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DRAFT (Footnotes forthcoming)

TRANSFORMING HEALTH CARE SO WE CAN KEEP OUR PROMISES

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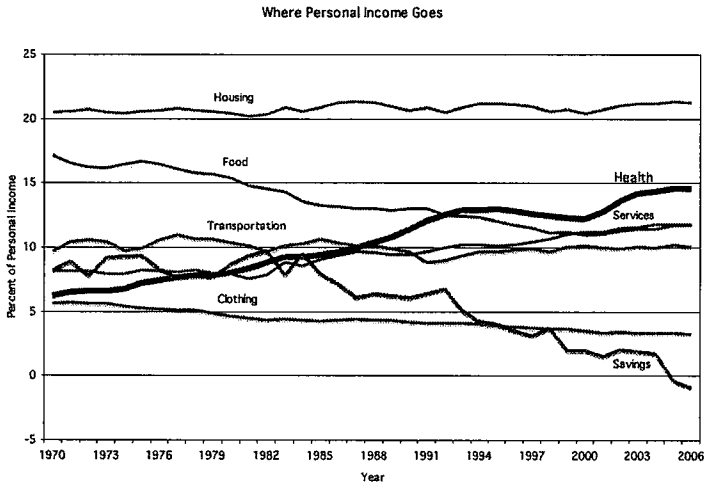
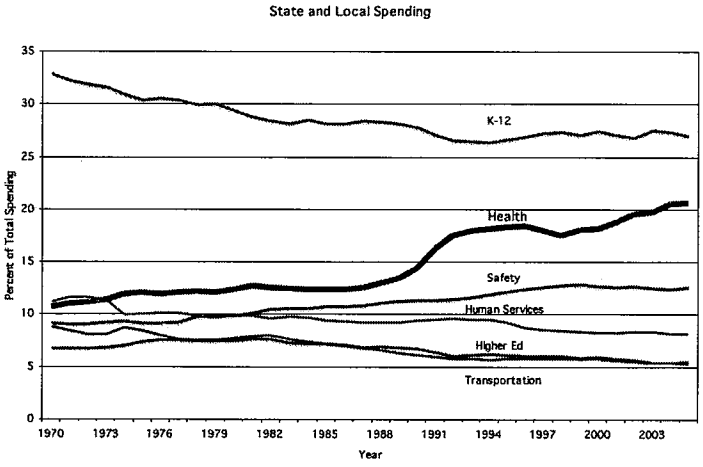
In early December a few years ago a room full of people who had just been elected as their states' governors were gathered to prepare to take office. A fiscal expert laid out the financial realities they were about to confront. After walking through trends in revenue he got to the punch line: health care costs are rising so fast there will be virtually no new money available to pay for the promises you made in your campaigns. At that point one governor-elect leaned over and said to another, "I want a recount."





Health care is bankrupting America. It is bankrupting our families, our businesses and our governments. Since 1960, costs have accelerated 10 percent a year—doubling every 7.5 years. We spend 16 percent of our gross domestic product on health care, almost double the European average, *yet the World Health Organization ranks the U.S. 37th in the world for the overall quality of its health care system.* In the last 25 years, the share of personal income people have had to commit to health care bills has tripled, while the savings rate has gone *negative.* Health care is now the number one cause of personal bankruptcy. And American businesses spend so much more on health care than their foreign competitors that they face a serious disadvantage.

The fiscal squeeze is even more debilitating in the public sector. By 2005 state and local governments together spent 21 percent of their budgets on health, almost double the figure from 1972. Where did the money come from? Education, down from 39 to 32 percent; human services, down from 11 to 8 percent; and transportation, down from 8.7 to 5.5 percent. Every time health care gobbles up another

percentage point—*every 3 years*—we lose the equivalent of 150,000 teachers. For states alone health care consumed *a third* of all spending by 2005. If current trends continue, it will devour *half* of all state spending within 11 years.

The federal numbers are even worse. In 1972, the federal government spent 5.6 percent of its budget on Medicare and Medicaid. By 2006, the figure was 20.9 percent. In 15 years, under current policy, Medicaid and Medicare will consume half of all federal revenues (Social Security and interest on the debt will consume the other half).

All the money we spend does not necessarily buy us quality health care, however. According to the Rand Corporation, *patients receive the right care only about half the time.* Between 48,000 and 98,000 patients die annually because of medical errors in hospitals.

Meanwhile, both private employers and governments are cutting back wherever possible. The number of uninsured is now a record 47 million, and out of pocket costs are skyrocketing. The Institute of Medicine reports that 18,000 people without insurance die prematurely every year because they can't get the non-emergency care available to those with insurance, and many more suffer poor health because they lack care.

