



Toward Evidence-Based Health Care Reform

Volume 1 - 2005

As the title of this series indicates, we support health care reform that is based on facts about our health care system, sound economic principles and evidence gained from prior efforts in Vermont, elsewhere in America and the world. We agree it is important to be guided by noble visions and to promote equitable social policy. But vision can't be legislated; laws need to be grounded in reality, in what actually can be done here in Vermont. **New e-memos are posted regularly at www.vtreform.com.**

Table of Contents (Click on the title to view the article)

Facts and Reforms	2
FACTS AND REFORMS: Insurance Reform is Not Health Care Reform (11/7/2005) ...	2
FACTS AND REFORMS: Cost (11/11/2005)	3
FACTS AND REFORMS: Quality and Access (11/18/2005)	4
What Is Possible	6
Why a Single Payer is Impossible in Vermont (7/6/2005)	6
What 30% Savings? What the Lewin Study Actually Says About the Single Payer (9/7/2005)	8
New Hospital Budgets: Cost Shifting and Lessons for Reform (9/19/2005)	11
How other states are improving quality and safety (9/22/2005)	12
What Went Wrong With Cost Containment? (12/5/2005)	13
The Uninsured in Vermont	15
The AARP Survey: What it doesn't say about the uninsured (11/28/2005)	15
VT Is Fourth Lowest State for Impact of Uninsured on Insurance Premiums (7/21/2005)	17

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Page 1

Facts and Reforms ...

FACTS AND REFORMS: Insurance Reform is Not Health Care Reform (11/7/2005)

As the title of this e-memo indicates, we support health care reform that is based on facts about our health care system, sound economic principles and evidence gained from prior efforts in Vermont, elsewhere in America and the world. We agree it is important to be guided by noble visions and to promote equitable social policy. But vision can't be legislated; laws need to be grounded in reality, in what actually can be done here in Vermont. And there are some immutable facts we face as we work together to reach a consensus on reform, such as these key realities:

Vermont can't have a single payer. Federal laws do not allow a state to put everyone into one plan. People on Medicaid and Medicare cannot have their plans changed unilaterally by a state. Employees and their families covered by self-insured employers can't have their plans changed unilaterally by the state. Employers cannot be forced by a state to provide any health care benefits at all. It is questionable whether a state could charge a payroll tax and use that to pay for coverage for employees, without the state having to defend their tax in the federal courts, probably all the way to the US Supreme Court. Those proposing a single payer as Vermont's health care reform have not addressed this reality with the public. A realistic reform proposal must knit together multiple payers in the most equitable and efficient way we can.

Changing the financing system (from premiums to taxes) does not change the cost of health care. Insurance reform is NOT the same as health care reform. For reform to contain cost, it must change what is driving up costs. There is evidence about what is driving up costs and it is:

- Increased utilization of health care services, including surgery, diagnostic testing and pharmaceuticals.
- Increased provider charges fueled by inflation, workforce shortages and higher overhead costs.
- New technologies that are more expensive than what they are replacing – drugs that relieve symptoms with fewer side effects or that are more effective in treating illnesses, and new radiological equipment that produces extremely high resolution views of internal organs, systems and joints.
- An increasing burden of illness in our population. Our health care system is finding successful treatments for chronic illnesses, allowing people to live longer, often long enough to develop multiple illnesses. The stories about people who can't afford their 15 prescriptions are not simply about the cost of those fifteen prescriptions. They are stories of people whose lives have been saved, and who now have multiple illnesses and are dependent on 15 prescriptions and a lot of other health services to stay alive. Three-quarters of what we spend on health care in Vermont for treatment of chronic illnesses.
- Obesity, smoking and other high-risk behaviors have a very significant impact on our growing costs, and are beginning to overburden the health system.

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Evidence-Based Health Care Reform

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Page 2

The fact that there are uninsured Vermonters, and the complaints about insurance not being affordable are **symptoms of a cost problem** in the health care system. Reforms need to address the root causes, without making things worse. It's clear that everyone in this debate shares the goal of controlling costs and making care more affordable and efficient. Every proposal should be evaluated for whether it presents a realistic approach to controlling these cost drivers, but also will "do no harm" to what is working right.

[\(Return to Table of Contents\)](#)

FACTS AND REFORMS: Cost (11/11/2005)

Facts about Cost

Fact: 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.

Fact: 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: BISCHA)

Fact: 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

Fact: 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.

Fact: 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.

Fact: 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.

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Page 3

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:

Reform: 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.

Reform: 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%.

Reform: 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.

Reform: 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.

Reform: 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. ([Return to Table of Contents](#))

FACTS AND REFORMS: Quality and Access (11/18/2005)

There are many important but little recognized facts about Vermont's health care system that should guide our choices on what to include in reform package. This memo focuses on Quality

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Page 4

and Access to Our Health Care System: facts about our system, and the reform proposals the facts suggest.

