The Vermont Health Care Affordability Crisis:
What is causing it and how to fix it

By Otto Engelberth, published 04/22/05, and posted on
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For some time now, I have had a concern that paying for health care with employer provided health insurance is not working for many Vermonters. In my conversations with people, I sense a lot of confusion as to why this is happening. So I decided to write this paper, which not only describes why the system is failing, but also outlines what needs to be done to fix it.

In order for you to know where I am coming from, I am 65 years old; have a family, and am the founder and CEO of Engelberth Construction Inc., a 32-year-old construction business that now employs more than 200 people.

You could also say that I have 32 years of experience in the business of health insurance. In fact, for a period of time we were in the business, because we self-insured our employee's health insurance. In 32 years, I've seen the yearly cost, of a family's health insurance plan; go from $1500 to more than $9000. I have experienced the challenge of trying to keep health insurance affordable for our people.

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How employer based health insurance works

Before sharing my thoughts on fixing the health insurance affordability crisis, it would be helpful for you to understand my prospective on how employer based health insurance works.

Historically, employers got involved in buying health insurance for their employees back in the 1940s after the government imposed wage controls during the Second World War. They did this because it was a way to, in effect, pay employees more without violating the wage freeze.

Hence, the charade was born that "employers pay for health insurance, not employees". In my view, the reality is just the opposite. *Employees always pay for their health insurance,* because employers are paying their employees using health insurance as a form of compensation in lieu of Dollars.

Employers buy the health insurance, (which is a tax deductible cost) and then allocate the cost to the individual employee as labor burden. What this means is that an employee who has an employer provided family health insurance plan costing their employer $9,000 per year is, in effect, getting paid their base pay plus an additional $9,000, on which the employee pays no income or FICA tax. This has several interesting consequences:

1. By not taxing the health insurance compensation the employee receives, the government is subsidizing employees by the amount of the value of their health insurance times their income and FICA tax rate. *So the higher-income employee, with a combined tax rate as high as 60%, the real cost for their $9,000 family plan is $3,600, while the low-income employee with a tax rate as low as 15%, their real cost is $7,650 for that same plan.*
2. The private health insurance market is distorted, because the only way a person can buy health insurance with a savings outlined above, is through the employer/employee relationship. This unique tax treatment discourages other groups from banding together to provide competing sources of health insurance. These potential competing groups could include towns, counties, states, social groups, demographic groups, etc.
3. The employer's per-employee cost of health insurance varies depending on whether the employee is single, married without children, or married with children. But in most cases, the health insurance cost allocated to each employee is the average individual policy cost rather than the actual cost. This results in the employees with families being, in effect, subsidized by their fellow employees who are single.
4. Employees have little input into what health insurances their employer selects. This results in a feeling of loss of control over one of the more important factors in their lives.
5. Finally, the employee's perception that they are getting free health insurance has resulted in their high tolerance of the cost shift from Government health plans to private health plans.

Why the High Cost of Employer Provided Health Insurance is No Longer Affordable for Many Vermonters

Rapidly inflating health insurance costs have brought about a crisis in employer based health insurance. Over the past 25 years, the cost of health insurance has gone up more than 10% per year while total wages have gone up less than 5% per year. This has resulted in health insurance costs being an ever-increasing percentage of the employee's total compensation package.

Since market forces limit the total compensation that the employer can pay the employee, and the employee needs cash to pay living expenses, etc., there is a limit to the portion of the employee's pay that will be in the form of health insurance. When that limit is reached, the excess insurance cost is born by the employee, through higher deductibles, insurance co-pay, or limiting coverage.

For many employers, providing health insurance as part of their compensation package has become a "no-win" situation. Employers have the hassle of selecting and administrating the employee's plan, which in the end harms the employee/employer relationship because of unmet expectations. However, many of us employers continue to use health insurance as a part of our compensation package, because we recognize that we are the only place that our employees can buy health insurance with pretax dollars.

We are now at the point where many employees are bearing the full brunt of health insurance inflation, because employers are no longer able to shield them from it. This year's increase in health insurance rates will be nearly 15%. At this compounded rate of increase, the yearly rate for a family insurance plan will double to $18,000 in 5 years-- and in 10 years will double again, to $36,000. As health insurance costs escalate, more and more employed low- and middle-income Vermonters will be forced go without coverage, because they will not be able to afford it.

Part Two – Defining the Problem

At some point, this uninsured population will become so large that Vermont's voters will conclude that the private, employer- based health insurance system is broke, and insist that the government create an alternative health insurance framework. In anticipation of this, it will be helpful to discuss some of the key issues and principles that, in my view, need be considered in the process of creating such a framework.

