



NOTE: This paper was approved by St. Luke's Health System Board (September 22, 2009) reviewed or approved by Boise/Meridian/MSTI Board; Boise MEC; Boise Leadership; Magic Valley Board; Magic Valley MEC; Magic Valley Leadership; Wood River Board; Wood River MEC; Wood River Leadership. It will be reviewed quarterly.

Framing the Issue

Our nation has reached the point where virtually everyone from government and private payers to physicians, suppliers, pharmaceutical manufacturers and individuals believes that significant reform of our health care system is needed. Most appreciate there is no single, silver bullet solution, but rather a need for both compromise and change across the health care spectrum.

The need for reform is demonstrated clearly in just a few statistics:

- A significant number of people (approximately 16%) in America are uninsured.¹
- Access to primary care, even for people with insurance can be difficult.
- In 2004, more than \$154 billion was spent on the administrative costs associated with private insurance and government programs.²
- Across the country, there is as much as a 300 percent variation in per capita Medicare spending
- Health care expenditures in the U.S. are increasing at between 5 and 7 percent per year.

While there is a clear understanding that reform of our current system is essential, the picture of what real reform looks like is much more complex.

Numerous Reform Concepts, Not Enough Detailed Study

Countless reform ideas have been offered. There are aspects of these proposals with merit: health insurance coverage for the uninsured, liability reform, limitations on physician self-referral, payment based on outcomes, bundling of payments to begin to address the fractured payment system, attention to expanding patient access to primary care services, social policy to address providing care for illegal immigrants, simplifying insurance coverage, significant regulatory reform, and increasing the population's choice of healthy personal behaviors. But so far in the debate, an affordable and acceptable solution has yet to be agreed upon.

The proposals currently on the table have not yet been fully analyzed, and the impact they will ultimately have on making real improvements to our health care system is not yet understood.

¹ SHADAC estimates from the Current Population Survey Annual Social and Economic Supplements, 1995-2008. Note: 1995-2003 data are adjusted for Census correction announced in March 2007.

² CRS Report to Congress. US Health Care Spending: Comparison with other OECD Countries. September 17, 2007.

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However, a thorough analysis and understanding of the various interrelated components must be done to avoid unintended negative health care delivery consequences and perhaps a national financial catastrophe.

Payment Reform as Primary Focus is NOT Real Reform

While not yet well coordinated, the myriad proposals currently being considered do appear to have a common theme: control skyrocketing costs by reducing payments to providers. This approach has been employed by government (and private) payers for the last thirty (30) years, with history showing that rather than resulting in positive reform, the approach has only exacerbated many of the issues we currently face. For example:

- Per service underpayment has led to increased utilization of health services as providers look for ways to replace lost income.
- Underpayment from government payers has caused providers to shift costs to the private sector, resulting in higher costs being passed on to businesses and individuals.³
- Underpayment for non-procedural work, services such as care coordination and counseling provided by internists and family doctors, has contributed to the shortage of vital primary care providers leading to care fragmentation and reduced access to basic care.

St. Luke's Position

Real and meaningful health care reform must include changes that:

- Result in insurance coverage AND access to health care providers for all
- Provide tangible incentives, education, and support to individuals to make healthy lifestyle choices
- Incentivize health care providers to prescribe the best medically necessary care for each patient in an integrated fashion that is coordinated with other care givers
- Remove unnecessary, costly and burdensome administrative processes – a reduction in these requirements will have a direct impact on reducing the overall cost of health care. For reform to work, policymakers must dig deep into areas beyond reimbursement rates, and all stakeholders involved in the delivery of health care must be open to change, agree to cooperate and be willing to make compromises.
- Provide for meaningful tort reform

³ Milliman, "Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers." December 2008.

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Coverage and Access

The most important issues to address are insurance coverage and access to primary care. The current debate focuses on providing health insurance to 47 million individuals who currently are not insured. There has been very little discussion to-date about the number of individuals who are not receiving appropriate health care due to lack of access to a primary care provider. Health care reform must focus on solving both sides of the coverage equation.

Personal Incentives

It is clear that personal choices impact how healthy one is and thus how much medical care one needs. For instance, we know that smokers are more likely to develop chronic illnesses and cancer, and being overweight can contribute to developing diabetes and chronic heart conditions. We also know that when medical problems are caught early, the likelihood of successful treatment increases. Preventive care, regular check-ups, appropriate screening, education and health coaching are all important components to staying healthy. Incentivizing people to make healthy lifestyle choices, from not smoking to getting the recommended check-ups, will contribute to better overall health, and reduce costs.

Provider Incentives

The health care system must provide appropriate incentives to physicians, specialists, and therapists to deliver only medically necessary care. Overutilization of services in our health care system is one of the key drivers of increased cost. Simply put, utilization measures the volume of health care services provided to patients by clinicians. The service could be a lab test, a simple procedure, a surgery, an imaging study, or a visit to a doctor's office or the emergency department.

The research on utilization is startling. Areas of the country with more doctors, more hospitals, more free-standing facilities like imaging centers and physician owned, limited service surgery centers and hospitals – states like Florida and Texas – have dramatically higher utilization rates and health care costs per person than states like Utah and Idaho.⁴ For example, if a patient has well-controlled high blood pressure and is following an uncomplicated medical regimen, the patient might see their doctor every six or twelve months. In states with higher utilization rates, this same patient might see their doctor every month.

