HEALTH CARE POLICY: SOME BACKGROUND AND CONTEXT

House Committee on Health Care

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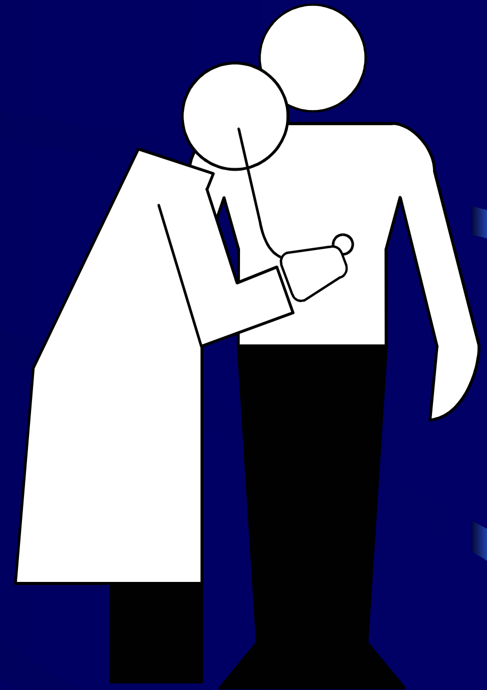


AMERICAN HEALTH CARE POLICY: SOME BACKGROUND AND CONTEXT

Voices from the past

1. Key Elements of Health and Medical Services
2. Defining Features of Health Services
3. Costs and Cost Trends
4. Insurance for Health Care Costs
5. Regulatory Restraints
6. Pressures are Building
7. Change is in the Wind
8. The Future will look a lot like the Present
9. Fundamental Questions & Premier Sciences
10. Useful Facts and Factoids

Health Care in Vermont: Database and Timeline (Attached)

- “Whatever means may be employed the time has come for action. European countries may not have proceeded with the greatest wisdom, but they have acted. Most of them have developed organized systems of medical care. We in the United States are now in a position to go forward intelligently. …a body of data is at hand which will enable each community and state to take wise and adequate action. Delay can no longer be tolerated.”
  Final Report of the National Committee on the Costs of Medical Care ***1932***

- “Tougher-minded Americans will see that a clear view of the complexities opens the way to constructive action. … Only the fainthearted and the easily confused will be daunted by these complexities”
  John W. Gardner, Excellence-Can We Be Equal and Excellent Too? ***1961***

- Given the current climate there is little doubt that this type of activity (public policy changes to reduce health care spending) will continue. Difficult questions with potentially unsatisfactory conclusions, must be answered. The most pressing is, how are costs going to be dealt with, without endangering access to quality care?
  Health Care Costs in Vermont, Department of Health **1983**

- This is not just a Vermont problem; in fact, many of its causes, as well as its solutions, lie beyond the bounds of our small state. Nevertheless, we cannot wait for others to act; we must grapple with the issues and propose solutions to assure the well-being of our citizens.
  Executive Order establishing the Vermont Blue Ribbon Commission on Health **1991**

- We are rapidly approaching the point at which these (health care) costs will directly conflict with our ability to do such things as maintain roads and bridges … to promote agriculture and tourism, or to provide any other services our citizens have come to expect. This commission is united in our belief that decisive action must be taken by the legislature in the immediate future and that new and unprecedented ways of approaching the challenge … must be given careful consideration.
  Bipartisan Commission on Health Care Availability and Affordability **2001**

- Key Elements of Health Services and Medical Care
  - Health care is huge…
  - “Lenses”
  - Key Players

Key Elements of Health and Medical Services:

- Health care in the USA—and Vermont—is:
  - ***Huge***—15% of every dollar in U.S. economy (was 13% in 2000—forecasts say 17% by 2014)
  - ***Nimble***--responsive to market, scientific, social , and political flows
  - Always ***changing***--never quiet or complacent
  - A blend of ***private and public*** sector interests
  - A blend of ***nonprofit and for profit*** approaches
  - ***Powerful***—very well honed political skills
  - **Nearly 15% of the Vermont economy--$2.8 Billion**
  - **(Vermont: would be 2nd highest spending "nation" on earth!)**
  - **Good business for Vermont—30,000 clean jobs**
  - **Most major health care players in Vermont are nonprofits**

Key Elements of Health and Medical Services:

- Viewed through different "lenses", health care may be seen as a:
  - ***Professional*** relationship--between patient and doctor or nurse
  - ***Social*** relationship--between government and citizens
  - ***Business*** relationship--between suppliers and customers
  - ***Personal*** relationship--among self, families and friends

  Each perspective brings ***different*** emphases, expectations, values and issues--and ***language***

  Solutions designed from each view may differ in important ways

  The perspectives are ***inseparably intertwined*** resulting in ***contradiction and tension***, for policy makers, providers and us

Key Elements of Health and Medical Services:

- Key players include ***people***:
  - Patients, spouses, partners, children, friends, self
  - Physicians, nurses, therapists, technologists
  - Legislators, policy makers, regulators, bureaucrats
  - Citizens, advocates, special interest groups
  - Suppliers, owners, investors, deal makers
  - Employers, insurers, policy holders
  - Provider networks, patient panels, risk pools
  - Managers, programmers, analysts, staffers
  - Students, teachers, researchers, designers
  - Clergy, bartenders and cosmetologists?!?
  - **Only 5 Vermont counties have enough MD's**
  - **Most Vermont RN's now work outside hospitals**

Key Elements of Health and Medical Services:

- Key players include ***organizations***:
  - Hospitals, nursing homes, home health agencies--***institutional*** providers and provider organizations
  - Physician practices and other independent, ***individual*** providers and provider organizations
  - Ambulatory care facilities
  - Respite and hospice facilities
  - Self-help organizations
  - Integrated delivery networks (Fletcher Allen, Dartmouth)
  - Voluntary health agencies (Heart, Cancer Societies…)
  - **Vermont: smallest state in USA with a medical school**
  - **Vermont Blue Cross is 2nd smallest Blue Cross in USA**

Key Elements of Health and Medical Services:

- Key players include still ***more organizations***:
  - Public health agencies (federal, state, local)
  - Actuaries, reinsurers, underwriters
  - Brokers, agents, buyer cooperatives, watch dog groups
  - Political parties, political action groups, unions
  - Think tanks, foundations, laboratories
  - Medical, nursing, and allied health schools
  - Manufacturers of drugs, technology, equipment, devices
  - Suppliers, vendors, consultants
  - **VT government as health care *regulator, payor & provider***

- Defining Features of Health Services
  - “The American Way”

Defining Features of Health Services in the United States:

- Predominantly ***private*** sector ***delivery*** of care
- ***Blend of public sector and private sector*** financing of care
- ***Public financing*** greatly influences ***private financing*** of care
- Wide ***variety of payment*** modes or strategies (fee for service, DRG…)
- Reputation for high ***technical quality***
- Responds to demands that are ***unpredictable*** but often ***hard to defer***
- "Health" and "health care" ***definitions are inexact, controversial***
- Consumer and provider are often ***shielded from costs and prices***
- Highly ***creative*** technology, delivery systems, payment means
- Absence of a ***constitutional*** reference to ***"health"*** or to ***"health care"***