How Government's Rules Impact Healthcare Funding

The Impact of Medicare and Medicaid

It will be important to recognize that the federal government's Medicare and the state's Medicaid health insurance programs are the "800-pound gorillas" in the health care market. They purchase 60% of all health care services, and pay 45% of the dollars flowing into the system. They are also one of the major causes for the private health insurance affordability crisis; because their payments do not cover the cost of the services they buy. So providers have no choice but to charge the rest of us more in order to

survive financially. In the case of hospitals, it means that they could charge private payers 1/3 less if Medicare and Medicaid payments covered the cost of services they buy. This "cost shift" phenomena virtually assures that private insurance premiums will inflate at ever increasing rates as the number of Vermonters in the private insurance pool shrinks.

In my view, Medicaid is a major part of Vermont's health insurance problem. This is because Medicaid is the Vermont's fastest growing and largest health insurer. They now cover 15.8% of all Vermonters. And they only pay 50% of the cost of the health care services they buy.

The amount of and projected growth in the State's portion of Medicaid costs is causing a funding crisis for State government. This year, the State's Medicaid costs are projected to be $367 million. If nothing is done and health care costs grow at the compounded rate of 10% per year, by 2010, State funded Medicaid costs will exceed $650 million.

And if you need more to worry about, the funding crisis would be worse if Medicaid paid the full costs of the medical services they buy. How much worse? Just double the numbers in the previous paragraph.

If Vermont decides to implement a health insurance plan that would cover Vermonters who are presently insured by Medicaid, it will be important that the federal government be willing to contribute their 61% of the total Medicare funding to that new plan.

<u>The Role of Public Health in the Delivery of Health Care</u>

Generally, the role of public health is to deal with the health issues that have the potential to put the public as a whole at risk. When thinking through any alternative health insurance scenarios, I believe that it will be helpful to be aware of the line that defines where the responsibility of public health ends, because that is where the role of any health insurance system begins.

<u>Reduce Health Care Costs by Acquiring Prescription Drugs at Globally Competitive Prices</u>

In the United States, prescription drugs represent $162.4 billion of the $1.6 trillion total annual healthcare expenditures. This works out to an average of $540 per year that each of us spends on prescription drugs.

You are probably aware of efforts by individuals and groups to buy healthcare related drugs in Canada, because they are less expensive there. So far, the federal government has blocked these efforts. Is this a big deal? Let's look at the numbers.

In the October 2003 issue of the *Life Extension Magazine* published a chart comparing the prices of prescription drugs in Europe and the United States. The following is a listing of the percent that Europe's price is *less* than ours: Premarin 84%, Synthroid 86%, Coumadin 89%, Prozac 73%, Prilosec 88%, Norvasc 47%, Claritin 90%, Augmentin 81%, Zocor 59%, Paxil 44%, Zeatril 85%, Prempro 66%, Glucophage 94%, Cipro 82%, Zoloft 70%, and Pravachol 68%.

I think that you would agree that the price differential is a big deal!

But that's not the whole story. In that same issue, the magazine also published a chart showing the cost of the generic active ingredient in several popular prescription

drugs. The following list of the generic active ingredient as a percentage of the of each drug's U. S. price: These are: Celebrex 0.46%, Claritin 0.33%, Keflex 1.19%, Lipitor 2.13%, Norvasc 0.08%, Paxil 3.45%, Prevacid 0.29%, Prilosec 0.15%, Tenormin 0.13%, Vastec 0.2%, Xanax 0.02%, Zestril 3.56 %, Zithromax 1.27%, Zocor 2.47%, and Zoloft 0.85%.

I could be wrong, but to me, it seems that these percentages are an indication that there is a real disconnect between the actual cost of these drug's ingredients and their pricing in the U.S. market. I would guess that if M&Ms were priced on this same basis, they would cost at least $10 per bag.

Our Government in Washington DC tells us that paying highly inflated drug prices is one of the benefits of living in the "Land of the Free and Home of the Brave." What is really scary is that it appears that they are prepared to put people in jail to assure that we are not denied that right.

Why does the country that champions free trade tolerate the price abuse of their citizens by the U. S. Pharmaceutical Industry? In my view it is money.

Since 1997, the drug industry has spent $650 million lobbying congress. Who knows how much they contributed to political campaigns of Congressional and Presidential campaigns. As evidence of their clout, the drug industry got its pricing structure written into law in the recently enacted Medicare reform legislation.

In my view, being able to buy medical drugs at Global prices is a necessary prerequisite to having an affordable healthcare insurance. How can this be done?

- First, it will be very important for the insurer to truly represent the interests of the healthcare customers.
- The health insurer needs to be able to band together with larger pharmaceutical buying pools, to achieve global drug pricing for its customers.
- If all else fails, the insurer needs to have the right to not fund the purchase of drugs that is not globally priced.

<u>Understanding Tax Policy's Impact on Health Insurance</u>

The discussion of tax policy as it relates to health care funding falls into two broad categories. The first has to do with the tax treatment of health care related expenses that are paid out of pocket by the taxpayer.