Health care is literally eating our families out of house and home—and our governments out of education, transportation, and human services. We need a recount. We need to transform our health care system from a burden to a benefit, from an economic threat to a competitive advantage.

Changing the Rules of the Game

Nobody likes these results and nobody set out to produce them. Rather, well-intentioned people created the rules, incentives and institutions that have driven the system ever since. If we want a better result we have to change the rules of the game. Four key problems deserve our immediate attention.

First, we focus most of our energy and money on responding to illness, rather than sustaining health. We have a "sick care" rather than a "health care" system.

Second, our medical institutions were designed to provide episodic care for acute illnesses, but the real burden has shifted to chronic problems that need continuing and coordinated care: diabetes, asthma, cancer, AIDS, etc.

Third, our system is so fragmented between myriad medical practices, hospitals, and insurance companies that it produces enormous waste. Multiple specialists dealing with the same patient rarely coordinate their care, so patients fall through the cracks. One out of five lab tests must be repeated because previous records are not available, and one of seven hospital admissions occurs for the same reason. *And complex administrative processes consume 25-30 percent of health*

care dollars. Up to half of that is tied up just in sending out bills and other insurance-related documents (including letters saying "This is not a bill") that have no purpose other than moving money from payers to providers.

Fourth, our fee-for-service payment system creates perverse and expensive incentives. Providers make more money by performing more services. Indeed, if a doctor or hospital makes a mistake or omits something important and the patient has to be treated again, the doctor or hospital makes more money!

Studies prove that fee-for-service payment leads to more care but poorer outcomes. It actually creates disincentives to improve quality or make care more cost-effective, since practitioners who find ways to cut back on procedures make less money.

Transforming the System – Cost, Quality and Coverage

Our health care system is in slow-motion collapse. No one is happy with it: not doctors, not nurses, not hospital administrators, not employers and surely not patients. Tinkering around the edges will not fix it.

Many governors and legislators are struggling to create universal health insurance. But solving the *insurance* problem without solving the quality and cost problems is a mirage. Pennsylvania Governor Ed Rendell had it exactly right when he told the *New York Times*, "If we're ever going to have accessible health insurance for all Americans, we have to begin by containing costs. If costs continue to spiral out of control, there is no way the government can afford to pay for it."

We believe states can and must cut this Gordian knot, once again functioning as America's laboratories of democracy. Our health care system doesn't need any more tinkering, it needs transforming. To us transforming health care would mean cutting its costs by 25 percent, increasing the likelihood of patients getting the "right care" by 50 percent, and covering 100 percent of our population. The consequences of succeeding at this task would be enormous:

- Better health plus better, more affordable care for everyone;
- Resources freed up to address education, transportation, human services, infrastructure and other priorities;
- Dramatic increases in economic competitiveness (better than a tax cut); and
- Increased disposable income for families.

Reformers have put forth two general models to fix this ailing system. Some liberals propose a single-payer, single-administrator system, to cut administrative costs and use the savings to provide universal coverage. They cite the fact that Medicare spends only four percent on administration, and their ideal model often looks like Medicare for all.

While this model would achieve universal coverage and cut some costs, it would leave the fee-for-service payment system in place, insuring continued rapid cost inflation and quality problems. Nor would it address the fragmentation of medical practices that creates so much waste.

Conservatives typically prefer to intensify the market dynamics in the system by making consumers more sensitive to the price of medical services. They propose to do so by maintaining insurance for catastrophic costs, but with high deductibles before insurance kicks in and with health savings accounts (HSAs), which give individuals money they can use to purchase medical services. Experience suggests that this would change consumer behavior, in both good ways (more efficient use of health care) and bad (less purchase of needed drugs and therapies by the chronically ill, leading to greater hospitalization and higher costs). However, this "consumer-directed" strategy does not address the real cost drivers in the system, since it leaves fee-for-service medicine in place and provides insurance for those who consume a great deal of health care. By most estimates, 80 -90 percent of health care costs are incurred by only 30 percent of the population. These people will quickly exceed the deductible, at which point 100 percent of their medical bills will be covered and any incentive to shop for cheaper care will disappear.