Defining Features of Health Services in the United States:

- Our approach is often described as a reflection of the ***"American Way".***
  - We tend to favor "***equal opportunity for all" or*** "personal responsibility and choice" and "rugged individualism"
  - We tend to shun "***equal benefits for all***" or "assured solutions for the collective good" or "external system-driven remedies"
  - Demonstrate comparably ***greater tolerance for poverty***
  - Value ***freedom of choice for some*** over ***assured access for all***
  - Show ***faith in technical solutions*** to problems—"fix my knee!"
  - ***Spend*** money willingly to find and influence answers
  - Reflect necessary inventiveness due to ***geographic isolation***
  - ***We're unwilling to follow*** others; our ***own ideas will be better***

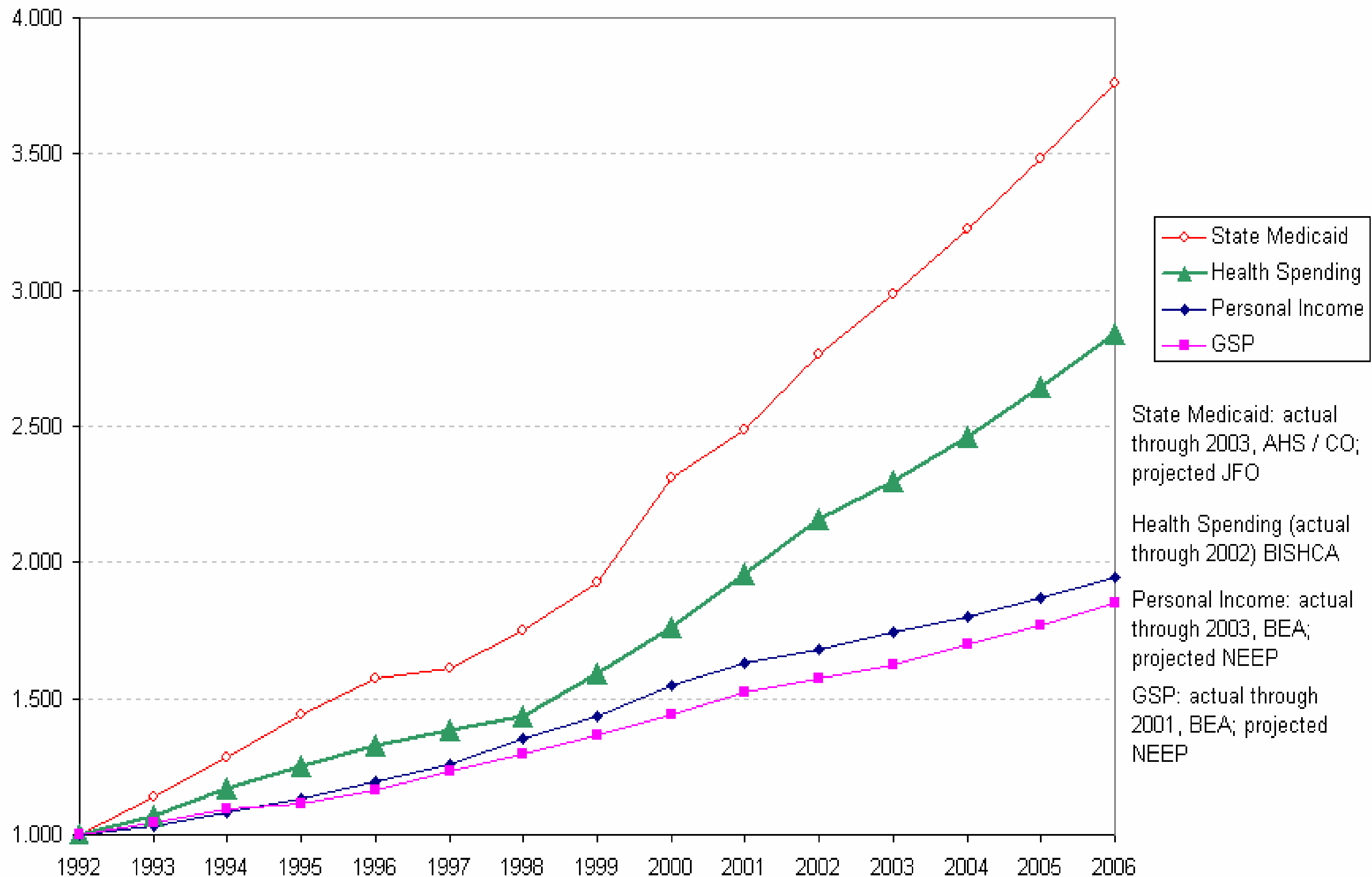
- Costs and Cost Trends
  - High costs
  - Changes in costs
  - Sources and uses of health care funds
  - Uneven distribution of costs
  - “Whose costs are we talking about?”
  - Where the money comes from

Costs and Cost Trends :

- ***High medical care costs*** and ***acceleration of costs*** are familiar problems .
- High costs and high rates of health care inflation are ***very old problems.***
- In 2002 health care costs accelerated by **9.3%** to **$1.7 *trillion*** dollars.
- Health care costs ***accelerate and decelerate at different rates over time.*** (costs appear responsive to regulatory cycles and public sector interest).
- These problems are broadly familiar--***they challenge every state and nation—*** regardless of size or type of their health care system.

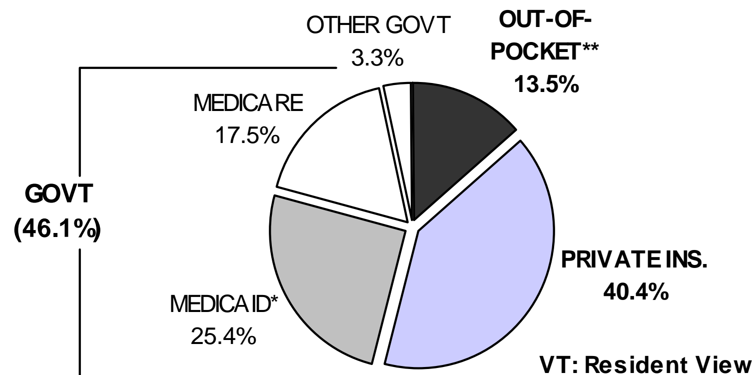
Costs and Cost Trends :

- "Newest kid on the cost acceleration block" is ***rising cost of drugs (Spending on prescription drugs grew by 16% in 2001).***
- Costs per person are uneven – ***our sickest 5% cost about 50% of total; our sickest 10% cost about 70% of total.***
- **From '92 to '98 VT health spending/person grew 47% (30% for USA)**
- **Drugs, long term & outpatient care are key cost drivers in Vermont**
- **Vermont health costs per person are lower than US average – $4,600 per capita in Vermont; $ 5,400 per capital across USA**



Health Spending, Personal Income, and Gross State Product
Relative Growth, Vermont, 1992-2006
4.000
3.500
3.000
2.500
2.000
1.500
1.000
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
State Medicaid
Health Spending
Personal Income
GSP
State Medicaid: actual through 2003, AHS / CO; projected JFO
Health Spending (actual through 2002) BISHCA
Personal Income: actual through 2003, BEA; projected NEEP
GSP: actual through 2001, BEA; projected NEEP