As I pointed out above, the government is not uniform in the way it taxes the individual's health insurance transaction, while in the case of other types of health related costs the tax rules are complex and inconsistent. The consequence of this policy is that the upper income people who work for employers who do offer health insurance as a part of their compensation package receive a significant tax subsidy, while lower income employees in most cases do not. I think the question we need to ask is, "Is this a rational and fair public policy?"

The second category has to do with the types of taxes used by governments to raise the money used to pay for publicly funded healthcare. Medicare is funded by Federal FICA tax, which is a tax on gross wages. Medicaid and public health are funded by federal and state income tax.

Keep in mind that the "cost shift" resulting from Medicare and Medicaid under payment for the health care they buy is an additional, hidden tax, which is paid by all who are not covered by these programs. And in the case of employer-supplied health

insurance, the "cost shift" tax is regressive because employees pay for it using pretax dollars.

If government funds healthcare insurance, it is important to understand that there is essentially three ways that the government collects taxes. One is by taxing a transaction, as we do in sales, value added, and income taxes. The second is by taxing an asset, as we do with property tax; and the third is by taxing a person, as in the case of a poll tax. Of these, the transaction tax is the most volatile, because a transaction, by definition, is optional. So the tax on transactions tends to discourage people from making them.

Some have suggested that a way to encourage people to buy health insurance is to make its cost tax deductible. Keep in mind that this is not an incentive for those who can't afford health insurance because they pay little or no income taxes.

In my view, a real challenge in developing an alternative to our present employer-based health insurance system is how to incorporate the present employer-based health insurance tax subsidies into the new system.

The Role of Health Insurance

Does Insurance have a role in health care funding?

Let's look at some of the per-person cost statistics. If the average American's annual cost of healthcare is $5,440 and the expected life span is 68 years, the per-person average lifetime cost would be $370,000. Of this, 40% or $148,000 occurs in the last 6 months of life.

Another statistic to consider is that 10% people consume 70% of the total health care expenditures. This means that the average lifetime health care costs for the top 10% of consumers is $2,590,000.

Given these numbers, it seems to me that we will need a mechanism to pool our resources and share risk. Very few of us have the personal discipline or the financial capability to set aside savings to pay for catastrophic healthcare costs. It is also probable that some people will need a subsidy, because they do not have the means to contribute their per-person $5,440 annual share of the cost.

The Limitations of Traditional Health Insurance

In my view, traditional health insurance has several limitations as a funding source for healthcare:

- One limitation comes from the fact that it is essentially a one-year contract between the insurer and the insured or insured group. And as such, it is priced on the insured's health care risk factors for the coming year. These risk factors are driven several variables -- some of which, such as our lifestyle, are within insured's control, while others, like our age and our genetic make up, are not. I think the question that needs to be asked is whether it is rational for the insured to price their health insurance risk on a year-to-year basis. I don't believe it is, because the time may come when the insured's health risk factors may make it impossible to buy heath insurance at any price.

- Another disadvantage of a one-year contract is that it gives insurers little incentive to reduce the cost of health care, and to invest in long-term customer support and proactive health care.
- Another limitation of traditional health insurance is that lower income Vermonters can't afford it. More than 60,000 Vermonters have chosen to go without health insurance for this reason. Put your self in their shoes: Would you pay $9,000 for a family health insurance plan if your total income were $30,000? I doubt it.
- Medicaid and similar programs are the byproduct of the lack of affordability and availability of traditional health insurance for many Vermonters. Most of these programs are funded by some income related taxes. Each has their own overhead costs, adding to the cost inefficiencies resulting from multiple duplicate systems.
- People choose to "game the system" in a traditionally insured healthcare funded market. "Gaming the system" is when a person who can afford health insurance decides not to buy it, knowing that if they need expensive health care they will always be able to get public assistance to pay for it.
- Traditional health insurers have little influence over the medical delivery systems, because of their short-term commitment to the market; and their size is small relative to the total health care market. Given this, they are in no position to resist provider "cost shift" or influence the development of a common information system with all of its potential benefits.

<u>Does it make Sense for the Employer to be a Source of Health Insurance?</u>

If you accept my premise that employees always pay for employer provided health insurance, then you will probably agree that having the employer to be agent and gatekeeper for Vermonter's health insurance is an unnecessary complication that is sustained by Government tax policy.