Facts about Quality and Access

Fact: Vermont was recently ranked third by the United Health Foundation in America's Health: State Health Rankings, a report that combines personal behaviors, community environment, public health policies and health outcomes.

Fact: In 2003, Vermont ranked second in a national study comparing quality of care for Medicare patients with heart attacks, congestive health failure and strokes. (JAMA January 15, 2003-Vol 289.)

Fact: According the VT Health Resource Allocation Plan, every town in the state is within 30 miles of at least one acute care hospital, 4 of 13 health regions in the state have a serious shortage of primary care physicians, with shortages particularly acute in towns with fewer than 10,000 residents.

Fact: Our health care workforce is aging. The average age of a Registered Nurse in Vermont is 47. More than two thirds of our nursing workforce is over the age of forty, with other professions citing an even older workforce.

Fact: VT is currently one of five states with insurance regulations requiring guaranteed issue and one of three with "pure" community rating. This means that any individual or small business has access to insurance, regardless of their health status or past health claims, and that insurance premiums are the same for everyone, not adjusted for demographics or health status. (FamiliesUSA credits this, in part, with explaining the low percentage of uninsured in our state.)

Fact: All of Vermont's hospitals are fully accredited by the Joint Commission on the Accreditation of Hospitals and Health Systems. All of Vermont's HMOs are fully accredited by the National Committee on Quality Assurance, in addition to undergoing rigorous reviews annually by BISCHA.

The facts do not support claims that our health system is broken, in chaos or disarray, as some have suggested. It does not have to be torn down and rebuilt from the bottom up. There are weaknesses and there is plenty of room for improvement, but not a crisis. Reforms should build on the strengths of the current system and further improve access, quality and safety. Based on the Facts, here are some recommended Reforms:

Reform: Continue the move toward more transparency about quality, safety, costs and outcomes that started with the Act 53 community hospital reports. Hospitals, physicians and insurers must cooperate in providing current information on comparative provider costs and quality to all consumers.

Reform: 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.

Reform: Establish a Patient Safety Program within the Department of Health to work non-punitively and confidentially with hospitals to investigate adverse events and ensure that corrective action is taken. Funding is needed for this important public safety effort.

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Page 5

Reform: Invest in proven health care workforce development strategies to improve access to care throughout the state by funding the recommendations of the Human Resource Investment Council's Workforce Development Partnership. With \$100,000 in funding, the Partnership can expand the state's capacity to coordinate and expand on existing recruitment and retention efforts for many healthcare occupations.

Reform: We need to provide the health care system with the tools and incentives to become more efficient, without compromising quality or access. The state should establish low interest loan funds for provider investments in information technology, for moving to 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%, saving money by eliminating costly errors.

Reform: We need to use our current system more efficiently and make future investments carefully to avoid duplication and increase productive use of expensive health care technology assets. For example, we should consider whether the growing use of hospital emergency rooms for routine health care is a sensible use of scarce resources. The Certificate of Need program should compare competing applications for approval and certify the highest needs and best uses for our funds. This may require the public to scale back expectations about what services will be available in every community hospital, but with good planning we can provide access for everyone to all needed services, while keeping costs sustainable.

[\(Return to Table of Contents\)](#)

What Is Possible ...

Why a Single Payer is Impossible in Vermont (7/6/2005)

According to Health Care for All, a VT advocacy group for a single payer, their goal is "a universal and comprehensive health-care system based on a single, statewide plan with administration supervised by a non-partisan commission with every Vermonter covered without regard to age, income, employment or medical condition."

But on the same website, here's what their key legislative ally says:

"Single payer supporters like Rep. John Tracy, D-Burlington, said the single payer plan concept he has been working on as chairman of the House Health Care Committee was designed to be a safety net and supplement to private insurance, not a replacement... 'Our intention is not to put insurance companies out of business. What we need to do is re-engineer the way health care is provided. ... We need a way to reasonably finance health care. Individuals need to be part of the game.' "

Question: When is a "single payer" not a single payer?

Answer: When there is more than one payer.

Rep. Tracy (co-chair of the legislative Commission on Health Care Reform) claims to be working on a single payer plan that "is a supplement to private insurance, not a replacement." That doesn't sound like a single payer, does it? Or has the proposal changed? Is it actually not a single payer any more?

More to the point, are Rep. Tracy and the other "single payer" advocates finally acknowledging that it is simply not possible to have a single payer? Because the fact is, we can't - not without

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Page 6

a specific Act of Congress, the signature of the President, and/or a long and expensive battle in federal court to overturn federal laws. Here are the facts...

- In 2006 Vermont will spend \$3.8 Billion on health care. \$1.8 Billion, or 48% of those funds, are for Medicare and Medicaid beneficiaries. These are entitlement programs, and benefits are dictated by federal laws and regulations.
- \$2 Billion of the funding came from private insurance, and nearly half (approximately 46% of the \$2 billion or 26% of overall funds) was from self-insured, employer-sponsored plans. These plans are governed under federal law (the Employee Retirement Income Security Act, or ERISA), and are not subject to state laws.

