



# Toward Evidence-Based Health Care Reform

Vol. 1, No. 7

## FACTS AND REFORMS: Cost

*Welcome to "Toward Evidence-Based Health Care Reform," a periodic e-memo providing facts, figures, examples and analysis of current issues in health care reform in Vermont. The memo is written by Jeanne Keller, Keller & Fuller, Inc., and sponsored by BRS, Inc., a member organization providing a range of services and support to Vermont's small businesses. For more about BRS, please visit our website: [LINK](#)*

*To review past issues of Toward Evidence-Based Health Care Reform, [click here](#).*

*To read and download the comprehensive health care reform proposal supported by BRS and several other Vermont business associations, [click here](#).*

There are many important but little recognized facts about our health care system in Vermont that should guide our choices on health care reform. This memo focuses on **Costs**: the **FACTS** about our system and the **REFORMS** the facts suggest.

### Facts about Cost

- F** The biggest cost shift to private insurance premiums is underpayments to doctors and hospitals by Medicaid and Medicare. A significant driver of hospital budget increases for 2006 was identified as the Medicaid cost shift from legislative cuts last session. According to Blue Cross/Blue Shield of Vermont, without the cost shifts from government programs, their rates could be 20% lower.
- F** Vermont spends less per capita on health care than the rest of the nation (\$4,909 vs. \$5,670), but the cost growth rate was nearly two points higher than the national rate from 1999-2003 (8.7% vs. 7.7%). (Source: BISHCA)
- F** Care for people with chronic conditions (e.g. cardiovascular disease, hypertension, chronic mental conditions, asthma, arthritis, cholesterol disorders and substance abuse accounts for \$2.3 billion of Vermont's total \$3 billion spent on health care (78% of all spending). Today, 52% of Vermont adults are either overweight or obese. Obesity has been linked to much higher than average per capita health expenditures and chronic illness (e.g. diabetes). Here in Vermont, care for chronic diseases accounts for:
  - 78% of health care spending
  - 76% of hospital admissions
  - 72% of physician office visits
  - 88% of prescriptions filled
- F** Blue Cross & Blue Shield, MVP and The Vermont Health Plan, all non-profit companies, insure over 90% of the private insurance in Vermont. These non-profits pay out over 90 cents of every premium dollar to cover health care claims.
- F** A recent study by single-payer advocacy group FamiliesUSA reported that Vermont is the fourth *lowest* state for cost impact of the uninsured on premiums. The cost impact on average individual premiums is only \$143 per year.
- F** Vermont ranked #38 in hospital expenses per day in a 2003 report from the Kaiser Foundation. In addition to keeping overall expenses in check, hospitals' average cost per adjusted admission is budgeted to increase by 4.8% from 2005 to 2006.

As can be surmised from the facts, legislating effective cost containment will be very difficult. Our hospital costs are among the lowest in the nation, and our Hospital Budget Review process

is already slowing growth. Covering the uninsured will have a miniscule affect on premiums. Continuing to cut back on Medicaid payments to providers, or imposing a global budget on hospitals will increase cost shifting to the privately insured, raising premiums more.

If we examine the **facts** about **costs**, it is clear that we must focus significant attention on prevention and treatment of chronic diseases. Vermont is already leading the nation by having a statewide, collaborative initiative to improve chronic care that involves all provider groups, insurers, state government, consumers and advocates. The Vermont Blueprint for Health Chronic Care Initiative, coordinated by the Department of Health, is developing innovative solutions and providing support to help doctors and patients effectively manage chronic disease.

The goals of the Blueprint are three fold:

- It will rehabilitate the existing fragmented system by building cooperation among providers, patients, the community, and insurers - encouraging them to work together on chronic disease management instead of the isolation of their health care niche.
- It will give health care providers the support they need to deliver world class, evidence-based health care through the provision of improved information technologies and training in chronic care treatment and management.
- It will optimize treatment options for people with chronic disease by creating information networks that allow them to tap into community resources, classes, and activities to improve quality of life and take a central role in their own health care.

In addition to investing in efficient treatment for chronic care, other reforms are needed to dampen the cost increases for insurance, reduce cost shifting from Medicaid, and make consumers and providers more aware and sensitive to the cost of treatments. **Based on the Facts, here are some recommended Reforms:**

- R** Focused effort is needed on preventing people from becoming patients, by targeting risk factors such as obesity, smoking, pre-hypertension and other precursors to chronic illness. Particular attention should be given to education of our children and young adults.
- R** We need to give the health care system tools and incentives to become more efficient, without compromising quality or access. The state should create low interest loan funds for investments in information technology, for electronic medical records and common electronic claims processing, and for technologies like bar coding and electronic order entry that have proven to reduce medication and treatment errors by over 50%.
- R** Continue the move toward more transparency about quality, safety, costs and outcomes that started with the Act 53 community hospital reports. Require that consumers be given current information on comparative provider costs and quality.
- R** Institute “pay for performance” in Medicaid and private insurance to align payments to providers with quality and evidence-based treatments, instead of paying more for more treatments, visits and procedures.
- R** Establish a Patient Safety program within the Department of Health to work non-punitively and confidentially with hospitals (like VOSHA) to investigate adverse events and ensure that corrective action is taken. Allow providers to say “I’m sorry” without fear of lawsuit.

***Our e-memos are posted and downloadable from our website: [www.vtreform.com](http://www.vtreform.com).***