In the present system many employees don't have access to health insurance because their employers don't make it available. Also, employer-based health insurance is not an option for the many people work as part time or temporary employees. This also holds true for those who work as independent contractors as well as those who are unemployed. And even those who do have employer based health insurance live in fear that they will loose it because of a layoff or the need to change jobs. *I believe that Vermonters deserve better.*

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<u>The Health Insurer's Role in Health Care Decisions</u>

In a pure market economy, the customer is making cost/benefit decisions every day. The customer's basis for making these decisions is their needs, wants, values, and financial capabilities. However, in today's health care environment, cost/benefit analysis has virtually no role in the patient's treatment decisions. Some of the factors clouding the decision-making environment are:

1. Most patients do not directly pay for much of the cost of their treatment -- so at the time of decision, cost is not a factor in their decision making process.
2. Medical professionals are trained to do what it takes to get the patient well, with little regard for cost.
3. In most cases, patients cannot make an informed decision because they lack sufficient knowledge about the benefit of the health care procedure in question.

4. The patient's medical condition may prevent their being involved in the decision making process.
5. Many patents believe that health care is their right; therefore they deserve care regardless of cost

This approach is incompatible with the real world of limited resources. Up until now, patients have been in denial concerning the need to have cost be a factor in their health care choices. They have rejected efforts to make cost/ benefit a part of the health care decision-making process. The most recent example was the unsuccessful efforts by employers to reduce the growth in health insurance costs by offering HMOs.

For the patient, the real world of limited resources is represented by the amount of the health insurance premium Vermonters will be willing, or able, to pay for their healthcare insurance. And there is a direct relationship between that premium and the level of risk that the insurer will cover. If that is true, health insurers have to develop a basis for the cost/benefit prioritizing which health care risks their plan will cover. Hopefully, those that are being insured will grow up and be a part of this prioritizing process. Because, not making these hard choices results in underpayment for all services, and this will eventually reduce the quality and availability of health care services.

It should be noted that, as the costs and utilization of insured health care services go down, there would be the option to utilize the money saved to expand health care coverage.

Some people would argue that this means that health insurers would ration health care. I disagree. My dictionary defines rationing as--- to restrict the consumption of a commodity or service via supply, apportioning, or distribution.

Health insurers do not ration health care services, because they do not restrict their supply. Nothing restricts a person from buying additional insurance to cover health care risks not covered by a basic health insurance plan or paying for those services with funds from other sources.

<u>Health Insurance's Potential Impact on Economic Development</u>

In my view, the cost of health care and how we pay for it will impact Vermont's economic development in several ways:

- It has been my experience that if all employees have health insurance coverage, it reduces the cost of workman's compensation insurance, because they have less motivation to find creative ways to have all their health issues be covered by their employer's workman's compensation insurance.
- If the health insurance system would coordinate and purchase the health care services required as a result of a workplace injury, there would be continuity of healthcare for the injured employee. There would also be significant workman's compensation insurance cost savings as a result of the health insurer's buying power and health service-delivery efficiencies.
- Since the cost of living for employed Vermonters includes the cost of health insurance plus out-of-pocket health care costs, an insurance system that could be effective in capping or lowering those costs, while maintaining quality, would make it easier to keep and attract a high quality workforce in Vermont.

- A health insurance system that results in Vermonters making healthful living life style choices could have a positive impact on their effectiveness in the workplace. There would be a reduction in health related absenteeism. They would be more physically able to focus on the task at hand. And particularly important in an era of knowledge based careers requiring years of training, good health will make it possible for people to add years to their effectiveness in the workplace.
- If health insurance is no longer a part of the of the employer-employee relationship, it would:
    - Simplify establishing employee compensation.
    - Ease employee mobility in the work marketplace.
    - Ease employee retirement planning.
    - Eliminate one influence for age bias in the labor market.
    - Eliminate employee social partnerships as an employment issue.
    - Eliminate one of the major disadvantages of being a temporary or part-time employee.

Improving Healthcare Outcomes

Health Insurance's Potential to Enhance the Treatment of Chronic Illness

A chronic illness is defined as an illness that requires treatment over a period of more than three years. According to the Vermont Chronic Care Initiative, 51% of all Vermonters have at least one chronic illness. The Initiative also states that care for people with chronic conditions (e.g. diabetes, asthma, cardiovascular disease arthritis, etc.) account for:

- 78% of health care spending
- 76% of hospital admissions
- 72% of all physician visits

Given these numbers, I think treating chronic illness will be an important consideration in the development of any health insurance plan. Since chronic illness is by definition long-term, an important feature, of any new health insurance plan, will be that its relationship with the chronically ill patient will be long-term. With such long term relationships, the plan would be able to play a major roll in assuring that health care is delivered and paid for according to best-practice protocols for disease management.

Delivering the Benefits of Proactive Healthcare

Much of what we presently define as health care is of the reactive nature. Our present health insurance plans reflect this definition, in that they are designed to pay for health care when things go wrong.

I think that we have to ask our selves if this approach optimizes our quality of life and is the most efficient use of our health care dollars. Certainly it hasn't worked out that way for people who are suffering from preventable chronic illnesses, such as diabetes and cardiovascular disease.