Experts on ERISA agree that states are preempted from: mandating that employers provide health insurance; taxing employers who do not provide health insurance ("pay or play"); taxing health care providers (e.g. hospitals) in amounts that "significantly affect" self-insured plans by raising the cost of self-insured plans; and mandating the types of coverage provided by self-insured plans. Only Congress & the President can waive the ERISA preemption for a state, and only one state, Hawaii, received such a waiver and that was in the early 1970s.

So, nearly half of the funds in VT's health system come from Medicaid and Medicare, and another quarter comes from self-insured employers, meaning that about **3/4 of funds come from sources that Vermont cannot legislate, control, regulate or otherwise govern without waivers and approval from both Congress and the Executive branch of the federal government.**

That means that no matter what the legislature does, it cannot order anyone from Medicare, Medicaid or a self-insured employer into a uniform state plan. There can never be a single payer, in other words. There will always be Medicare, Medicaid and self-insured employers. The legislature's proposals can only control commercially insured (Blue Cross/Blue Shield, CIGNA, MVP, etc) plans and out-of-pocket expenditures, or less than 30% of what is currently spent in Vermont.

This has enormous implications for what Vermont can and cannot do to reform the system within our own borders:

- A "global budget" for a hospital cannot restrict the price paid for or services delivered to persons covered by Medicaid, Medicare or self-insured employers, without risking action by the federal government or lawsuits by self-insured employers and their employees.
- While the state has some latitude (if it gets permission from the feds) in how it delivers Medicaid benefits, the state cannot force people covered by Medicare or self-insured employers into that same plan.
- Federal laws dictate the minimum benefits for Medicaid and 100% of what is covered by Medicare. Self-insured employers are allowed to determine 100% of their plan design, without state interference or mandates. Thus, the state cannot establish a single, uniform benefit package and impose it on any of these groups.
- The state cannot impose a payroll tax on all employers to fund a "universal plan" without risking a protracted, expensive lawsuit in federal court to test whether this is a violation of ERISA. Past case law indicates that it would be very hard to construct a state payroll tax, either on insuring, non-insuring or self-insuring employers that would withstand such

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Page 7

a challenge, because it is intrinsically linked to provision of health benefits, which is precisely what the federal law preempts states from governing.

And there will surely be a court challenge. Self-insuring and multi-state companies that already provide generous health care benefits, like General Dynamics, IBM, BankNorth, National Life, General Electric, Eveready Battery, etc, are not likely to accept a new payroll tax or trade their current health plan for a state plan. Their combined resources could mount a formidable legal challenge to the Attorney General's office, which would be required to defend Vermont's "single payer" law, with the legal fees picked up by tax payers.

That's the reality. If Vermont wants a single payer, Vermont needs an Act of Congress, the signature of the President, or victory in a protracted and expensive lawsuit against the biggest corporations in America. **Is this how Vermonters want our legislature spending their time and our tax dollars? Do we want to spend another ten years getting nowhere on reforming our system? Or can we dedicate ourselves now to implementing realistic and credible reforms?**

[\(Return to Table of Contents\)](#)

What 30% Savings? What the Lewin Study Actually Says About the Single Payer (9/7/2005)

In 2001 the Office of Vermont Health Access funded a study on the impact of a single-payer system on health spending in Vermont. This study, conducted by The Lewin Group, Inc. (quickly known thereafter as "the Lewin study" or just "Lewin") is still used to back up claims about savings from moving to a single payer in Vermont, even if it were legally possible to do so.

Many who quote the report apparently haven't actually read it. Lewin fans do not explain the strict managed care limitations assumed in the estimates, for example, nor do they explain where savings come from. The 30% savings in administrative costs hyped by single payers fans appears nowhere in the report, although Lewin is frequently cited as a source. Also, Lewin, like any study that estimates expenditures and savings, is based on a series of assumptions; unless a health care reform proposal adheres to all of the same assumptions, the proposal cannot legitimately claim even the small savings projected by the study.

The key findings of the study are contained in a table found on page iii of the Executive Summary. It is reprinted in its entirety below, with commentary.

Commentary

1. As seen in the table below, the biggest source of savings of administrative "savings" (nearly 70% of the estimated administrative cost reduction) is the elimination of private insurance companies. On page 12 the study states "Overall, statewide insurer administrative costs would be reduced from \$173 million under current policy to \$67 million under the single-payer model for a net savings of about \$106.5 million in 2001." This saving in relation to total system cost in 2001 of \$2.519 billion is a 4% cost reduction. This also means that Lewin estimates running the single payer will cost \$67 million/year. In June 2005, Rep. John Tracy told a Rutland audience the Democrats' proposal will NOT replace private insurance, so these even these savings cannot be claimed for his proposal.

