Healthcare Reform in America

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There has been little real change in the care delivery system in America in several decades. The health trinity of improving access, decreasing costs, and increasing quality outcomes continues unchanged today. An attempt at reform at the federal level was made in 1994, with little success. Attention occurred again in 9/11, particularly to the status of public health; little change ensued. In the meantime, the number of under and uninsured has increased, costs have increased, and there is little demonstrable improvement in care quality. We have evolved a highly regulated market of care delivery in which consumers are increasingly confused by the flood of information available, and are increasingly unable to navigate the system when they need to use it.

Clearly, there are a number of events in the country that are increasing the buzz and the dialogs on the part of both consumers and the private sector. For consumers, the cost of insurance continues to rise, reaching 14% of median household expenditures on a per capita basis in 2004, and the annual inflation in the cost of using the system is about twice the annual increase in wages. The number of un- and underinsured now exceeds eighty million, accompanied by sharp increases in public sector spending such that expenditures on health care are expected to reach about 15% of the gross domestic product by 2025. It is also estimated that the uninsured are receiving about 50% of the care they need, and that the added cost of providing that care would increase health expenditures approximately 4% over what it is today. For businesses, the cost of health care is limiting international competition for goods and services produced in the U.S.. Small employers continue to lack sufficient access to affordable insurance products for their employees. Large self-insured employers, while being a single payer with universal coverage and offering choice in plan design, are increasingly shifting more cost to employees and moving into defined benefit systems, e.g. high deductible insurance with some form of personal or health savings account.

This talk will not detail the ills of the system. They are well documented and increasingly apparent. Rather, this talk will summarize the discussions at the federal and state level as understood by this observer, and will present actions taken, in the few places that has occurred.

So, what is being discussed at the **nation (federal) level?**

On the national level, there are several areas of agreement:

1. The care delivery system must become more efficient at all levels and for all participants. However, there are some differences in the definition of efficient, with the economists favoring it as "willingness to pay"; and the care delivery system defining it as "medical outcomes of value".
2. The insurance must be affordable at all levels, with over 50% of the people supporting some form of government guarantee of insurance, with the federal government not necessarily being the single payor.
3. Information on the costs and quality of care delivery, and the metrics that are used to define and monitor them, must be transparent and available to consumers.
4. Electronic information systems that communicate need to become a reality.
5. The role of the employer will become increasingly less important
6. Academic health centers can have an important role to play in reform by: providing consumer information for decision-making and for navigating the delivery system; producing the workforce and the delivery models; providing exemplary practice metrics; providing the data for evidence-based decision making by health providers and administrators.
7. The major issue in achieving universal access is really financial in that it is very difficult to finance coverage without some increase in either taxes and/or the employer mandate.
8. Income redistribution will be a major factor in reform.

Outside of this common area, the dialog depends on one's point of view. If one views the topography from the political right, one sees high costs caused by the presence of insurance and the over utilization of services by those with it, such that coverage expansion will result in large tax increases and a greater role for government in cost containment. So, universal coverage is not in the vision. The answer seems to reside in an increasingly greater degree of control by individuals over utilization of services and in driving efficiency. Such tools as non-group purchase HSA-eligible insurance are promoted to assist these ends. Malpractice reform is viewed as a way to reduce costs; and health information systems as a way of creating the informed consumer.

If one views the topography from the political left, one sees a view that the high costs emanate from the profit incentive, the imperfect marketplace of health, and the power of providers, insurers, health systems and pharmaceutical companies in controlling the market. While favoring universal coverage, the rest of a plan or point of view is lacking. A single payer (public) approach remains alive, with the decisions driving efficiency emanating from the bureaucracy and the process that created it (CMS model), while favoring solutions that are acceptable to large, well organized supporters, e.g. organized labor.

The center views the topography as a hybrid between the political left and right, seemingly favoring incentives and information on the quality and cost of care to drive efficiencies, group purchasing mechanisms, and further mandates to control costs and

subsidies to achieve affordability. There is also a clear preference for universal coverage for both social equality and economic reasons.

Given the need for alignment of public demand, political will, and a widely acceptable plan that is necessary, transformative change is not likely at the national level for some time.
As a result of the gridlock at the federal level, most of the action in health reform is at the **state level**. Two approaches will be discussed, one being implemented and one in the planning stage.

The Massachusetts Action:

The State of Massachusetts recently enacted legislation that substantively increases access and institutes measures to improve quality and decrease cost. The legislation provides health coverage to 95% of the uninsured, using a variety of mechanisms to provide this universal coverage:

1. An individual mandate that all citizens must have coverage, with penalties for non-compliance. This will generate about $1.2B.
2. Subsidies starting when wages reach 300% of the federal poverty level (FPL) and full subsidy at the 100% of FPL. 300% FPL is a yearly wage of approximately $60,000. At this level, the individual mandate results in an expenditure of about 14% of wages.
3. Creation of new affordable plan designs
4. Employer Assessments--$50M of new revenue
5. State Insurance Connector--$125M of new general revenue allocated to health and not tax cuts
6. Medicaid expansion—$180M additional federal match to restore certain benefits (dental, eyeglasses), and to increase payments to acute hospitals, physicians and community health centers
7. Use of pre-existing funds in the state's Uncompensated Care Pool by redirecting them from hospital payments to insurance subsidies. This pool is formed from taxing hospitals, business and the state and generates about $600M per year.