Spending Distribution by Payment Source, 2002



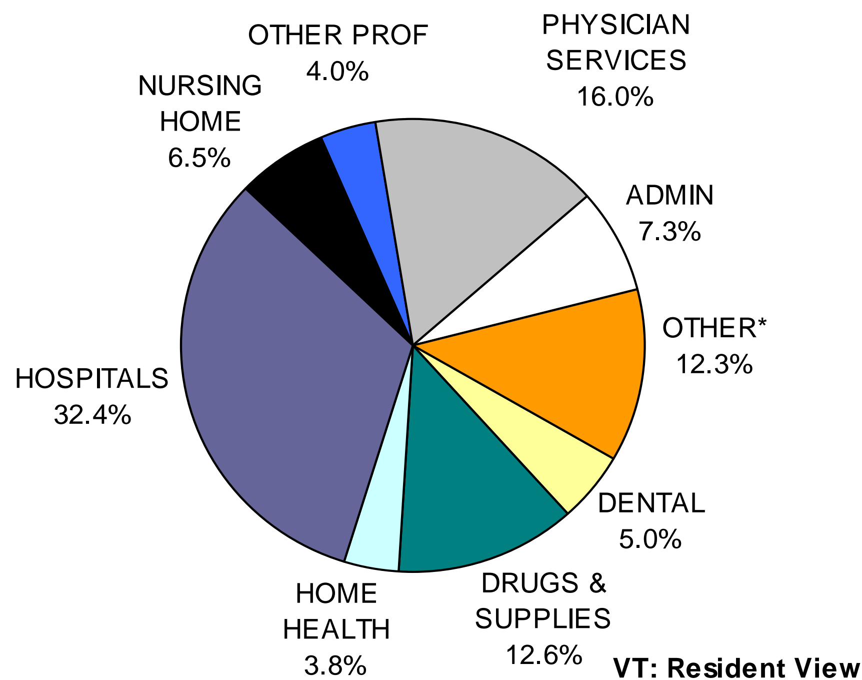
Notes:
* In contrast to other payers for health care services, a large portion of Medicaid spending (about 50%) covers long term care services, including nursing home care, home health services, and community mental health services. About one-third of Medicaid dollars flow through other state agencies such as DAIL, VDH and DOE that manage a variety of programs.
** Out-Of-Pocket does not include individuals' share of premium payments. Premium dollars are captured under Private Insurance per the CMS National Health Expenditures model.

Expenditure Analysis

PAYMENT SOURCES

Government funding sources account for just under half of the health care dollars spent on Vermont residents.

Spending Distribution by Provider Category, 2002



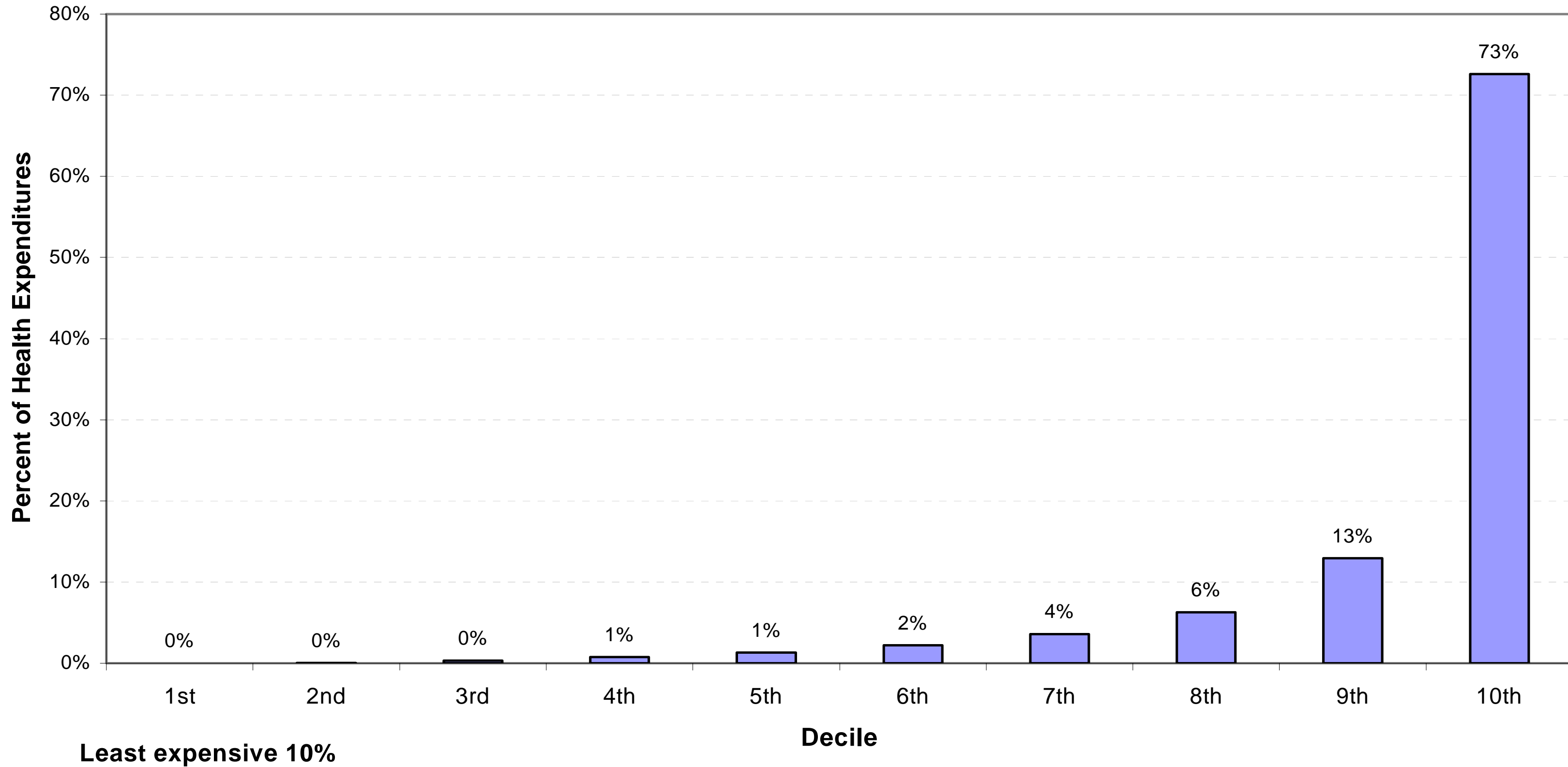
*Govt health activities accounts for 74 percent of spending in "Other" (primarily Medicaid expenditures for direct care programs administered by the Vermont Agency of Human Services). Other also includes vision, DME and other miscellaneous providers.

Expenditure Analysis

SPENDING CATEGORIES

Hospital and physician services account for the largest share of the health care dollar.