Even the automobile manufacturers have figured out that the least expensive way to warrantee their cars and have a happy customer is to make sure that the owners do the

scheduled maintenance. This strategy also works well for dental insurers, who know that, long-term, their costs are lower when we have our teeth cleaned and we are coached in the proper care of our teeth. For these same reasons, I believe that preventive health care needs to be an integral part of health insurance strategy.

How to Improve Our Quality of Life and Reduce Our Health Care Costs with Healthy Lifestyle Choices

During the course of normal living, we tend to focus on things like family, career, financial security, and doing things we enjoy. It is in our nature not to think much about our health until something goes wrong. Unfortunately, if the thing going wrong is a disease such as adult onset diabetes, cancer, heart disease, emphysema, or AIDS, we are faced with the possibility that the deterioration of our health is irreversible. Only then are we willing to consider making life style changes in an effort to salvage our quality of life.

This attitude results in a much higher probability of serious illness, and the resulting higher health care costs --- and the insuring group eventually pays for these higher costs.

So the question that needs to be addressed by any health insuring system is, "*How can we get people to choose to live a healthy life style before a health crisis happens?"*

Let's look at some of the reasons why our present environment has little impact on our making healthy life style choices.

First of all, the health care environment has very little *financial incentive* to do so. Doctors, hospitals, and drug companies primarily get paid for treating sick people. Health Insurance providers have little incentive to invest in promoting healthy life styles in their clients, because typically they insure a client for too short a period of time to get a pay back for any such efforts. Also, many people are not motivated to reduce their health care costs, because they are insulated from the cost of their care--- either through their insurance or they lack the means to pay for their care, so they get it free.

Secondly, our *culture* does not encourage healthy life styles. There is a prevailing attitude that says, "If it feels good do it, and down the road, if something goes wrong, it is someone else's fault and they will pay to correct it". This attitude is reinforced by much of the advertisement that we are bombarded with on a daily basis. Lets face it: There is not much money to be made from convincing you to do things like taking a daily walk, controlling stress, stopping smoking, moderating your alcohol intake, eating fruits and vegetables, taking vitamins and minerals, and reducing your intake of fat and sugar.

Unfortunately, it is this culture that has got us to the place where the cost of health care is growing so fast that it will soon be beyond being affordable for the average person. *Since life style driven chronic illness costs represent over 50% of health care costs, a major issue that any alternative health insurance structure will need to address will be how to influence the life style choices of the people they insure.*

I believe that choosing healthy living is dependant on two things. First of all we need to have the knowledge of the factors that result in good health. Second, we have to be able to make healthful living an integral part of our life style. The first involves learning; the second involves habitual behavior. Of these two, the challenge of making healthful living our habitual behavior is the primary roadblock to choosing good health.

It has been said that we "do what we do" because of the consequences that we experience when we do it. And if we "do what we do" for 21 days, it becomes a habit --- and then we do it without thinking.

When developing a plan for making healthful living our habitual behavior, it is important to recognize that consequences do vary in their effect on our behavior.

1. Is the consequence positive or negative for us? A positive consequence has maximum impact, while the negative one tends to encourage the minimum behavior necessary to get by.
2. Is the consequence immediate or future for us? An immediate consequence has a much stronger influence than one that is in the future.
3. Is the consequence certain or uncertain for us? Clearly a consequence that is certain to happen is of much greater influence than one that is uncertain.

Given this prospective, it is clear that the consequence of possible poor health may not be an effective motivator for choosing a healthy life style, because it is a consequence that is negative, future, and uncertain to happen.

Knowing this, let's think about how a health insurance plan would need to be structured in order to effectively influence people to live a healthy life style. My thoughts are:

- The insurer will need to effectively help insured in their gaining knowledge of the characteristics and benefits a healthy life style.
- The insurer will need to create consequences that influence insured to make healthy life style choices.
- The insurer will need to have a long-term relationship with the insured, in order to get a pay back for the cost associated with helping the insured in their achieving a healthy life style.

Patient Safety

Patient Safety is a serious problem that is discussed at length in The Institute of Medicine's book, *To Err Is Human: Building a Safer Health System,* In this report they make the statement, **"we concluded that tens of thousands of Americans die each year from errors in their care, and hundreds of thousands suffer or barely escape from nonfatal injuries that a truly high-quality care system would largely prevent".**

The IOM estimates are that 44, 000 to 98,000 Americans die in hospitals each year as a result of errors in the health care they receive. Assuming uniform distribution of errors per capita, Vermont's hospital medical error deaths would be between 112 and 250 patients per year. To put this in context, errors from medical errors is the 8th leading cause of death in the United States – ahead of Motor vehicle accidents, breast cancer, and AIDS.

While we do not have specific data on Vermont, these numbers show that patient safety and medical quality control is a serious problem that needs to be a consideration in healthcare reform.