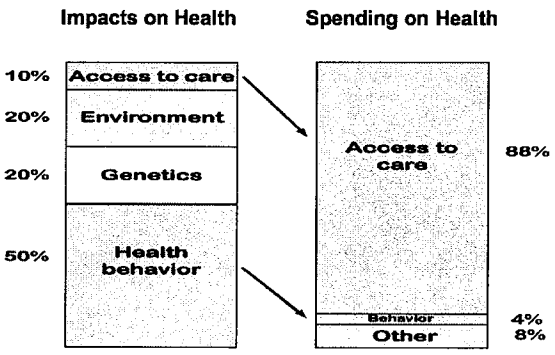
We suggest a third way, which goes beyond the ideologies of left and right. It creates a new, more powerful set of incentives built on these simple principles:

- ***Prevention is better and cheaper than care.***
- ***Personal behavior determines health outcomes—and it must change.***
- ***Incentives should reward better, cheaper care, not more care.***
- ***Health care is a team sport: integrated, managed care is most cost-effective.***
- ***Information technology can improve quality and lower costs.***
- ***End-of-life care should be planned before it is needed.***
- ***Everyone should have health insurance.***

Transformation Plan

1. Make behavior matter.

One way of describing America's health care problem is that we experience too much care and not enough health. Our most important goal, after all, is not *health care,* but *health.* And the biggest obstacle to good health for many Americans is not a lack of care; it is their own behavior. We are still paying for smoking, the epidemic of the 20th century. We are just beginning to pay for obesity, the epidemic of the 21st century.



According to the U.S. Centers for Disease Control, four big factors influence our health: personal behavior, the environment (elements in our air, water, homes, communities, workplaces and food that cause disease), access to health care, and our genetic makeup. Of these four, personal behavior is by far the most influential, while health care is the least. Nevertheless, we spend 88 percent of our health resources on treatment, but only 4 percent on changing personal behavior. If we want better health, we must invest in changing behavior.

We can make behavior matter by:

a. *Changing minds.* Leaders should launch sustained public campaigns on obesity, exercise, diet, smoking, drugs, alcohol, driving, etc.
b. *Changing habits.* For example, require vaccinations, dental and eye exams for all school age children and provide them in schools.
c. *Changing prices.* Health plans should be required to give premium discounts based on healthy behavior (e.g. health club participation, not smoking), compliance with disease management plans, body mass index, and similar factors. States should tax cigarettes, alcohol, and junk food at levels that reflect their true health care costs.

Taking on behavior can be tricky, because no one wants the government telling him or her what to do. But governments can make people responsible for the consequences of their behavior. This is the most powerful and least used lever available to us.

Pursuing this part of transformation will result in greater prevention, less acute care, less progression of chronic disease, and better health. A good beginning.

2. Replace fee-for-service payments for procedures with prepayment of annual fees for patient care. Use competition between integrated, managed care systems to get the best combination of quality and price.

In an experiment run by the Rand Corporation, group medical practices that cared for patients for a set, prepaid fee cost 25-30 percent less than those paid on a fee-for-service basis. The fundamental reason was that they had clear financial incentives to become more cost-effective. Prepaid *delivery systems,* such as health maintenance organizations (HMOs), have similar incentives and even more weapons to improve quality.

To capture these benefits, states should switch to prepayment for all health programs they fund. Wisconsin's insurance program for state employees offers a good model: it defines a basic benefit package and asks health plans to submit bids specifying the annual dollar amount they would charge for this package. The program uses price and quality measures to define three tiers. Plans in tier one, which are low in price and high in quality, cost the least for state employees. If they prefer a more expensive plan in tier two or three, they are free to choose it and pay the monthly difference. But the majority of members choose tier one plans, and this fact creates a powerful incentive for health plans to lower their prices.

Wisconsin put this approach into effect in 2003. In Dane County, which includes the state capitol, the state employee plan covers 30 percent of the market. Competition between health plans has reshaped the market in Dane County, while driving costs for individual and family plans 14 percent below the statewide average and 30 percent below the most expensive regions.

To make this happen states must:

a. *Create a large purchasing pool.* States should start with state employees and retirees, Medicaid, the State Children's Health Insurance Program (SCHIP), and other state health plans, then add local government and education employees to the pool—more than 21 percent of the market in a typical state. If the state adopted a mandate that residents have health insurance, it would also add the uninsured to the pool—another 16 percent in the average state. Then it could invite in non-profits, associations, and businesses.

b. *Define a basic package* of care to be provided based on hard evidence about which services are most cost-effective. The benefits package could have a deductible and require co-payments, to discourage wasteful use of medical care. But preventive care and chronic care would be covered without deductibles or co-payments, because such charges discourage the purchase of needed drugs and care. Health savings accounts (HSAs) could also be useful elements of the benefit package, especially if combined with information for patients on the price of procedures and the quality of providers and outcomes.

c. *Include integrated long-term care* on a prepayment-for-care rather than fee-for-service basis.

d. *Get competitive proposals* from all plans in the state. Encourage proposals from integrated managed delivery systems and from plans that shift from fee-for-service payments to providers to prepayment for packages of care.

e. *Rank all proposals based on quality and price.*

f. *Buy the best.* With the rankings in hand the state should arrange its payments for Medicaid, SCHIP, and other public programs—as well as those for employees and retirees—so that all are encouraged to buy the package with the best care at the best price.