Distribution of Health Expenditures in the U.S. Population



Source: Agency for Healthcare Research and Quality / MEPS, 1999

Cost of Chronic Conditions

Blueprint for Health

CHRONIC DISEASE

Care for people with chronic conditions

(Most common: cardiovascular disease diabetes, hypertension, chronic mental conditions, asthma, arthritis, cholesterol disorders, substance abuse)

accounts for:

- 78 percent of health care spending
- 76 percent of hospital admissions
- 72 percent of all physician visits
- 88 percent of all prescriptions filled

"…chronic conditions last a year or longer, limit what one can do, and/or may require ongoing medical care."

Data Source: "Chronic Conditions: Making the case for ongoing care". Partnership for Solutions, Johns Hopkins University for the Robert Wood Johnson Foundation. December 2002.

Changes in costs are ***the net of***:

- Upward pressures from cost "***accelerators***" such as
  - + Payment methods which stimulate services (fee for service)
  - + Increased use of services as the population grows and ages
  - + Increased average severity of need and intensity of service
  - + New technology, prevention and treatment methods
  - + Influence of specialist MD's ($850,000 in orders/year)
  - + Care provided in more expensive sites (hospitals)
  - + Upward market pressures (such as shortages, monopolies?)
- Downward pressures from cost "***decelerators***" such as
  - - Payment methods which do not stimulate services (fixed fee)
  - - Improved ability to maintain health, wellness and independence
  - - Development of lower cost treatment and care options
  - - Influence of primary care MD's ($350,000 in orders/year)
  - - Public regulatory controls on insurer rates and payments
  - - Public regulatory controls on budgets and new capital spending
  - - Downward market pressures (such as surpluses, competition?)

When we complain about "costs", whose "costs" are we talking about?

- Through the "***professional lens***" cost may be the burden of the expenses needed to provide care such as support staff, rent, supplies, equipment, malpractice insurance …
- Through the "***social lens***" cost may be the burden imposed on the federal, state and local budgets (federal Medicare spending, state Medicaid costs, local costs for town employee's health insurance).
- Through the "***business lens***" cost may be the burden of bottom line lost to premium expense for employer share of employee health insurance, workers compensation insurance, and short or long term disability insurance; and employee wellness programs.
- Through the "***personal lens***" cost may be the burden of your share of employer-based insurance premiums; out of pocket costs for deductibles and non-covered services; and property and income tax burdens related to public spending for health care.

- Sources of health care *revenue:*
  - Ultimately all sources are from the ***same pockets***:

    Taxes paid by ***individuals*** to support health care spending

    Taxes paid by ***employers*** to support health care spending *

    Premiums for health insurance paid by ***employers*** *

    Premiums for health insurance paid by ***individuals***

    Direct out of pocket costs paid by ***individuals***

    Direct expenses paid by ***employers**** (employee wellness etc.)

    Philanthropic giving by individuals and employers

    * Arguably resulting in lower salaries and/or profits

Most of resulting revenues flow to private and public health ***insurance plans*** that then make payments to private and public ***health programs***

These ***plans and programs*** pay individual health care ***providers*** and organized ***groups of providers***

- Insurance for Health Care Costs
  - What is health insurance?
  - What are Medicare and Medicaid?
  - The “cost shift”

INSURANCE FOR HEALTH CARE COSTS

- *Health insurance plans* are:

-Mechanisms to *help insulate individual consumers from the risks* associated with paying uncertain for health care costs by substituting ongoing payments of a known amount for unpredictable payments of unknown, possibly larger amounts.

-Mechanisms to *help insulate providers from the risks* that they will not be paid for delivering health care services to insured persons.

-An insurer's *risk or gamble* that premium income will be less than amounts paid to providers and the costs of administering the insurance program (including funding of required reserves.)

-The insurer may be a company selling policies to dozens of employers and individuals, or a single entity self-insuring its own employees or members (a growing trend)

➢ **Vermont closely regulates insurers' pricing and practices**

INSURANCE FOR HEALTH CARE COSTS

- ***"Managed Care"*** is (***was***?) a uniquely *American* contribution to the international world of health insurance strategies

–Was a frequent "catch-all scapegoat" for changes perceived as broad faults across current health care practices

–Precisely, a *contractual* relationship among *providers*, an *insurance* plan and those *insured* that is intended to:

- *Improve the value* received for the premium dollar
- *Reduce insurance risk* carried by the insurer, and
- Help to *control growth* in health insurance costs.

-Some observers now are saying *"managed care is fading away"* — perhaps a marketplace victim of *perceived rationing by MCO's*

➢**Managed care had less impact in VT than in many other states**

INSURANCE FOR HEALTH CARE COSTS

- ***Medicare* is a federal health insurance program for most Americans over 65**
- States have ***little to say*** over how Medicare operates within their borders
- Medicare dollars are a ***mix of federal tax monies and beneficiary out of pocket dollars*** (the out of pocket share can be expensive)
  - **VT has low costs, so we get back less in Medicare benefits than we pay to the federal government in Medicare taxes**
- ***Medicaid* is a federal-state health insurance program for many Americans who are poor—but by no means for all our poor**
- States have ***much to say*** about who is eligible for Medicaid and what the benefits of eligibility are within their borders
- Medicaid dollars are a ***mix of federal and state tax monies and beneficiary out of pocket dollars*** (the out of pocket share can be relatively expensive)

INSURANCE FOR HEALTH CARE COSTS

- Both Medicare and Medicaid programs stipulate ***national minimum health insurance benefits*** — despite political arguments that say "we could never decide that"!
- Depending in the state, ***Medicare benefits may be better or worse than Medicaid*** benefits

- **A relatively high percent of Vermonters are insured by Medicaid**
- **Vermont Medicaid benefits are better than in many other states**
- **Medicaid cost shifts in VT may inflate private premiums by ~20%**
- **MVP may sell same policy for 25% less in Glens Falls than in Bennington**

INSURANCE FOR HEALTH CARE COSTS

- Medicaid & Medicare costs ***challenge state and federal budgets***
  - Federal Medicare spending in 1980 was $ 58 billion
  - Federal Medicare spending in 1994 was $ 227 billion (up 290%)
  - Federal budget officials are striving to rein in Medicare spending

