

**VERMONT BUSINESS ROUNDTABLE
HEALTH CARE WORKING GROUP**

STATEMENT OF PRINCIPLES REGARDING HEALTH CARE REFORM

Approved by the Board of Directors

May 11, 2004

Ratified by the Membership

June 3, 2004

Updated July 7, 2004

Preamble

The goal of the Vermont Business Roundtable (VBR) is to help discover ways to provide better access to the highest quality healthcare possible, for our employees and all the citizens of Vermont.

As an organization of business people, we realize that this can only be accomplished by facing head-on the necessary limitations of the “art of the possible”. In the case of healthcare, this means accepting that there will never be enough funds in the system to pay for everything possible (or even desirable) and therefore some form of rationing (i.e. limits in terms of choice, coverage, benefits, and cost) will always be required. Part of the job will be to make this reality part of the general consciousness while fostering an attitude of personal health responsibility in every citizen.

While the dimensions of the current challenge are daunting, as professional managers and entrepreneurs we sense that, through radical but well orchestrated reform, the current level of healthcare spending can obtain far better results for our state.

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I. The Real Crisis in Health Care: A Chronically Ill Health System

With three years of double-digit increases in health insurance premiums, Vermont once again has a healthcare cost problem, symbolized by yet another increase in health insurance premiums, which is attracting the attention of legislators, policy makers and employers. We have reached this point before, in fact, several times in the last couple of decades. If the end result this time is to be more successful, we must approach the problems facing the health care system in a fundamentally different way. To use a health care analogy, the problem is not an acute illness that will be fixed by the “silver bullet” of a single prescription or a sophisticated surgery. Instead, the health care system has a chronic illness with multiple symptoms which have persisted for decades and which will require long term interventions and fundamental changes in behavior to manage the ‘patient’ to a better outcome. What are some of the most critical symptoms?

First and most visibly, medical costs continue to be out of control. The total expenses for health care services for Vermonters increased from \$1.7 billion in 1996 to \$3.2 billion in 2004, an increase of \$1.5 billion over eight years. This represents a 88% increase during a period when overall inflation was in the low single digits. However, the rate of increase in medical costs has been much higher than general inflation not for the last three years, not for the last ten years, but literally for decades, since the late 1960’s. Attempting to pay for these increased costs is forcing employers to redefine health insurance by shifting more responsibility to their employees, and is squeezing federal and state budgets that are already stressed to the breaking point.

A second symptom is that for all the resources that we devote to health care, we still do not provide health insurance for all Vermonters. Sixty thousand, or approximately 10% percent, of Vermont residents do not have health insurance and thus have major financial barriers to obtaining the health care that they need.

Finally, the quality of care that we provide falls far short of the standards we have set. Preventable medical errors in U.S. hospitals kill 50,000 to 100,000 Americans each

year, more people than are killed in traffic accidents. In addition, if you have a chronic illness, the chances are only 50/50 that you will get the care that best medical practice dictates that you should receive. As we continue to age, living longer more productive lives, the demands and expectations placed on the health care industry will only increase.

Costs, access and quality: these are problems faced not just by Vermont, but also by every state in the United States, as well as by other countries. These three symptoms are linked to each other, and cannot be solved in isolation because they are the result of a single health care system that integrates users, providers and payers of care. In formulating a prescription for the chronic illness in Vermont's health care system, we must learn from the past efforts of others who have tried to address these same, persistent problems. What can we learn from their work?

This policy paper first summarizes four major policy issues which have emerged from past attempts to heal the health care system and which shape its structure and performance. The four issues then provide a template on which to build a vision for a long-term prescription for Vermont's health care system, as well as some explicit initial steps. Hopefully, this paper will help catalyze the formulation and implementation of a constructive solution to the current crisis in health care, a solution that will deal with all of the symptoms of the chronic illness so that the health care system can be restored to better health. It is too essential to the well being of our State and its residents to be left to languish in its present state.

The Vermont Business Roundtable has previously published several policy papers on health care. Why are we writing another piece, and why now? First, health care policy will be a major focus of the next legislative session, and we are concerned about various proposals which we believe represent overly simplistic solutions to a much more complex problem. Perhaps the best way to express this is the classic admonition to new doctors, which we echoed, in our 2000 health care statement –

1. **“First, do no harm”**. We believe that some of the proposals being circulated could in fact make the problem worse, not better, and want to provide a framework for a more informed debate about the appropriate course of action.
2. **Second, we see worrisome signs** that the health care system in Vermont and the country may be reaching a tipping point, which would drive a period of rapid, unplanned change. Employer-based financing has been one cornerstone of the American health system, but it is showing severe signs of strain from the cumulative effects of out of control costs over the last forty years. The health care system as a whole has tolerated the chronic illness thus far and has proven to be remarkably resilient to efforts to change it either from inside or outside. However, the rapid collapse of employer financing would create a vacuum that could stimulate a sequence of uncontrolled changes in the health care system. While we strongly believe that change is essential, our preference is for that change to be deliberate and intentional, rather than unplanned.

II. Four Major Issues Which Shape Vermont's Health Care System

Given the complexity of the health care system and its importance for all residents of Vermont, it is easy to become bewildered by the myriad issues covered in the public dialogue about health care. **We believe that four basic questions lie at the heart of the debate over the Vermont health care system:**

1. How should health care insurance be funded?
2. How can we provide “universal access” or health care insurance for all?
3. How can we improve the performance of the health care system to make it be more affordable and have more uniform high quality?
4. What is the appropriate design of the Vermont health delivery system – our statewide network of hospitals, physicians and other care providers – to meet the needs of Vermonters in the future?

