist role in redefining health insurance coverage, and they can act as intermediaries in assembling and disseminating health information. There is considerable variability of health insurance costs across industries and occupations. Determining the roots of this variability may lead to a lowering of these costs. Further studies on these issues should be pursued.

[1] Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, 2008, *Income, Poverty, and Health Insurance Coverage in the United States: 2007*, Current Population Reports, U.S. Census Bureau, No. P60-235, August, p. 19, available at www.census.gov/prod/2008pubs/p60-235.pdf. The U.S. Census Bureau estimates that approximately 46 million people, or 15% of the population, had no form of health insurance, employment-based or otherwise, in 2007.

[2] See table 5 in www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf.

[3] Kaiser Family Foundation, 2008, "Employer health insurance costs and worker compensation," Snapshots: Health Care Costs, March, available at www.kff.org/insurance/snapshot/chcm030808oth.cfm.

[4] For a detailed explanation of the value-based approach to health care, see Michael E. Porter and Elizabeth Olmsted Teisberg, 2006, *Redefining Health Care: Creating Value-Based Competition on Results*, Cambridge, MA: Harvard Business School Press.

[5] Typically, the majority of health care costs are not measured over the full care cycle. For further details, see the section summarizing Elizabeth Olmsted Teisberg's speech in Sam Kahan, 2008, "Creating value-based competition in health care," *Chicago Fed Letter*, Federal Reserve Bank of Chicago, No. 254a, September.

[6] Len M. Nichols and Sarah Axeen, 2008, "Employer health costs in a global economy: A competitive disadvantage for U.S. firms," New America Foundation, report, May, p. 10, table 4, available at www.newamerica.net/files/EMPLOYER%20HEALTH%20COSTS%20IN%20A%20GLOBAL%20ECONOMY.pdf.

[7] Ibid., p. 6.

[8] For potential employer costs, see www.mass.gov/legis/summary.pdf, pp. 3–4.