



# Toward Evidence-Based Health Care Reform

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## What is making health care unaffordable?

*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: [www.brsvt.com](http://www.brsvt.com)*

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*To read and download the comprehensive health care reform proposal supported by BRS and several other Vermont business associations, [www.vtiha.org](http://www.vtiha.org).*

House Health Care and Senate Health & Welfare will be holding a public hearing on April 24, 2007 at 6:30 pm in Room 11 of the State House inviting testimony on the following questions:

- [What do you believe the next steps should be in health care reform?](#)
- [What makes your health care affordable or unaffordable?](#)
- [Catamount Health is the current program for moving toward access to affordable, quality health care for all Vermonters. What specific suggestions do you have for expanding Catamount Health?](#)
- [In particular, what kinds of groups or individuals should be considered next for inclusion in Catamount Health? Why?](#)

Always seeking an evidence-base for any health care reform, here are our answers.

## What do you believe the next steps should be in health care reform?

**Answer: We need to focus on achieving success and results in key initiatives already underway before we take on new areas of reform.**

- **Get Catamount up and running for the uninsured, so further decisions can be based upon evidence and experience as opposed to anecdotes and computer-generated assumptions.** The premium rates are already higher than projected, and enrollment for the uninsured won't even start until October 1. Let's focus on making Catamount a success at reducing the number of uninsured.
- **Implement the recommendations of various Act 191 work groups and task forces designed to reduce the rate of growth in health care costs.** As the legislatively mandated impact study emphasized, the cost of health care is the underlying problem; insurance premiums and the number of uninsured are symptoms of that problem. We should focus on attacking the problem itself. Recommendations from the 35 Act 191 task forces have not been acted upon. The state still has not implemented key health care reform elements of Act 53, passed nearly three years ago, because Act 191 pushed those initiatives to the side. Let's actually finish the work on reforms already on the books, assess the results, and then decide what to do next.
- **Bring Vermonters together to engage in the success of the Blueprint. The Blueprint**

**for Health is what makes Vermont's reform truly unique, and we owe it to ourselves and the nation to make this a priority.** We cannot load yet another set of complex reforms on the same state agencies, health care providers and community groups responsible for making the Blueprint a success, without further compromising that effort. The House expressed concern that the Blueprint wasn't making enough progress fast enough; the best way to really torpedo the effort would be to give OVHA, VDH, BISHCA and the provider organizations yet another reform initiative with short deadlines. Let's finish the work on this before moving in another direction.

## **What makes your health care affordable or unaffordable?**

Answer: In answering this question, and *evaluating answers given* to this question, it's important to emphasize the distinctions among (a) *cost of health care services*, (b) *cost of health insurance* and (c) *out of pocket expenses for health care*. There are different causes for each of these three being "affordable or unaffordable," and different actions are necessary to make any of these "affordable." As the legislatively commissioned study on the economic impact of tax-funded healthcare reform points out, the *cost of health care services* is what *underlies* the cost of health insurance and out of pocket expenses. *The legislative report points out that changing the financing mechanism for health insurance (e.g. from private premiums to taxes), or subsidizing someone's out of pocket expenses does NOT make health care affordable.* Many other actions are necessary to contain the cost of health care, in order to make health insurance and out of pocket expenses affordable.

With those distinctions in mind, here are the four principle things that are making health care, health insurance and out of pocket health expenses unaffordable:

- **The cost shift from Medicaid to the private sector.** Legislators have made it clear they don't want to hear about this. "We already know about the cost shift," is the way such testimony is dismissed. However, reducing the Medicaid cost shift is the single most effective step the legislature could take to reduce the cost of health insurance. The Medicaid cost shift is two-and-one-half *times* the cost shift from the uninsured. Right now in Vermont, private insurance is saddled with over \$90 million in annual "surcharges" to make hospitals whole from Medicaid underpayment. In fact, private insurance, through the cost shift, is financing nearly ½ of the total cost of the Medicaid hospital benefit. Because of the federal match for the program, the Vermont tax share for Medicaid is only 22%. This means that private insurance pays twice as much as taxes to cover Medicaid hospital benefits.

According to a legislatively mandated (and it appears, ignored) study, 14% of this year's private insurance premium increases was due entirely to the government cost shift. The paltry \$1 million increase in the budget this year for Medicaid (that won't even go into effect until half-way through the fiscal year) won't even make a dent. The longer the state puts off fixing the cost shift, the harder it will be to fix it.

- **Poor Alignment of Financial Incentives.** Health care providers are at little financial risk for providing services of little or no utility, nor are they "rewarded" for doing a better job than those who do a less good job at keeping patients well. One of the fast growing areas of costs, for example, is lab and radiology. It doesn't hurt patients to run a lot of tests to rule things out, and "someone else will pay for it." Hospitals expand their emergency departments when a majority of care delivered there could be done in a physician's office at lower system cost (albeit less conveniently for physician and consumers.)

Consumers may have more financial exposure now than before (higher out-of-pocket expenses and deductibles), but are they truly scrutinizing what services are offered, taking prevention

seriously, and managing their own health wisely? It's far easier to take a pill to reduce cholesterol than to exercise and make dietary changes, and then complain that pharmaceutical costs and deductibles are too high.

These are very tough problems we must address as a society. Simply changing the financing from premiums to taxes doesn't fix it. It only means that the tax system will have to start keeping up with the current rate of health cost growth.

- **Lack of public engagement in healthy lifestyles.** Public investments in initiatives like the Blueprint for Health are essential, as are investments in community infrastructure like recreation opportunities. Our schools need resources to embed healthy living into education. And the people responsible for making this happen (Health Department, providers and community groups) should be allowed to focus on this instead of being sent down another reform initiative path by new legislation assigning yet more responsibilities.

## **What specific suggestions do you have for expanding Catamount Health?**

Answer: **Don't expand Catamount until we have the experience and data to make informed decisions.** Catamount Health has not yet covered even one uninsured person. We have no experience with what it will actually cost, how costs will grow, whether people will buy in. Why are we even discussing expansion?

## **In particular, what kinds of groups or individuals should be considered next for inclusion in Catamount Health? Why?**

Answer: **The next group that should be considered is the uninsured who aren't already enrolled.**

Most people are not aware that **the budget for Catamount Health currently envisions fewer than 25,000 uninsured to be enrolled.** Obviously, if our goal is to have 96% of Vermonters insured by 2009, we should continue to work on enrolling the uninsured before we add groups of people who are already insured, and who may overwhelm Catamount and its budget before the uninsured can be helped.

And, as noted above, we still haven't enrolled a single person in Catamount, and we are 18 months from the conclusion of its first year of operation. We don't know yet if it will be successful for the uninsured, who have no other options.