2. While Lewin is often quoted in a context of how high hospital and physician administrative costs are under the current system, the estimate of the total savings for all hospitals is only \$27

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Page 8

**Changes in Health Spending in VT Under a Single-Payer Program in 2001
(in millions)**

Changes in Health Services Utilization		
Increase in Utilization Due to Expanded Coverage		\$62.9
Utilization Increase for Previously Uninsured	\$23.1	
Expanded Coverage for Those Already Insured	\$39.8	
Changes in Administrative Costs		
Net Change in Admin Costs		(153.6)
Insurer Admin costs	(106.5)	
Physician Admin Costs	(\$19.8)	
Hospital Admin Costs	(\$27.3)	
Managed Care Adjustment		
Managed Care Adjustment		\$2.8
Prescription Drug Rebate		
Prescription Drug Rebate		(\$30.2)
Net Change in Health spending		
Net Change in Health spending		(\$118.1)
a/ Includes all persons in the state including those with public and private coverage.		

million, or 2% of the \$1.03 billion hospital costs estimated BISHCA for the same year. Physician administrative costs would decline by around \$20 million, according to Lewin, or around 5% of total costs when compared to the BISCHA expenditure budget for 2001.

Total administrative costs (hospital, insurer and physician) would decline, according to the Lewin study, by \$153.6 million. According to BISCHA, in 2001 the total system cost was \$2.519 billion. Savings of \$153.6 million out of \$2.519 billion represents a total reduction in administrative costs of 6%.

So where does the much vaunted “30% savings” and “30% reduction in costs” estimates come from that are so often ascribed by single payer advocates to the Lewin study? It’s simply not in Lewin. As seen above, neither physician nor hospitals will see reductions greater than 5%, and even with elimination of insurance companies the total reduction in administrative cost relative to total system cost is around 6%.

The 30% savings figure simply does not show up anywhere in this study.

3. Savings in hospital administration would come largely from replacing per-patient billing with an annual global budget. Because hospitals would be globally funded based on the projected services for patients in their service areas and would have no machinery for billing for out-of-area patients, this model must assume that patients would be required to go to the hospital whose budget includes funding for that patient. (For example, the way public schools are budgeted.) **This is entirely at odds with the “free choice of provider” cited by the single payer advocates.**

4. The study assumes that “provider payments are adjusted to eliminate provider windfalls for care already paid for through cost shifting.” The accompanying chart (p. 21) shows a \$50 million in new payments for the previously uninsured, offset by \$50 million reduction for prior cost shifting to other payers for those costs. However, the report does not address at all the cost impact to eliminate the cost shift from Medicare and Medicaid, which is far greater than the cost shift for the uninsured. **If rates to providers for Medicaid/Medicare patients are**

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raised to the level of private insurance payments, there would be a huge windfall to providers and extraordinary cost increase to the government payer (and taxpayers), which is not addressed at all in this study. (See Vol 1 No 1 of this newsletter for a recent study reporting that VT has the fourth lowest cost shift for the uninsured in the nation.)

5. "The program will be reimbursed for services provided to persons who are covered under the CHAMPUS," and "Federal Medicare program funding for Vermont residents would be transferred to the Vermont single-payer program. This includes federal funding for Part-A and the federal share of funding for Part-B." Unless the program envisioned by Lewin is part of a nationwide health care reform package, **the program Lewin envisions is possible only by a specific Act of Congress granting this right to the state of Vermont. How likely is that?**

6. Access for the currently insured would change in the Lewin model, which "would feature a primary care provider referral (i.e., gatekeeper) model... Specialist visits without a referral would be covered subject to a 50 percent co-payment." This is at odds with claims by the single payer advocates program that allows entirely free choice of provider without care management. Their costs will be much higher than Lewin estimates.

According to Lewin, "the impact that these changes in the use of managed care would have on utilization, are mixed. Persons who are currently in fee-for-service plans may actually see a reduction in utilization due to the use of the primary care provider referral model. Conversely, persons enrolled in restrictive HMOs would probably tend to experience a net increase in utilization." According to Lewin, only around 3% of Vermonters participate in HMO plans. **This means that their model is predicting that 97% of Vermonters would be placed in a more restrictive plan than they now have.** Again, Vermonters are not told this when being pitched the Lewin model and its "savings."

All ambulatory (non-inpatient) care would be subject to a \$10 co-payment for all participants. The study does not waive this co-payment or discuss a sliding scale based on income; a plan that did so would experience different (i.e. higher) costs and utilization.

7. Savings of \$30.2 million over 2001 pharmacy costs are assumed by moving everyone in the state into a prescription drug program that would receive current Medicaid rebates. However, the pharmaceutical industry is not required under federal or state contracts or laws to extend their rebates to everyone in a state. (This has been the subject of lawsuits already.) Thus, these savings are not likely to accrue.