Using Innovation to Reduce Costs and Improve Health Care Delivery

Information technology is having a revolutionary impact on business, our workplace, and many other aspects of the way we live our lives. *This is particularly true in activities that are subjected to market forces.* Tools such as computers, cell phones, the

Internet, digital photography, credit and debit cards, and bar coding, are changing the processes we use to do things, how we access information, and how we communicate with each other.

Because of the distortions of its market forces brought on by government regulation and third party payers, the application of information technology, to the health care industry's processes and customer interaction, has lagged behind those we see in other areas of our world.

Here are some of the ways that state-of-the-art application of Information Technology could improve the delivery of health care:

1. Centralizing each individual person's health care records in one site. This could be on an electronic card and/or possibly a "stand alone" secure health care record site.
2. The centralized information system could be used to red flag treatments that are incompatible with the patient's current diagnosis, and/or with other treatments the patient is presently receiving.
3. Universally accessible information systems could be developed that describe a best-practice interactive diagnostic decision tree. This system would go a long way in improving diagnostic outcomes and reducing litigation.
4. Information systems could be used to facilitate remote diagnosis and follow up monitoring of patients.
5. Information systems could be used to educate patients about their condition, their treatment, and the steps that they need to take for the best possible outcome.
6. If all the participants in the health care delivery process had compatible information systems, it would allow greater flexibility in optimizing processes between providers, payers, and customers.
7. The accumulated data in a centralized information system could be used to develop a "Consumers Report" to inform health care customers, informing them about the effectiveness of treatments and providers.

Part Three – Fixing the Vermont's Health Care System

"Every system is perfectly designed to get the results it gets"

What should a reformed health care system do?

If you have read Parts One and Two of this paper, you have some idea of the range of issues that need to be considered when developing a plan for reforming Vermont's health care system.

Before proceeding with the discussion about how fix Vermont's healthcare system, it would be helpful describe what a reformed health care system should do. I believe that the reformed system should do the following:

- Give all Vermonters reasonable continuous access to a defined range of health care and wellness support.
- The cost of that health care and wellness support needs to be affordable for all Vermonters.
- Require and equip all Vermonters to be proactive participants in achieving and maintaining good health.

- To have as a long-term goal, to lower Vermont's total health care costs by thirty five percent.
- Healthcare provider compensation needs to be adequate to sustain quality healthcare professionals and infrastructure.
- Improve health care and wellness outcomes.
- Enhance Vermont's quality of life and economic development environment.

The goal of lowering health care costs.

The most visible symptom the health care problem is that health care, as it is presently delivered and paid for, is no longer affordable for lower income Vermonters. And this affordability problem will grow because the cost of health care is growing at an unsustainable rate.

It seems to me that any reform proposal worth its salt must, at a minimum; deal with the unsustainable inflation in aggregate health care costs in order to be viable over the long term.

In addition, I believe that health care reform needs to have as a goal to bring our health care costs more in line with those of the other industrialized western nations such as Germany, Sweden, Denmark, Switzerland, Australia, and Canada.

To achieve this goal, we would need to reduce our total health care costs by 35%, resulting in a reduction of our average annual per person health care costs from $5,100 to $3,300 and reducing Vermonter's total health care costs from $3,200,000,000 to $2,080,000,000. This works out to an annual per person reduction of $1,800 and a total cost reduction of $1,120,000,000.

My reason for advocating this goal is twofold. First of all it would solve Vermont's the health care affordability problem. And secondly, these industrialized nations, mentioned above, have proven that superior health outcomes can be achieved for this cost. In my view it is masochistic (this means to inflict one's self with a wound) for us to continue to spend the kind of money we are now spending. It is as if we are taxing each person an extra $1,800 per year with essentially nothing to show for it!

So how do we go about achieving this cost reduction goal? It is my view that in order to reach this goal, a health care reform plan needs to achieve a sustained reduction in costs that are achievable today, by focusing on the following areas:

- *Reduce the need for health care by keeping people well.* In this area of potential cost savings are all the activities that we commonly refer to as "wellness". Included in this broad category are immunizations, preventive care, and all the efforts that are described as healthy lifestyles. The results of success in this area would be an eventual dramatic decrease in Type 2 diabetes, cardiovascular disease, and lifestyle related cancers. On the flipside, those who avoided those diseases would experience enhanced quality of life.
- *Eliminate the delivery of unnecessary health care and ineffective health care.* The Institute of Medicine estimates that the correct diagnosis and treatment on happen about 50% of the time. The results of success in this area would be the substantial reduction in clinical and medical costs as well as an improvement in the patient's experience.
- *Reduce medical error related costs by improving the quality of health care delivery.* The Institute of Medicine estimates that 48 to 98 thousand people die

and hundreds of thousands people are injured every year in the USA as a result of their medical care. It goes without saying that there are substantial costs associated with patient injury and the resulting fatality.