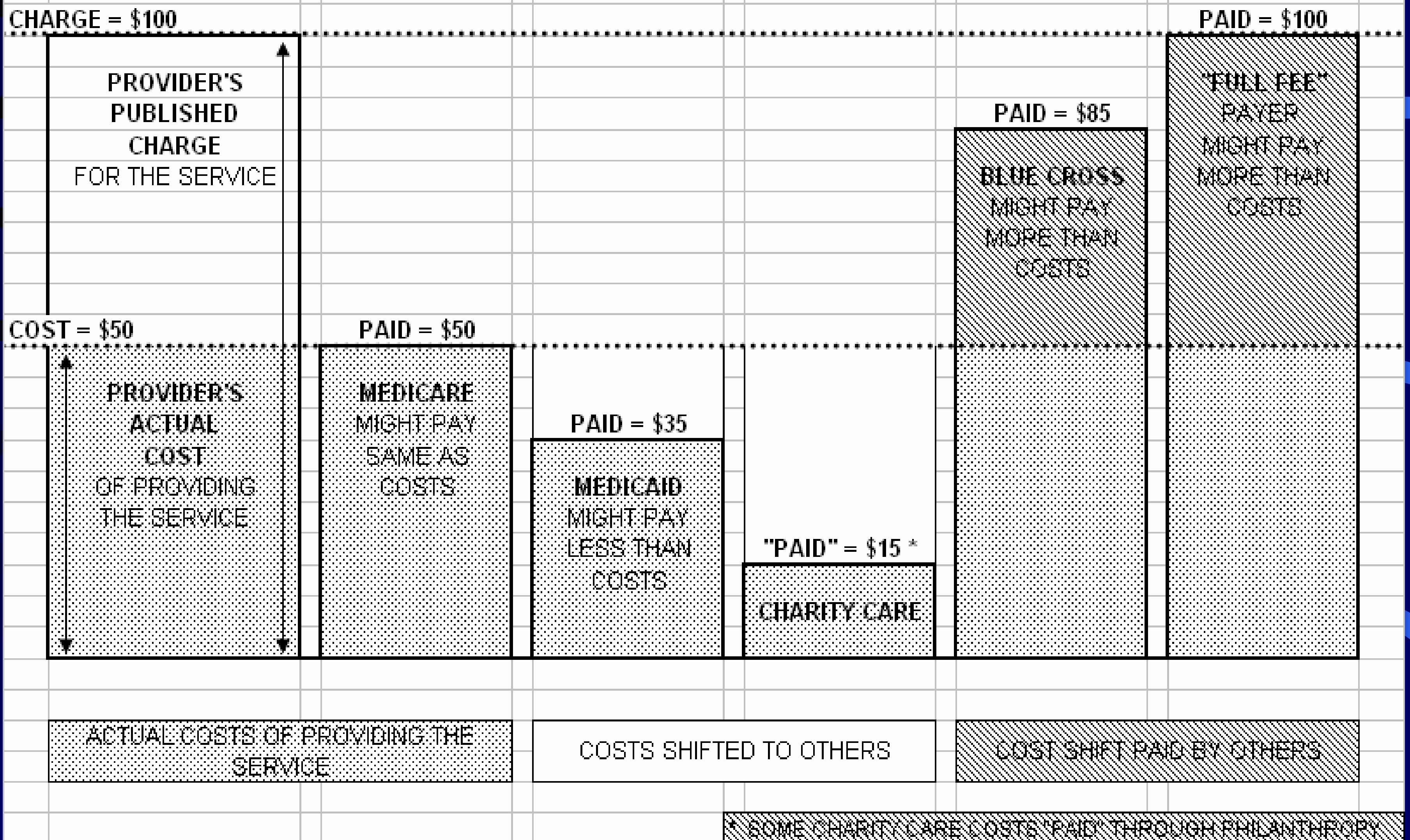
  - **Vermont Medicaid spending in 1994 was $ 77,000,000**
  - **Vermont Medicaid spending in 2003 was $ 173,000,000 (up 125%)**
  - **Vermont budget officials are striving to rein in Medicaid spending—an immediate shortfall of $70 million?**

INSURANCE FOR HEALTH CARE COSTS:
The health care "cost shift"

- All sources of payment for health service are *not treated equally*
- Some pay amounts *equal to the costs* of providing the care
  - For some providers, Medicare is in this category
- Some pay *less than what it costs* to provide the care
  - For most providers, Medicaid and "personal pay" fit in here
- Some pay *more than what it costs*
  - For most providers, these are the "Blue's", MVP and other private insurance payors
- In aggregate, the costs not covered by one group of payors are "shifted" to those who pay more—*typically Medicaid and charity care shortages are "shifted" to private payors such as Blue Cross*

INSURANCE FOR HEALTH CARE COSTS:
The health care "cost shift" (continued)

- The cost shift has been *routine for 40 years or more*
- Much of the cost shift burden is borne *knowingly – if not voluntarily* – as reluctant acknowledgment of "how it all works"
- Cost shifts are common – colleges and airlines have them too
- Private insurers have been more vocal recently about the burdensome impact of the cost shift on the affordability of the health insurance premiums they charge
- "We the people" will pay either way – through added premium or tax dollars – *unless* aggregate costs go *down*
- Providers will also pay either way by market or regulatory measures to control their costs


A SIMPLIFIED ILLUSTRATION OF THE HEALTH CARE "COST SHIFT"
CHARGE = $100
PAID = $100
PROVIDER'S PUBLISHED CHARGE FOR THE SERVICE
PAID = $85
"FULL FEE" PAYER MIGHT PAY MORE THAN COSTS
BLUE CROSS MIGHT PAY MORE THAN COSTS
COST = $50
PAID = $50
PROVIDER'S ACTUAL COST OF PROVIDING THE SERVICE
MEDICARE MIGHT PAY SAME AS COSTS
PAID = $35
MEDICAID MIGHT PAY LESS THAN COSTS
"PAID" = $15 *
CHARITY CARE
ACTUAL COSTS OF PROVIDING THE SERVICE
COSTS SHIFTED TO OTHERS
COST SHIFT PAID BY OTHERS
* SOME CHARITY CARE COSTS "PAID" THROUGH PHILANTHROPY
costshift.xls
1/30/05

- Regulatory Restraints
  - “Not free to do as they please”
  - “Layers” of restraint
  - Regulation and government in Vermont

❑ ***Regulatory*** Restraints:

-- Most health care players—*particularly providers and insurers*—are ***not free to do as they please***.

-- Depending on state where located and player type, they will fall somewhere along a ***"regulatory continuum"***:

- ***laissez faire*** model (private, free market)
- ***self-regulating*** model (private players set own rules)
- ***limited public control*** model (such as C.O.N.)
- ***public utility*** model (public tightly controls the private system)
- ***public service*** model (public owns the system)

-- Regardless of location, virtually all providers are subject to the primary federal health care regulatory agency—the Centers for Medicare and Medicaid Services ("CMS", formerly "HCFA")

❑ *“Layers” of Regulatory* Restraints:

Regulatory programs stem from concern for the size, power, economic impact and vital nature of health care services:

- ***Federal* level**:
  - Medicare conditions of participation
  - Medicare payment restrictions
  - Medicare compliance enforcement
  - Controls on Medicaid waivers
  - HIPAA (privacy protection), etc.

- ***State* level**:
  - Licensure
  - Certificate of Need
  - Rate Setting & Budget Controls
  - Professional Practice boards
  - Medicaid payment restrictions
  - Mandated Benefit laws
  - “Rule 10” for Managed Care, etc.

- ***Health Care Industry* level** *:
  - Accrediting, credentialing, certification, JCAHO (the “Joint Commission”), AAMC, HEDIS, NCQA etc.