We must ask whether higher utilization, or in other words, "more" health care services leads to "better" health care? Researchers at Dartmouth say "No." In fact, evidence suggests that the quality of care in low spending states may be better than the care delivered in high spending states.⁵

The problem then isn't that lower utilization means lower quality care; it is that higher utilization means more costly care for the same quality.

⁴ Fisher ES, Bynum JP, Skinner JS. *New England Journal of Medicine* 360:849. February 26, 2009 *Perspective*.

⁵ Skinner JS, Staiger DO, Fisher ES, *Health Affairs (Millwood)* 2006: 25:w34-w47.

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For Idaho, these facts are critical given current reform proposals under consideration which would cut reimbursement rates, or the per service amount paid for care, by the same percentage for every area of the country.

The net effect for Idaho, currently ranked by a 2007 Kaiser Family Foundation study as the third lowest cost per capita state in the nation,⁶ would be dramatically reduced dollars without any reduction in the demand for high quality care. Contrast the Idaho situation with a state like Florida, where utilization and costs are high, thus providing more opportunity for a reduction in expenses. To address this underlying inequality, Congress must account for the impact of utilization in any legislation being considered. In other words, don't penalize Idaho for having some of the nation's lowest per capita costs and utilization rates.

Additionally, incentives need to be tied to effective coordination of a patient's care process; particularly as it relates to the coordination of care for patients with chronic conditions. A patient with a chronic condition such as diabetes or heart disease will be cared for by multiple care givers. Making it easier and more financially feasible for those care givers to collaborate on the care plan for their mutual patient will result in more efficient and effective care.

Administrative Costs

Two other areas that must be addressed in order to achieve significant reform are administrative costs and the health care system's tremendous regulatory burden.

The U.S. Congressional Research Service estimated administrative costs of private insurance and government programs in 2004 at about \$154 billion.² The American Hospital Association estimates more than 25 percent of overhead expenses of hospitals and medical practices are spent complying with the thousands of rules and regulations that apply to health care providers. Simplifying administration and the resulting exorbitant cost of compliance and reporting will reduce health care costs.⁷

Administrative costs also include the cost of "defensive medicine." The threat of lawsuits causes health care providers to order more tests and procedures than are medically necessary. The need to assure that a serious diagnosis is not overlooked is a major contributor to the rapid growth in advanced imaging (CT and MRI) as well as laboratory testing. Without doing these additional tests to "rule-out" unlikely but possible conditions, doctors open themselves to accusations of malpractice. It's easier to order the test and avoid the worry. Evaluating effective tort reform models – like the one passed by the legislature in Idaho in 2003, can provide guidance in how to implement real and meaningful change. Reforming the way our society adjudicates injuries from medical malpractice will result in cost savings by reducing this practice of "defensive medicine."

⁶ Health Expenditure Data, Health Expenditures by State of Residence, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, released September 2007.

⁷ Statement of the American Hospital Association to the Senate Finance Committee Roundtable on Health Care Delivery System Reform Washington, DC April 21, 2009.

Additional Issues for Consideration

There are several additional societal issues that should be part of the reform discussion. While this paper will not go in depth on each of these issues, they are offered as points for further dialogue because they do have an impact on health care in our country.

- Differentiate between social problems versus medical problems. For instance, the oft quoted disparity between life expectancy in the United States and other Organization for Economic Co-Operation and Development (OECD) countries may alone not prove we have a bad system. If suicide, murder, and traffic fatalities and accidental deaths, are removed from life expectancy figures, we regain ascendancy. Life expectancy of a black male in Harlem is similar to life expectancy in Bangladesh. These are social problems and require a social solution. If we are not able to clearly define the problems impacting our health care system, we cannot begin to fix them.
- Move Federal dollars currently invested in Medicare and Medicaid to focus government payment on chronic and catastrophic care, for all Americans, regardless of age or ability to pay. (In a 2009 Kaiser Family Foundation study, chronic and catastrophic care is estimated to consume 75 percent of all health care spending).
- Provide incentives to those who provide improved, evidence-based management and outcomes of chronic disease instead of paying for discrete procedures, services and supplies.
- Provide incentives for completion of advanced directives and practicing safe and healthful behaviors (stop smoking, limit alcohol use, eliminate drug abuse, increase exercise, maintain proper weight, etc.). An emphasis must be placed on wellness and preventive care and behaviors rather than rescue care. The cost of dialysis for kidney failure due to obesity caused diabetes is predicted to bankrupt Medicare in 20 years. We are in the early stages of fantastically expensive epidemics – diabetes and obesity. Real and meaningful incentives (or in some cases disincentives), along with appropriate education and coaching to support healthy lifestyles, can and must be designed to impact these issues.

Compromise and Cooperation is Key to Reform Success

Everyone agrees that we must stop our health care system from devouring our economic future. To achieve real reform – the kind that reduces cost AND increases the quality of care for patients - will require all of the stakeholders involved in the delivery of health care to step up, accept change, cooperate, and agree to compromise.



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