- *Redesigning the health care delivery processes to improve efficiency in administration and delivery of services.* In this area, the potential cost savings will be the driven by the effective application of information technology on process redesign. This process redesign will be possible in all areas of health care and wellness including diagnostics, treatment selection, patient records, patient education, communication, quality control, patient involvement in their own health, and financial reimbursement.
- *Have cost / benefit analysis be a part of treatment decisions.* While this approach can be controversial, it's my view that it has to be a part of the health care decision making process that leads to reduced costs. The challenge is to agree on how to quantify the value of the benefit part of cost /benefit.

At this point I do not have definite estimates as to the percent reductions in health care costs that would be achieved over time from each of these areas of focus, but I am comfortable in estimating that the 35% reduction is achievable if we are willing to implement the health care reform measures that are laid out in this paper.

Past Efforts to Control Health Care Costs.

Controlling health care costs is not a new problem. Over the past 50 years, Vermont's State Government has made several attempts to reign in the growth in health care costs. These efforts occur at roughly15year intervals, the last being in the early 1990s.

To date, all of these efforts have failed to reach consensus on how to proceed, so the cost health care continues to grow. On one side are those who advocate a market driven solution (our present system) and on the other side are those who advocate for a government driven and funded system.

Those who advocate a market driven system believe that buying health care has the same dynamics as buying a home, an automobile, a TV set, or a meal at your local restaurant. For these purchases, the sequence usually begins with a realization that you have a need, then moves to the research phase that includes an evaluation of the item's cost and where you can buy it. Along the way you might have a conversation with a sales person and *ultimately you make a decision to buy or not to buy*.

Why has our present market driven health care system failed to keep cost in check? Is health care a market driven service? Let's look at why health care does not fit the market driven mold:

- Sixty percent of health care is bought buy the government through Medicare and Medicaid programs. This means that the patient in these programs are not likely to have cost of service be a part of their decision to buy or not to buy. Private health insurers also tend to take cost out of the decision making process for the patients they cover.
- The need for health care is in most cases a negative unplanned event for the patient. In many cases, for that person it may be a once in a lifetime event. For example, we don't plan for a heart attack, a trauma causing accident, or cancer,

and when we experience one we are not likely to the market research and decision-making process of an automobile purchase. Furthermore, for the patient, deciding not to buy is probably not an option.

- The health care customer (patient) probably will not be able to intellectually understand the product they are buying. Using the market model, they are totally dependant on the Doctor who acts as both the sales person as well as the deliverer of service.
- The health care infrastructure, particularly hospitals, with associated staff and equipment, have more in common with you local fire station than the local store or restaurant. Like he fire station with its fireman and fire truck, the hospital needs to be there and have the capability to promptly take care of a negative event when it happens.

On the other hand, those who advocate for a government run system have not made a convincing case for how they would control health care costs. Their approach has been to propose a cap on the amount of money that would be allocated to health care and to assume that some all wise person or persons would use the funds in an optimal fashion.

Given government's track record with Medicare and Medicaid, the public was skeptical of their capability to run a cost efficient health care system.

A further complication for those advocating a government run system is the issue of funding and how to raise the money. Somehow there seems to be a difference in the public's mind between the money they now spend for health insurance premiums and health care purchases verses the money they would spend in taxes to fund a public run system. They are both dollars but one is referred to as premiums and cash and the other is referred to as a tax.

Information Technology opens the door for a new approach to health care system reform.

The development of information technology has made possible a third option for bringing about an affordable and effective health care delivery system that was not possible 15 years ago. Just as it has changed how we do most of the things we do, information technology has the potential to enable health care system to do what we want it to do.

It is almost as if the only limitation on information technology's potential applications, in matters relating to our health, is our imagination how to use it and our willingness to change. The following are some of the ways that it can be used in the delivery of health care:

- Improve *patient safety* by providing complete, accurate, and timely patient information to the health care delivery team, including pharmacist. The Institute of Medicine conservatively estimates that that 44,000 to 98,000 Americans die annually and hundreds of thousands suffer or barely escape form nonfatal injuries that result from errors in health care they receive.
- Substantially *reduce the administrative costs* of delivering and paying for health care. Estimates are that today, administrative costs represent approximately 30% of the total health care costs.