  * Self-imposed

Regulation and Government in Vermont

- Vermont is one of a few states that has retained strict C.O.N. rules (Vermont is in "most restrictive" tier with 7 other states)
- Each biennium, about 125 pieces of health care related legislation are introduced in Montpelier; typically 24 of these will become law
- Since 1965, there have been at least 5 different organizational approaches to regulating health care in Vermont
- Over a dozen Vermont state government departments have key health roles (from Agriculture to the Vermont Veterans Home)
- Over 40 health-related professions are regulated by Vermont government (from acupuncturists to veterinarians)
- Vermont is one of a few states with a "Patients' Bill of Rights" law

		(GOVERNOR'S OFFICE)				
948	PROCTOR	HILL-BURTON FEDERALLY MANDATED HOSPITAL PLANNING (HEALTH DEPARTMENT--Focus on federally mandated statewide planning and financing)		NONE		NONE
964	HOFF	CENTRAL PLANNING OFFICE (GOVERNOR'S OFFICE)		NONE		NONE
965	HOFF	GOVERNOR'S ADVISORY BOARD ON HEALTH PROGRAMS (GOVERNOR'S OFFICE)		NONE		NONE
966	HOFF	NORTHERN NEW ENGLAND REGIONAL MEDICAL PROGRAM (UVM--Federally mandated; Focus on disease-specific program improvements)		NONE		NONE
966	HOFF	EDUCATION AND HEALTH BUILDINGS FINANCE AGENCY * (INDEPENDENT AGENCY--Focus on tax-exempt financing of capital projects)		NONE		NONE
967	HOFF	COMMITTEE ON COMPREHENSIVE HEALTH PLANNING (GOVERNOR'S OFFICE--Focus on statewide health planning)		NONE		NONE
968	HOFF	COMPREHENSIVE HEALTH PLANNING AGENCY ("314a" Agency) (HEALTH DEPARTMENT--Federally mandated; Focus on statewide health planning) -- CONNECTICUT VALLEY HEALTH COMPACT ("314b" regional agency) -- NORTHERN COUNTIES HEALTH SYSTEMS ("314b" regional agency) -- HEALTH DEPARTMENT ("314b" regional agency for remainder of state)		NONE		NONE
970	DAVIS	COOPERATIVE HEALTH INFORMATION CENTER OF VERMONT (INDEPENDENT AGENCY--Focus on uniform hospital data collection & analysis)		NONE		NONE
971	DAVIS	HEALTH SYSTEMS INCORPORATED (INDEPENDENT AGENCY--Federal R&D program; Focus on statewide health planning)		NONE		NONE
976	DAVIS	HEALTH POLICY COUNCIL *** Federal "Health Systems Agency" Freestanding planning agency Mandated consumer focus	MEDICAL CARE REGULATION Federal statewide "SHPDA**" Agency Planning/Regulatory unit of Health Dept Mandated technical focus	NONE		NONE
977	SNELLING	HEALTH POLICY CORPORATION Federal "Health Systems Agency" Freestanding planning agency Mandated consumer focus	MEDICAL CARE REGULATION Federal statewide "SHPDA" Agency Planning/Regulatory unit of Health Dept Mandated technical focus	NONE		NONE
979	SNELLING	HEALTH POLICY CORPORATION Federal "Health Systems Agency" Freestanding planning agency Mandated consumer focus	MEDICAL CARE REGULATION Federal statewide "SHPDA" Agency Planning/Regulatory unit of Health Dept Mandated technical focus	HEALTH POLICY CORPORATION Freestanding agency (DECISION BY HEALTH COMMISSIONER)	MEDICAL CARE REGULATION Division of Health Department	NONE
983	SNELLING	HEALTH POLICY CORPORATION Federal "Health Systems Agency" Freestanding planning agency Mandated consumer focus	MEDICAL CARE REGULATION Federal statewide "SHPDA" Agency Planning/Regulatory unit of Health Dept Mandated technical focus	CERTIFICATE OF NEED REVIEW BOARD (DECISION BY THE REVIEW BOARD)		HOSPITAL DATA COUNCIL (DECISION BY THE COUNCIL)
987	KUNIN	HEALTH POLICY COUNCIL FREESTANDING STATE-FUNDED HEALTH PLANNING AGENCY No further Federal mandate for health planning		CERTIFICATE OF NEED REVIEW BOARD (DECISION BY THE REVIEW BOARD)		HOSPITAL DATA COUNCIL (DECISION BY THE COUNCIL)
992	DEAN	HEALTH CARE AUTHORITY (GOVERNOR'S OFFICE--Focus on statewide planning and regulation)		HEALTH CARE AUTHORITY (DECISION BY THE CHAIR)		HEALTH CARE AUTHORITY (DECISION BY THE CHAIR)
996	DEAN	HEALTH CARE ADMINISTRATION * (BISHCA--Focus on statewide planning and regulation)		PUBLIC OVERSIGHT COMMISSION * (SUPPORTED BY TECHNICAL PANEL; DECISION BY BISHCA COMMISSIONER)		PUBLIC OVERSIGHT COMMISSION * (SUPPORTED BY TECHNICAL PANEL; DECISION BY BISHCA COMMISSIONER)
003 TO PRESENT	DOUGLAS	BISHCA / HEALTH CARE ADMINISTRATION * (BISHCA--Focus on system resources; HEALTH--Focus on system outcomes)	HEALTH DEPARTMENT *	BISHCA / HEALTH CARE ADMINISTRATION * (DECISION BY THE COMMISSIONER)		BISHCA / HEALTH CARE ADMINISTRATION * (DECISION BY THE COMMISSIONER)

* = Still in operation today.

- Pressures are building
  - The uninsured

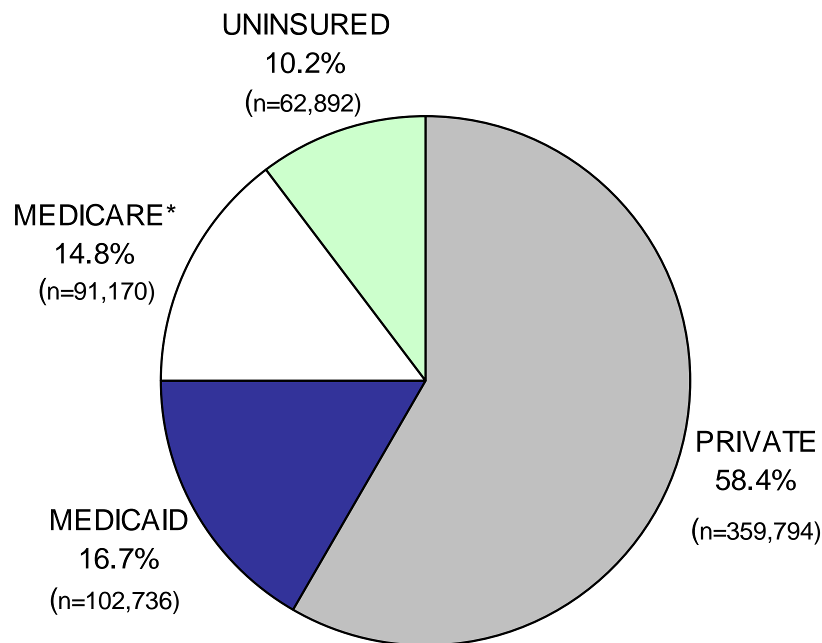
- *Pressures* are building about

  – The 14% or 45 million of us who ***lack health insurance*** (perhaps not enough appreciation for the other access factors such as apprehension, distance, language).