An analysis of the forecasting model used by Lewin is beyond the scope of this writer, but most likely would reveal additional surprising assumptions. What we can see, however, is that agreement with and honesty about the assumptions used and conclusions drawn is essential to having a reliable, valid and evidence-based approach to health care reform.

The legislature's Commission on Health Care Reform will be letting contracts to consultants for two more studies (in the Commission's words) "in support of the goal of providing full and universal access to health care in Vermont." An economic impact study will "contrast the effects of the current health care system to the effects of a system providing universal access to health care on Vermont's economy, including effects on businesses, employment, economic growth, economic competitiveness, providers of health care, health insurers, and Vermont residents." The financing study will "compare alternative mechanisms to fund the state's health care system, including but not limited to income tax, payroll tax, consumption tax, more limited taxes, risk pools, and tax credits for the purchase of health insurance. The comparison shall consider relative effectiveness in achieving the goal of universal access."

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Evidence-Based Health Care Reform

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Page 10

We hope that when choosing a contractor, approving a study plan and evaluating the final report, the Commission will carefully review and disclose all underlying assumptions and apply the study results correctly, in the spirit of Evidence-Based Health Care Reform.

[\(Return to Table of Contents\)](#)

New Hospital Budgets: Cost Shifting and Lessons for Reform (9/19/2005)

When Rutland Regional Medical Center (RRMC), Southwestern Medical Center (SWMC), Springfield and Brattleboro Hospitals presented their 2006 proposed budgets to the Public Oversight Commission (POC) and the Department of Banking, Insurance, Securities and Health Care Administration in August 2005, the hospitals cited the legislature's cuts to Medicaid reimbursement as one of the major drivers of their rate increase requests.

"[RRMC President and CEO Tom] Huebner said recent reductions in government reimbursement are expected to cost RRMC about \$1.8 million more than is customary. The loss of Medicare and Medicaid dollars is 'worth 3 percent so our rate increase would be down to 6 percent [from a proposed 9%],' Huebner said. 'Government programs need to start paying what it costs to care for their patients.' " (Rutland Herald, Aug. 28, 2005)

"The Southwestern Vermont Medical Center plans to submit a rate increase request of 9.8 percent, the second highest of any hospital in the state. The request is largely due to cutbacks in state Medicaid payments, according to Thomas Lenkowski, the hospital's chief financial officer.

"The state is looking for hospitals across the state to make do with \$19 million less from state Medicaid sources and SWMC's share of that cutback is slated at \$1 million. The money will have to be made up from somewhere, Lenkowski said. 'They're paying \$1 million less for the same services we provided last year,' he said. 'The state is forcing someone else to pick up the costs.' " (Bennington Banner, Aug. 14, 2005)

This demonstrates that any list of what is driving up the costs of health insurance has to include the cuts to Medicaid reimbursements for hospitals. The hospitals responded to the Medicaid cuts by raising their rates to private payers to cover the gap -- in other words, the legislature's recent action to cut back on Medicaid reimbursements to providers didn't actually "contain costs," it simply added to the cost shift from Medicaid to private payers.

In a "single payer" or payroll tax funded model proposed by current legislative leaders, what happens if the legislature still cannot make the tough choices to rein in Medicaid costs by reducing eligibility or benefits, requiring more co-pays, etc? What would happen if they put everyone into a state program as rich as Medicaid (which is basically what H. 524, tried to do)?

Currently the "release valve" for the hospitals and physicians is to cost shift to private insurance --- the legislature can over-commit on Medicaid and underpay providers, and the hospitals and doctors reallocate their costs out to the private payers (protecting the legislature from having to raise taxes or impose other pain directly). If the legislators don't have that release valve any more, will they simply raise the new payroll tax instead?

If the legislature wants to take on the discipline of running a health care system, shouldn't they start with what they are running now (Medicaid)? It's ironic that the response of legislative leaders to Governor Douglas's Medicaid Global Commitment is a deep concern that VT taxpayers

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Page 11

will end up holding the bag if Medicaid costs can't be controlled, when their own proposal would put everyone in the state into a single payer with taxes as the only source of financing.

The opposition among employers and providers to the legislature running health care isn't that businesses and providers are mean-spirited, greedy or stingy. It's because they are concerned, based on their experience that what is now the cost shift to private insurance premiums might simply become a cost shift to employers and employees through a new payroll tax. They would like to see some hard evidence of the political and fiscal discipline that will be necessary to make a state-directed universal program affordable and sustainable

[\(Return to Table of Contents\)](#)

How other states are improving quality and safety (9/22/2005)

While Vermont lawmakers discuss whether we should be the first state in the US with a single payer, other states have implemented government programs to improve quality and safety for patients, reducing costs for their citizens over the long term by eliminating errors and unnecessary utilization.