- Assure that patients receive the *recommended health care 100% of the time* through the use of a diagnostic process that is information system driven. Current estimates by the medical community are that today, this only occurs half of the cases.
- Reduce the cost impact that *medical liability litigation* has on the way health care is delivered and medical liability insurance. Since information system driven diagnostic and treatment processes would represent the established best practice, providers who deliver medicine using these processes could not be sued.
- Improve the probable outcome in *trauma cases* because the provider, with whom the patient may have no previous relationship, would have timely access to accurate information on the patient's medical history form the information system.
- Improve the *transparency of the healthcare for patients* by giving them access to their charts, what they can expect the diagnostic process to be, and information on possible remedies for their condition as well as information on what to expect from those remedies. In addition, the patient will have access to the provider's track record in dealing with their condition.
- *Reduce pharmaceutical costs* using an information system driven pharmaceutical selection system. The system's selection process would reflect the best current knowledge. I assume that this would save the pharmaceutical industry significant marketing costs and relieve us from having to set through endless blood pressure and sexual enhancement adds.
- Will *enhance health care employee mobility* because the information system would be the same in all health care providers' offices.
- Will make it possible to deliver *quality health care to sparsely populated rural areas* of Vermont because small provider offices would be using the same low cost state of the art information systems.
- Lower health care costs by revising some diagnostic and delivery processes *to utilize lower cost labor*, some of which can be provided by the patient and their family.
- System could provide interactive dialogue and information that has the potential to influence and *support Vermonters to make healthy life style choices* and provide the necessary support for them to be a proactive participant in achieving and maintaining good health.
- Would improve the efficiency and reduce costs for small medical practices. *Facilitate the timely payment* for services to providers.

<u>The rules for the effective application of information technology</u>

Those of us who have gone through the development and application of information technology (IT) in our own businesses have learned that there are some rules that need to be followed in order to make a successful transition. These rules and their implications for IT in health care reform are as follows:

- The effective application of IT involves *comprehensive process redesign*. The saying goes, "If you are going to build a new road, you don't pave over the old cow paths". For health care and wellness, this will require a reexamination of how all aspects of the delivery of these services are presently done.
- As processes change, *the jobs and skills necessary to so those jobs change*. For health care, the implications are huge. The various professions, their associated licensing,

and the institutions that train them will eventually need to change in order to adapt to the new processes.

- The effective application of IT *requires that everyone use it*. For those involved in health care, this can be a real challenge. The industry is made up of many small businesses that are not used to being forced to conform to an imposed process. Especially if it means that the effectiveness of their performances will be measured by the system.
- The successful application of IT will *empower the customer* by breaking down the barriers between the organizations that serve the customer as well as the barriers between the customer and those organizations. If the health care customer is the patient and the bill paying entity, the provider community will have to get used to being accountable to them.
- An added bonus of the effective application of IT is the added capability of real time *knowledge management* as well as the application of that knowledge. For health care, the implications of this added bonus will revolutionize the way health care is delivered. Today, much of the health care knowledge is carried around in health professional's heads or kept in hard copy form in a language that most laymen cannot understand. In the future health care information system, this knowledge will reside in the system and be accessible to and be useful to all of those involved in the health care process, including the patient.
- There is an *up front financial cost* involved in the development and implementation of IT before getting the huge pay back from improved efficiency. For health care, that cost will have to be factored in to the budgeting process. Fortunately, with more than six billion people now living on Earth, the potential market for the software and health knowledge developed could be well worth the investment.

<u>The health care customer drives reform.</u>

The accepted wisdom is that the customer drives change in any market. In the health care market, the primary customer is the patient along with the person or entity that pays for the health care and wellness service.

It is my view that in reforming healthcare, the customer will drive the reform process in the market through information technology system. In effect, the customer will be using the information system to communicate their needs to the market.

It follows that, in order to achieve this, *the customer needs to control the information system and insist on its use by those providing health care services use the system.* In order for the customer to accomplish this, the customer needs to control the flow of health care funds to assure payment for the system and have the leverage to assure provider use of it.

<u>What would an effective customer entity look like?</u>

In my view, having one "customer entity" is the best way to achieve the goals that I have outlined for health care system reform because one entity will have the ability to focus on getting the job done in a way that multiple entities would never be able to.

This entity would need to be established by state statute that would outline its governance structure as well as its mission. The entity's governance structure needs truly

represent all Vermonters in their role as customers of the health care and wellness system and be immune from the influence of citizen and provider special interest groups. Its mission would need to incorporate the goals that are out lined in Part Three of this paper.

The entity's funding sources would include Federal funds that are allocated for Medicare and Medicaid as well as a new separate State tax that would maintain the present income tax deductibility for funds used for health care. The new Tax's rates would be structured so that they would reflect Vermonters ability to pay on an after tax bases of calculation.

The new entity's mission would stipulate that the entity would be able to limit coverage for heath care and wellness services and that limitation would reflect the values of Vermonters and the level of funding that they would be willing to support. The entity's role would not preclude the purchase by Vermonters of health care and wellness services not funded using other resources.

So, what do you think?

Now that you have had a chance to read my thoughts on what I think Vermont's future health insurance could look like, you need to weigh in on the discussion. You are a health care consumer. You are the customer. Your voice needs to be heard.

One way that you can be heard is to give me your feed back on the concepts that I have outlined. I would love to hear from you.

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