Governments are such large players in the health care marketplace that what they do (or don't do) will drive the entire market. If our model can hold annual price increases to 3.5 percent, while they rise 10 percent a year in other states, it will cut health costs by 26 percent in just five years.

The scope of change suggested above will appear daunting to some and will be opposed by others, particularly those who benefit from the wasteful incentives in the current system. But we can no longer afford the waste and low quality we get today. Transformation along these lines will lead to better care, higher quality and lower costs for our families, businesses, and governments.

3. Create statewide systems for electronic health records (EHR), claims and billing.

Between 1995 and 2005, while the rest of the country suffered through doubling health care costs, the Veterans Health Administration's cost per patient remained level, yet quality increased. With 10,000 fewer staff, the VHA more than doubled the number of patients it served. One big reason: it had the most advanced EHR system in the world.

In 1993 Utah's health insurers, providers and the state came together to create the Utah Health Information Network (UHIN). Their goal was to avoid the creation of duplicate systems as each payer moved into electronic processing of claims. In 1995, Executive Director Wayne Nelson estimated that savings could be up to five percent of total health care costs. Today the system includes virtually every payer and provider, and the savings are eye-catching. At Intermountain Health Care, claims processing now costs .1 cent per transaction—a fraction of the three cents per transaction it would pay otherwise.

Governors should gather the leadership of every major health care provider, hospital and insurance company to create a statewide, interoperable EHR system as good as the VHA's (which is available for free) and as cost effective as Utah's claims and billing system within five years. Financing should be shared between the state and those who would benefit the most: insurance companies, hospitals and integrated delivery systems. To encourage widespread adoption, the governor should announce that at the end of five years, the state would cease reimbursing any provider not using the systems.

Governors should gather the leadership of every major health care provider, hospital and insurance company to create a statewide, interoperable EMR system as good as the VHA's (which is available for free) and as cost effective as Utah's claims/ billing system within five years. Financing should be shared between the state and those who would benefit the most: insurance companies, doctors, hospitals and integrated delivery systems. To encourage widespread adoption, the governor should announce that at the end of five years, the state would cease reimbursing any provider not using the systems.

4. Create state policies to encourage end-of-life planning for everyone.

No one knows how many of our health care dollars go to elderly people in their last year of life, but 25 percent is a good guess. This is one reason American health care is so expensive: we succeed in keeping many people alive into their eighties, then spend an enormous amount in their last few months as their systems collapse. In many cases this serves no rational purpose and pleases no one, including the patient. But doctors and nurses are taught to do everything they

can to help patients, and in the absence of specific policies that tell them otherwise, that's what they do.

Leadership on this issue could make a big difference. Governors should engage the public in a discussion about the benefits of end-of-life planning. Then state policies should encourage the preparation of health care directives. The state should make forms readily available with accessible advice for those who need it and provide a health premium discount for those who have a health directive on file. Talking about end-of-life issues is not easy. Not talking about them will make the dying process more difficult and more costly.

5. To make health insurance universal, mandate that all residents have it.

Without a mandate, many employers will not provide insurance, and many young, healthy adults will not buy it. As it gets more expensive, the number of uninsured Americans will rise. When they get sick or are injured and arrive at the emergency room, the rest of us will pay for most of their care. This is profoundly unfair.

The competitive approach to getting better quality and cost would work without universal coverage, but it would work better with it. To get the lowest prices in the purchasing pool a state needs to insure as many people as possible, including young, healthy people. And to get enough members to reshape the health care marketplace, it would help to have the uninsured. The only practical way to include them is a mandate, whether imposed on employers, individuals, or both. We believe an individual mandate is more realistic, politically, and that a state must subsidize health insurance for lower income people.

These five ideas do not encompass everything a state can do to get lower-cost, higher-quality, universal health care—just the most important steps. States also need to change the way doctors are educated and trained. They need to change the ratio of general practitioners to specialists. They need to reexamine the way they regulate health care. And they need to rethink the way they handle medical malpractice, moving toward a system of health courts modeled on the workers' compensation system.

Conclusion

The wellbeing of our communities and our economy is being threatened by our health care system. It costs too much and delivers too little. If we fail to transform it, it will bankrupt us. Along the way it will force us to abandon our promises to educate, support, transport, and protect our people.

In the coming decade, we will change the health care system, or it will change us. The choice is ours.

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