Over twenty states now require hospitals to disclose serious errors and hospital-acquired infections to state authorities. Many states have created patient safety institutes that require hospitals to collaborate on re-engineering their processes of care to prevent errors. Many states require hospitals to develop a corrective action plan for the error, and the state monitors for compliance and improvement. Some states – CO and MN - publish hospital specific reports each year, and some – CT, FL, ME, NY, RI, TN, TX, UT - publish aggregate information combining all hospitals and showing trends from year to year. Maine has developed an award program that publicizes hospitals that fully implement and comply with 28 nationally recognized safety practices.

These state-legislated programs have several fundamental principles in common:

- Patient safety is in the public interest – as important as restaurant safety and worksite safety, and government has a proper role providing oversight and ensuring accountability from institutions granted state hospital licenses.
- Concern that an explosion of litigation will follow public disclosure has a chilling effect on hospitals' willingness to cooperate with reporting systems. This is why most states have chosen not to publicly report hospital-specific error rates. However, all states have designed processes that hold hospitals accountable for fixing their errors, generally by involving state agency staff participating in confidential, non-discoverable reviews of reported errors and other adverse events. Within these confidential safety programs, state agencies still have the authority to impose sanctions or penalties, or seek court orders to enforce safety standards and require compliance.
- All systems or processes will produce the outcomes that they are designed to produce. This applies to systems/processes that produce errors – that is, a system or process that is error prone is designed in a way that allows errors. To eliminate errors, systems --- include the hospitals that deliver health care, and the processes and treatment protocols to deliver that care --- must be redesigned so that errors can't and won't happen. It takes vision, leadership, good data and information, participation of "front line" staff and accountability to the customer to successfully redesign a system or process for error-free outcomes. "Slapping the hands" of a hospital or practitioner that errs will not prevent

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Page 12

future errors. Making it imperative that the hospital reengineers its systems to be error-free all the time is the principle that state policy must enforce.

- Adequate and robust state oversight requires adequate state funding. These safety institutes and data gathering and reporting programs have been provided funding for staff and resources by their legislatures.

Not only is Vermont falling behind other states on overseeing patient safety, but numerous initiatives we have recently undertaken in Vermont – Managed Care Consumer Protection, Health Resource Planning, Certificate of Need reform, Hospital Budget Review Reform and Hospital Community Report Cards – passed the legislature without the additional staffing and resources truly needed by the agencies assigned responsibility (BISHCA, Dept of Health). “Oversight” and “reform” are only window-dressing without adequate staffing, and using those words misleads consumers who believe they are being protected.

[\(Return to Table of Contents\)](#)

What Went Wrong With Cost Containment? (12/5/2005)

Annual rate increases for employer-sponsored health insurance peaked in 1985 at more than 15% a year, then dropped to less than 5% in the mid-90s, but have been climbing again. What happened? This issue of our e-memo offers one possible explanation: government regulations and most current insurance plan designs have insulated consumers and providers from the cost of care.

In the pre-HMO days, with most insurance plans, the consumer paid a deductible, then shared in costs (usually an 80-20 split), and then the carrier paid 100% above the consumer's out-of-pocket limit. HMOs came to the market in the mid-1980s with a new economic model:

1. Instead of paying providers on a “fee-for-service” basis, HMOs would prepay a fixed monthly amount (capitation) to the provider. Under this model, the capitated provider would assume financial risk and make all medical decisions with the patient. There would be no need for the HMO to “bean count” when the provider assumed the risk.
2. Because a provider was prepaid each month whether the patient sought care or not, the patient was limited to using that provider. In return for the prepayment and exclusivity, providers negotiated lower fees and accepted financial risk.
3. Patients faced minimal financial risk. There was no longer a deductible, and patients only paid a per- service co-pay (\$5, \$10). This fee required the patient to think about initiating care, but wasn't high enough to impose a barrier to early and preventive care.

Using this model, HMOs caught fire in late 80s and early 1990s because of lower premium costs and inflation trends, and high patient satisfaction with low copays. However, many patients were unhappy about not having the anytime, anywhere choice of the old plans. They were limited to one primary physician and a particular network of specialists, hospitals and pharmacies. They were limited to using the ER for only truly emergency, life-threatening problems, not for convenience.

Eventually, patients rebelled and their anger was fueled by endless HMO bashing in the press and the organized provider lobby (AMA, AHA, etc). Providers who were unhappy with assuming

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Page 13

financial risk, or who lost patients to HMO network providers, were known to disparage HMOs to their patients. Employees pressured on their employers, who pressured the HMOs to reintroduce more choice. Legislatures and state regulators mandated HMOs to contract with “any willing provider,” and to let consumers go to emergency rooms without calling their doctors for a quick triage and to self-refer to specialists. What providers and consumers wanted, in effect, was the low financial risk AND open choice of the old indemnity plans, at the low premium cost of the HMO.