  – ***45 million uninsured exceeds the entire population of New England, New York & Pennsylvania!***

  - **Fewer in VT are uninsured than in other states: 63,000 or ~10% of Vermonters – but this has crept up from around 8% in the 1990's**

Vermont Health Insurance Coverage Profile, 2002



*About 15,000 Vermonters are dually enrolled in Medicare and Medicaid. These lives are counted under Medicare and not Medicaid.

Health Insurance Coverage

UNINSURED

PROFILE

10.2 percent of Vermont residents lacked health insurance coverage in 2002. This compares to 15.2 percent for the nation.

SOME WAYS TO THINK OF THE UNINSURED

VERMONT UNINSURED: 62,900 (2002)			
BURLINGTON	38,500	RUTLAND COUNTY	63,500
RUTLAND	17,350		
ST ALBANS	7,300	- OR -	
	63,150		
- OR -		ESSEX COUNTY	6,500
		GRAND ISLE COUNTY	7,200
MORRISTOWN	5,300	LAMOILLE COUNTY	23,800
ROCKINGHAM	5,300	ORLEANS COUNTY	26,600
LYNDON	5,600		64,100
WILLISTON	6,600		
WINOOSKI	6,900		
ST ALBANS	7,300		
ST JOHNSBURY	7,400		
MONTPELIER	7,700		
BARRE	9,100		
	61,200		

USA 44,700,000 (2003)	
VERMONT	*620,000*
NEW HAMPSHIRE	*1,290,000*
MAINE	*1,300,000*
MASSACHUSETTS	*6,450,000*
RHODE ISLAND	*1,100,000*
CONNECTICUT	*3,500,000*
NEW YORK	*19,200,000*
PENNSYLVANIA	*12,350,000*
	45,810,000

unisured.xls 01/30/05

❑ ***Pressures*** are building about:

- The ***numbers*** of free-standing health care organizations ***are shrinking*** as more markets favor:
  – Players that are members of networks (thus ***affiliations***).
  – Larger players (thus ***acquisitions and mergers***)
    --True for hospitals, medical practices, medical colleges, home health agencies, and insurers ("vertical" and "horizontal")
- This ***market consolidation*** results in ***fewer players, greater concentration of dollars*** **and** ***higher risks*** for all players.
- Consolidation may mean ***yesterday's competitor*** is ***today's partner.***
- This evolution is testament to the ***market clout of purchasers of care***.
- However, we may have over-corrected towards integration and we are now seeing some strategic ***dis-integration.***

Pressures are building about:

- Disproportionately ***high share*** of health care dollar used for care ***administration*** (some say we may already have ***plenty*** of financial capacity for the uninsured if we reduce high medical care administrative burdens and costly, futile end of life care).
- After 40 years of high growth relative to the rest of the market, our economy now may be shouting ***"uncle"*** — or is it??
- ***Increasing demands*** for care as "baby boomers" age (need for care correlates with age--highest use by infants and those over eighty) and for growing ***cost burden of "baby boomer" health care*** on the younger, smaller groups of wage earners.
- **In five years (2010), Chittenden county will have 27% more people over 65 and 36% more people over 85 than it did in 2000**
- Increasing focus on ***price*** without adequate measures of ***quality.***

❑ *Pressures* are building about:

- Uneven distribution **of *physicians*** (depending on specialty and location) and ***surplus of hospital beds*** in many regions.
- Growing ***shortage of nurses*** (from aides to registered nurses) as a result of aging of the caregiver workforce and fewer new entrants.
- Yesterday's ***nursing school valedictorian*** is probably ***an MD*** today (Today over 50% of medical school first year students are women)
- ➢ **VT's nurse educ programs are busy—74% more than 1999   Busy enough?**
- Need to better think through ***efforts to address surpluses and shortages***—we have a poor record of over-correcting supply of health care workers.
- Federal audits for ***compliance*** with intricate Medicare billing rules extract heavy, often disproportionate financial penalties.

- Change is in the Wind
  - The “Value Equation”

The *"Value Equation"*:

$$\text{Marketplace } \textit{Value} = \frac{\textit{Service}\text{ Quality} + \textit{Outcomes}\text{ Quality}}{\textit{Cost}\text{ of Services}}$$

- In order to ***maximize the value equation***, organizations must be able to ***define*** and ***measure*** their service, outcomes and cost elements; then ***improve*** them, and ***share*** the results using reporting formats such as :

  – ***Instrument panels, balanced scorecards, and quality compasses***

  – ***Information systems*** must be designed to support these reports through monitoring and relating structures, processes and outputs

  – Individual providers and public agencies (such as Medicare) are ***going public*** with informative "report cards"

  –***Federal "HIPAA" rules*** constrain some uses of health information for patient care and for reporting purposes

  –Much recent public attention on ***health care error rates***

- ***Change*** **is in the wind:**

  - ***Healthy skepticism*** for some Western medical traditions, growing appreciation for some ancient and emerging alternatives.
  - Acknowledgement that current focus on ***disease*** is denying benefits of alternate strategies focused on ***wellness*.**
  - More preference for a "***good death***" rather than "futile ICU heroics"
  - Reappearance of ***infectious diseases*** as major threats to wellbeing (HIV/AIDS, MRSA, SARS, tuberculosis, "prions", bioterrorism.)
  - Health care providers have changed strategies for success from "***revenue generation***" to "***cost controls and operations efficiency*".**
  - Unsure timing and duration of current and future ***economic trends***.
  - Redesign of care strategies around ***chronic*** rather than ***acute*** illness
  - The managed care phenomenon is redirecting providers from the ancient tenet of ***"first, do no harm"*** and the more recent ***"if you think it will help, try it" to*** a more contemporary ***"do only what we know will help" ("evidence-based practice") .***

- But the Future will look a lot like the Present

- But the ***future*** will look a lot like the ***present:***
  - The US has experienced ***recurring attempts*** to reform medial care through regulatory pressures as well as market pressures--these will continue. ***Is "health care revolution" un-American?*** *Ever happen in Vermont?*

    Are ***incremental reforms are more likely*** than radical ones?
  - There will be ongoing attempts to design health care improvements that reconcile the goals of ***high quality, affordable cost and full access*** (the "three corners of American health policy".)