Thus, the financial model has the characteristics of about 50% of revenue from individuals and 50% from public/private sources. Within the latter, 75% is from pubic sources and 25% from private sources (taxes).

The Connector is a new state agency that oversees the whole process, approves the base benefits set and the plan as well as the new policies regarding quality improvement and cost control.

Cost control will be achieved via transparency in care delivery, pay-for-performance, and the Cost and Quality Council.

Quality will be achieved via Pay-for-performance, the Cost and Quality Council, and the Health Disparities Council.

Administration will be performed via the Health Access Bureau, the Health Safety New Office and the Insurance Connector.

This is a plan of mandated universal access with universal insurance coverage achieved through a balance of individual, government and private (business, insurance) funding sources. A variety of processes are instituted in an attempt to balance government and marketplace roles and balance the public and private interests. True, strong leadership is a critical success factor.

The Minnesota Dialog: Moving to Action

Care delivery in Minnesota, with its widely consolidated health system and provider marketplace, has witnessed the demise of the health maintenance organizations, attempts to integrate health systems, provider taxes to fund care delivery to all but 5% of the uninsured via Minnesota Care, attempts at best practices for quality improvement, and the rise of the educated consumer as approaches to the health trinity of improving access and quality and reducing the cost of health care. Achieving these goals remains to be accomplished.

Much of the concern in Minnesota emanates from the increasing cost-shift to consumers and the their increasing out-of-pocket payments and the increasing cost to private businesses that is limiting their ability to compete in the global market; and the increasing share of the State's budget that is required for health coverage and benefits.

Several years ago, gubernatorial and a Citizens League plan was developed and has not been implemented. More Recently, Minnesota Medical Association developed a proposal for healthcare reform called: Physicians' Plan for a Healthy Minnesota. This year, a process called Healthy Minnesota began. With the support of the MMA, health providers, health systems, insurance companies, policy makers, public health officials and educators created a dialog with the intent to develop a plan for health reform in Minnesota. These individuals comprise the Steering Committee.

There are four areas of dialog that are beginning to develop recommendations with varying levels of specificity.

1. A Strong Public Heath System
2. Systems to Support Quality Care and Quality Improvement
3. A Reformed Health Care Market
4. A Reformed Insurance Market

A Strong Public Health System

Three recommendations have emerged to date:

1. Better integration of the clinical and public health systems that will identify and prioritize public health challenges, e.g. obesity.

   The approach to obesity builds on existing strengths and defines primary, secondary and tertiary prevention. These levels combine the modification of social and economic policy, e.g. mandated changes in food composition, regulation of food advertising and food labeling, with general and specific population screening, e.g. measuring BMI in schools and clinics, and screening of targeted diseases in populations of high prevalence (diabetes in Native Americans), and with direct preventive intervention, e.g. bariatric surgery.
2. Community-wide education in evidenced-based practice measures
3. Support of the public health infrastructure, e.g. increasing the workforce, databases and reporting functions, e.g. immunizations and emerging infections, and information systems

Systems to Support Quality Care and Quality Improvement

Several recommendations address consumer concerns and support the availability of information for decision-making to consumers, providers, and administrators:

1. Implement a community-wide information infrastructure across the continuum of care, including electronic medical records and personal health records (health abstracts, immunization records, and other heath information)
2. Provide consumers access to information regarding the quality of care, medical outcomes and cost of care at the point of service interface between the consumer and the provider and the care institution.
3. Provide consumers with a medical (health) home that also serves as a resource to help consumers navigate the care system.

A Reformed Health Care Market

The recommendations have the goal of a more patient-centered marketplace.

1. Mandate information systems that can communicate with each other across the continuum of care
2. Implement systems that improve the flow of information among all stakeholders in health
3. Reallocate resources toward higher value in:
   a. The supply chain
   b. Payment for prevention
   c. Primary care
   d. Chronic disease management
4. Pay-for-performance in meeting prevention and medical care outcomes
5. Incent/reward the implementation of best practices and evidence-based decisions

A Reformed Insurance Market

The recommendations all support universal coverage for all Minnesota residents.

1. Individual participation would be mandatory and enforced via the tax code with a penalty for not participating and a tax credit or deductible for participating.
2. A basic benefit set would be developed, e.g. using federal or Minnesota Care definition
3. A basic plan would be developed around the basic benefit set, e.g. care network, payment structure. Other buy-up plan choices could be provided. Each participant would pay the same premium for the base plan, or could choose to pay for one of the buy-up plan choices.
4. A community-rating (state-wide) would be used for determining the premium charge for the basic benefit set. There would be an affordability adjustment with subsidy based on either cost as a percent of earnings or actual wages relative to the federal poverty definition.
5. The basic plan would have "guaranteed issue" access.
6. The role of the employer is still under discussion:
    a. Pay or play
    b. Administrative role, offering the basic plan during open enrollment
    c. Treating the basic plan under 125 tax code for self-insured
7. There also needs to be a recommendation regarding the fate of Minnesota Care, e.g. continue, roll-in

The development of this universal access, mandatory participation consumer-focused model with public-private financing will continue through the Fall 2006. The intent is to introduce the recommendations in the next session of the Minnesota Legislature.