This tug-of-war over cost, choice and financial risk presents an important lesson: the way we deal with health care often ignores fundamental laws of economics. Here’s an example we’re all familiar with --- coverage for pharmaceuticals --- that demonstrates what went wrong.

HMOs built networks of pharmacies willing to accept a lower price in return for a virtually guaranteed market of consumers. Because of these significant discounts, HMOs could keep premiums lower, and charge patients a flat co-pay (\$5, \$10, etc) rather than impose a deductible and coinsurance. In this model, the key economic characteristics are:

- A patient has little economic barrier to getting a prescription, especially a prescription for a chronic disease, filled promptly.
- Pharmacies have an incentive to compete to provide the best discounts to the HMO, in return for being on the exclusive network.
- The HMO has an incentive to educate patients and physicians on cost effective prescribing because the HMO, not the consumer, is assuming a greater financial risk. HMO medical officers and pharmacy chiefs develop “counter-detailing” programs and formularies to guide the prescribing practices of their participating doctors to cost effective drugs, rather than respond to salespeople.
- The patient has less choice (i.e. using network pharmacies only) and is rewarded with lower out of pocket (both in co-pay and premium).

But patients didn’t like being limited to the network, and pharmacists who didn’t want to accept the discounts, or who were at a disadvantage to pharmacies who could buy cheaper at wholesale, went to legislatures to impose legal restrictions on the HMOs such as:

1. “Any Willing Provider” laws that require an HMO to contract with any pharmacy willing to accept the terms of the contract. In the first year after enactment of the law, all pharmacies may move down to the lower rates in the contract at the time. But in subsequent years at contract renewal, there is no incentive for any pharmacy to undercut other pharmacies because everyone ends up with the same contract anyway. Consumer pressure forced HMOs to sign up as many pharmacies as possible. Price competition, in other words, disappeared.
2. “Unitary Pricing” laws (promoted by independent pharmacies and small wholesalers) that prohibit manufacturers from charging a lower price to high-volume purchasers than they charge to low volume purchasers. This means high volume purchasers (in particular, HMOs and chain stores) are stripped of their ability to negotiate discounts, which raises costs at the retail level to the consumer.
3. “Anti-Formulary” legislation that allows physicians to override an HMO formulary when writing a prescription.

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Page 14

Thus, following the backlash against HMOs, plans now display the following economic characteristics:

- Fixed co-pays (\$10/\$20/\$25) that limit patient price sensitivity. While there may be a differential between generics and brands (usually no more than a \$5 or \$10 difference), there is no reason for the patient with a fixed co-pay to care about the retail price of the drug. Anything above the co-pay is the HMO's problem.
- The HMO is constrained by laws that prohibit it from negotiating deep discounts with pharmacies in return for channeling patients to them by setting up an exclusive network.
- Manufacturers and their wholesalers have no incentive to offer deep discounts to volume purchasers, because they would have to give the same price to any retailer, regardless of volume.
- The HMO is constrained by laws that prohibit it from establishing a formulary of lower cost, effective drugs for use by physicians. Physicians can prescribe at will, for example as influenced by drug company representatives, or under pressure from patients responding to advertising.

The impact wasn't just pharmacy benefits. Similar laws and rules limit how HMOs and other insurers can contain costs for hospital, physician, diagnostic and mental health services. Patient financial exposure is limited to flat, minimal copays, and provider financial exposure is unconstrained by either patient price sensitivity or contractual requirements. And everyone is angry about how fast costs are going up.

Could that be what went wrong with cost containment?

[\(Return to Table of Contents\)](#)

The Uninsured in Vermont

The AARP Survey: What it doesn't say about the uninsured (11/28/2005)

Policy makers should be careful drawing conclusions about the uninsured based on AARP's recent survey, and here's why.

The October 2005 AARP poll reported findings of "a telephone survey conducted with 1,000 Vermont residents 18 and older on the issue of health insurance coverage." The results are predictive of Vermonters at large with an error rate of plus or minus 3.1%, with 95% confidence.

However, the survey is on shakier ground in its analysis of the uninsured, because it consisted of only 118 respondents (just 12% of the total survey sample). The detailed report of the survey even includes a footnote saying "Due to the small number of respondents who are without insurance, these results should be interpreted with caution."

Statisticians will tell you that the plus/minus 3.1% margin of error on the total sample of 1000 does not apply to the uninsured subgroup of 118 people. Nevertheless, some provocative conclusions were drawn about the uninsured based on this very small and not statistically significant number.

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Page 15

For example, one of the bullet points in the Executive Summary states “over half of the uninsured residents have been uninsured for at least two years (most of them for five years or more.)” Because only the 118 respondents in the uninsured subgroup were asked this question, the 37% who reported being uninsured for five years or more translates to 44 people out of 1000. This is certainly not a figure with sufficient statistical significance to predict something in the general population of uninsured. That is why the detailed report included the footnote suggesting caution in interpretation.