    (Has Vermont demonstrated *sustainability* to be a fourth goal?)
  - There will be ongoing debate over the merits of "***choice***" v "***access***"
  - "***Allocating***" may become a more useful term than "***rationing***" **("HRAP")**
  - Debate will continue over what parts of health care are appropriate for the ***for-profit*** model, and which are best left to ***non-profits*** and ***public*** sectors.
  - **Vermonters are *very* interested in their health care: since the early 1900's there have been more than 15 major studies of health care in Vermont—including one *every 4 years* on average since the end of World War II**

- But the ***future*** will look a lot like the ***present:***
  - ***Health care practice changes*** will continue to closely parallel related ***business changes*** (a classic ***"chicken and an egg"*** situation!)
  - Is the market stimulating changes in practice? Or, are practice changes fostering market evolution?
    - Hospitals are increasingly ***outpatient*** focused
    - Only most ***intensive*** surgeries require hospital ***admission***
    - ***"Scope"*** procedures are replacing ***"open"*** surgeries
    - There are more ***noninvasive*** treatment options
    - ***Prevention*** and ***public health*** are returning to the spotlight
    - ***Admissions*** are ***fewer*** and ***lengths of stay*** are ***shorter***
    - ***Hospital acute care beds*** are being ***converted*** or ***closed***

- But the ***future*** will look a lot like the ***present:***
  - Market evolution continued:
    - ***"Quicker and sicker"*** discharges going to rehab and home care
    - ***Long term care at home*** rather than in a nursing home **(ACT 160)**
    - ***Home health*** and ***long term care*** are the new growth industries
    - ***Subacute*** and ***rehab*** units and facilities serve ***intermediate*** needs
    - ***Primary care*** training emphasized over ***specialty*** training
    - ***Better pay for Primary Care Physicians (PCP's)***
  - ***Drug costs*** challenge personal, insurer, and government budgets

    (Each of the top 7 "TV drugs" spends more on ad's than Nike does)
  - Concerns for ***inequities*** across population groups and related unrest
  - Consumers' concerns re ***erosion of choice*** and ***limits on access*** to care
  - Ongoing ***Medicare*** developments and reforms with wide impact

- But the *future* will look a lot like the ***present:***
  - **Leading *immediate causes of death* will still be (in some order):**

Heart disease
Stroke
Accidents/injury
Diabetes
HIV/AIDS
Cirrhosis of liver
Cancer
COPD
Pneumonia
Infectious/parasitic diseases
Suicide/Homicide

  - **Leading *contributing risk factors* will still be (in some order):**

Heredity/genetics
Diet
Alcohol use
Toxic agents
Sexual behavior
Tobacco use
Activity levels
Microbial agents
Firearms use
Motor vehicle use
Illicit drug use (cocaine and heroin in particular)

- Fundamental Questions and Premier Sciences

Four Fundamental Questions:

1. At 15% of Vermont's economy, ***are we spending too much*** on health care?

2. With a 9% growth rate, ***is it growing too quickly***?

3. Are the ***benefits*** of the 15% being ***shared equitably*** by all Vermonters?

4. Are the ***burdens*** of the 15% being ***shared equitably*** by all Vermonters?

Three premier health sciences for the twenty-first century?:

- EPIDEMIOLOGY – teaches us about clearly understanding and defining our mission and the work we are called to do in health care
- ECONOMICS – teaches us about clearly understanding with the choices we make given our inevitably scarce health care resources
- ETHICS – teaches us about clearly understanding our values as we make health care and economic choices in a wise and defensible manner

- Closing Notes — Useful Facts and Factoids

CLOSING NOTES: Some Useful *Facts and Factoids--*

- ***Consumer ignorance is eroding*** as purchasers of care become more sophisticated--demanding provider and health plan "report cards" (Medicare now publishing quality reports for all nursing homes, home health agencies and hospitals in the USA.)
- Information systems being designed to produce those report cards (***nontraditional measures—***clinical outcomes, satisfaction scores).
- American health care has long been the ***world standard*** for technical quality; recently others study our ***creative health care financing.***
- ***Universal health insurance*** for the US has been ***attempted—and failed—at least six times*** in this century--most recently in 1994.

Some Useful ***Facts and Factoids***--

- The germinal analysis of health access, quality and costs in the US was written ***generations ago***-- "Report of the Committee on Costs of Medical Care" (1932).
- American hospitals are ***unusual*** because we usually allow community physicians to admit and treat their own patients.
- Unflattering American statistics--***violence/accidents*** are leading causes of death and injuries here—and 18,000 annual deaths related to being uninsured
- ***"Hospitalists"*** are new players in American health care—physicians who practice exclusively within hospitals with a focus on "care management" (sometimes on hospital or medical group payroll, sometimes on insurer's payroll).

Some Useful *Facts and Factoids--*

- What we think of as ***"health care" has less to do with our well-being*** than ***heredity, lifestyle, nutrition, education and social class.***
- Some say ***only 10%*** of our health status relates to care we do or don't receive. Some say **50%** of what we do in health care is either ***wrong or unnecessary***.
- M***any*** patient encounters with the health care system result in ***little or no impact*** on the condition which lead to the encounter; when there is an impact, the chances for ***dramatic improvement*** of the presenting condition are lessened by the chances that the encounter will result in ***worsening*** of the presenting condition!
- This helps to explain why practice patterns for the same diagnosis or condition vary widely within regions--***"small area variations"*.**
- **Arguably, the two most influential public efforts for Vermonters' health are the Food Stamps and WIC programs—but these aren't mainline "health programs"**

Some Useful ***Facts and Factoids--***

- Health care consumption during middle age is often related to ***gender***—but kids and elders consume more regardless of gender

- The sheer ***size*** of the American health industry sets us apart from our neighbors-

15% of the US economy	*9.1% in Canada*
8.4% in Sweden	*10.9% in Israel*
7.8% in Japan	*7.3% in United Kingdom*

(Kansas has more hospital MRI machines than all of ***Canada!)***

- The ***trade and competitiveness*** implications of our disproportionate health care cost burden should be obvious.

- Borrowing from Vermont's "Act 60" lingo, compared to the rest of the world the United States is the "***goldest of the gold towns***"

Some Useful ***Facts and Factoids--***

- The ***price*** American auto makers pay for ***health insurance*** has a greater impact on their car prices than the cost of the ***steel***!

- ***Medical care costs can be staggering burdens***--For example, self insured employers in the following businesses must devote all of the profits on the sales below to recover the costs of one typical open heart surgery procedure (about ***$30,000***) performed on one of their employees:

300,000	toy action figures, or
1,400,000	gallons of gasoline, or
2,500	household years of electrical service, or
80,000	six packs of beer, or
3,500	automobile tires

- **Does anyone care to speculate about the implications should a Supreme Court "Brigham-like" decision require that the General Assembly to assure equal access to health care for all Vermonters?**

As we continue the struggle, we should always remember "Bill Gilbert's Maxim":

"Beware of well articulated,
beautifully supported solutions—
that are over-simplified and wrong."

Comments by Bill to the UVM Board of Trustees 1980's

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Actively engaged in Vermont health care, higher education and public policy for 30 years.

Current:

- President and CEO, VNA of Chittenden & Grand Isle Counties since 1999
- UVM Clinical Associate Professor of Medicine since 1977
- Member, BISHCA Health Resource Allocation Plan (HRAP) Advisory Committee
- Treasurer, Snelling Center for Government Board of Directors
- Member of several other community and professional organization boards

Previous (selected):

- Vice President for Finance, Fletcher Allen Health Care, Burlington
- Chief Financial Officer, University Health Center, Burlington
- Vermont Commissioner of Budget and Management for Governors Snelling and Kunin
- Chair, Vermont Higher Education Study Commission
- Chair, Finance Committee, Vermont State Colleges Board of Trustees

Education:

- PhD University of Iowa 1977 (Health Policy and Management)
- BA St Michaels College 1969