Despite the report’s warning, politicians jumped on the statement as though 37% of all uninsured Vermonters are uninsured for 5 years or more (based on 44 of the 118 uninsured responding). Senator Peter Welch, was quoted in the Rutland Herald (10/26/05) saying “That is actually stunning and alarming.” House Speaker Gaye Symington told the reporter the figure “added to a growing ‘sense of urgency’ among lawmakers.”

BISHCA’s Division of Health Care Administration is updating its insurance survey this fall. According to the Division, its survey will over-sample the uninsured in order to have more valid numbers for drawing conclusions. Until that or some other poll sampling more than 118 uninsured is released, we hope that legislators exercise some caution, and won’t craft legislation based on anecdotes heard at focus groups, self-selecting “public hearings,” or miniscule survey samples.

The survey raises a number of other questions. Here are a few:

- According to the survey, 64% of the uninsured lack coverage because they “cannot afford” it. How many of them are among the 43% of uninsured in a BISCHA survey who were eligible for Medicaid but hadn’t applied for it? Would knowing that almost half of the uninsured could be covered in existing programs reduce “the sense of urgency” among lawmakers to impose payroll taxes to create yet another state-run program?
- Only 66% of the insured reported having coverage for mental health services, and only 47% reported coverage for substance abuse treatment. The fact is Vermont requires all commercial insurance policies to cover mental health and substance abuse services to the same extent that other services are covered. This means that 100% of the insured MUST have coverage for mental health and substance abuse, calling into question the accuracy of self-reporting as a measure of what people have and don’t have for coverage.
- Even more odd is that only 96% and 95% reported having coverage for hospitalizations and doctors visits, respectively, when Vermont law requires 100% of policies in the state to cover those services.
- Those with insurance were asked whether they “worried that their insurer was more concerned with profits than quality.” Eleven percent (11%) reported being “extremely worried,” with another 19% “very worried,” and 25% being “somewhat worried.” The answers are odd considering that over 90% of the insurance in Vermont is provided by two non-profit insurers. Additionally, the two non-profit insurers pay out more than 90% of premiums dollars in claims, leaving only 10% for all administrative costs, reflecting a high level of efficiency.
- Almost as many people responded that VT’s health care system has “no problems” - 6% - as responded that the system is in “crisis” – 8%. More people (9%) said they “didn’t know” what state the system was in, than said the system was in “crisis.” And yet, the first bullet

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in the Executive Summary highlights the number of people who say the system is "in crisis."

- A "strong majority" reported that "all residents should have access to the same basic coverage," according to the survey. What does that question mean to you? Does it mean: "We all have the same plan?" Does it mean: "We should all have the same coverage?" Does it mean: "We all should have a floor of basic coverage but we can have more?" Does it mean: "My employer should be required to me with basic coverage?" Does it mean: "I'm willing to pay an income tax or payroll tax and have a basic state plan instead of having the plan that I have now?" Does it mean: "If I lose my current coverage, I'd like to have access to a basic policy, and everyone should have that same access."

There are no perfect surveys. It's hard to design a survey where polling methods and questions do not introduce bias into the results. That's why it is important to not rely on the headlines to know what surveys mean. And it's extremely important when writing legislation to also know what the results do NOT mean.

[\(Return to Table of Contents\)](#)

VT Is Fourth Lowest State for Impact of Uninsured on Insurance Premiums (7/21/2005)

Families USA, a leading national proponent of a single-payer health plan, recently published a study that, in their words, "quantifies, for the first time, the dollar impact on private health insurance premiums when doctors and hospitals provide health care to uninsured people." Paying a Premium: The Added Cost of Care for the Uninsured (Families USA Publication No. 05-101, 2005) states that in Vermont the impact of the "cost shift" for the uninsured on family premiums for employer-sponsored health insurance coverage is \$372 per year; the impact on individual coverage is estimated at \$143 per year. **These figures rank Vermont as the fourth lowest state for cost impact of the uninsured on premiums.**

By comparison, the impact on family premiums in New Mexico is \$1,875, in West Virginia \$1,796 and in Texas \$1,551 and the national average impact is \$922. The impact on individual premiums is highest in the same states: \$726 in New Mexico, \$660 in West Virginia and \$341 on average.

The impact in Vermont, in other words, is 58% *below* the national average for family premiums, and 60% *below* for individual premiums.

According to the study, the differences between states are a result of several factors:

- The number of uninsured in a state, which is a function of demographics, efforts by employers to provide coverage, and eligibility requirements for the state's Medicaid program.
- Dollars available from federal, state and local programs to offset uncompensated care
- Availability of "safety net providers" (example given: community health centers)
- Cost of services in a state
- Aggressiveness of debt collection by providers.

The entire study is posted on the Families USA website: [LINK](#)

[\(Return to Table of Contents\)](#)

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Page 17