We will briefly expand on each of these questions to clarify them. Each of them is quite complex and could be the subject of a book, so we make no pretense at trying to summarize all of the positions embedded in each question, or the pro's and con's of various proposed solutions

1. How should health care insurance be funded?

This issue deals with the question of how to administer the massive financial flows that support the health care system: how should the money be raised and how many different entities need to be involved in administering it? The existing “multi-payer” system of funding for health insurance evolved over a period of decades to involve a complex mix of employer, federal, state and individual contributions. Government is a major source of funds, covering some of the most expensive patients through the Medicare and Medicaid programs, which in Vermont account for almost half of all health care expenses.

However, most employed individuals under 65 years of age obtain insurance through work, with their employer contributing a significant amount to reduce the premium costs.

The steady increase in the price of insurance has made some question the viability of employer-based funding.

There have long been signs of erosion in employer-based coverage by small employers (less than 50 employees), and more recently even among large employers. Critics of the current multi-payer system have pointed out a variety of shortcomings, such as high administrative costs, regressive tax subsidies and the hassles of changing insurance whenever one changes jobs. Advocates of a “single payer” system which would consolidate the funding into a single, centralized source have been pressing their case recently and are expected to be active in the next legislative session.

One of the long recognized problems of the existing multi-payer system is the uneven price that government and private funders pay for the same service. Both state and federal governments have systematically paid less than the full costs of most types of care – hospitals, physician, long term care, etc. – which has resulted in a massive shifting of costs to private insurance companies, employers and individuals. This cost shift has exacerbated the affordability issue for employers and multiplied the impact of the underlying cost trends on them.

2. How can we provide “universal access” or health care insurance for all?

Universal access is sometimes confused with the first issue of single vs. multi-payer, so it is essential to recognize that providing coverage for all is a quite different issue from how we fund that coverage. Even though we spend more per person on health care than any other developed country in the world, almost one American in six does not have health care insurance. The lack of insurance limits their ability to obtain many important types of health care, which is not only inconsistent with our values, but also often ends up being more costly in the long run.

Most proposals to reduce and eventually eliminate this gap in health insurance coverage use a multi-payer approach to build on existing public and private programs, e.g. by expanding eligibility for state funded public programs or by providing incentives for all

employers to offer health insurance. Vermont has been more successful than most states in this area and only 10% of Vermonters do not have health insurance of some kind. However, recently other states have been aggressively exploring alternative ways to move more rapidly toward universal access, for example, Maine's voluntary Dirigo program and California's mandate that employers offer health insurance.

The starting point for moving towards universal coverage is reaching consensus on what constitutes a basic level of insurance coverage that everyone should have.

Health insurance is currently being redefined in general and the acceptable floor for what constitutes basic benefits is moving down, not up. The upward spiral in costs has resulted in employers and state governments reassessing what they include in the benefits for those they currently cover.

The wave of benefit mandates that were imposed in the last decade are now being reconsidered, and self-insurance is being considered by more employers to give them more flexibility in their benefit design. Also, there is broader recognition of the need to have patients and their families more engaged in managing their own health and making informed decisions about health care. Reducing benefits to transfer more financial responsibility for costs to patients not only reduces employer and government costs, but also creates stronger incentives for the patient to be more involved in their own care.

Another major debate in achieving universal coverage is whether the problem can ever be completely closed by a voluntary offering of insurance, or whether participation will have to be compulsory at some point. Many of the individuals who do not currently have health insurance in Vermont are eligible for coverage, but have elected not to sign up for it. Voluntary participation has a number of unfortunate side effects on insurance, including weakening the risk pool by having some of the healthiest individuals opt out of coverage, and attempts to "game" the system as people without coverage discover they have an expensive health problem and try to obtain coverage.

3. How can we improve the performance of the health care system to make it be more affordable and have more uniform high quality?

Ultimately, if health insurance is to become more affordable, then the current performance of the health care system will have to significantly improve. Changing the funding mechanisms, providing universal coverage, tinkering with the rate setting process to shift costs from one player to another – none of these does anything to pull costs out of the system. While making meaningful changes in a system as large and complex as health care is difficult, there are a number of signs that the system has room for significant improvement.

- First, a growing body of evidence by national groups such as the Institute of Medicine and the Institute for Healthcare Improvement has documented how serious quality problems have greatly increased costs. Preventable medical errors within both hospitals and outpatient settings not only hurt patients; they add costs as we try to compensate for the damage they have caused. The long time lags in disseminating best practices for medical care, whether dealing with complex surgeries or routine chronic care, results in our paying for a large number of treatments that are not evidence based, and in patients frequently not getting the appropriate care. Creating the culture changes and tools required to correct these long standing problems will be hard, but is certainly achievable.
- Second, the existing system does a poor job of involving the patient. The performance of the health care system is critically dependent upon engaging the patient more effectively. Part of this involves providing the financial incentives discussed above to help the patient make more informed decisions about their care. More importantly, patient behaviors need to change in order to prevent problems by living healthier lifestyles, to make individuals more proactive in self-management of their health care problems and to improve their compliance with care ordered by their providers.

- Third, for all the dollars spent on care and the concerns about administrative costs, health care has systematically under invested in clinical information systems and data tools. It has been much easier to invest in “bricks and mortar” for facilities than in much needed information systems. Given the highly fragmented nature of modern health care and the explosion of medical knowledge, the absence of basic tools, such as standardized computer physician order entry, has increased medical errors and the hassles of obtaining basic care. This has also built major barriers to documenting the care provided to populations, such as all Vermont residents, over time to identify opportunities for improvement on an individual and system-wide basis. As a first step, two administratively complex areas warrant attention, namely, the front-end data collection/patient intake records, and at the back end, claims and billings procedures.
- Fourth and last, international comparisons demonstrate that the current U.S. system pays significantly higher prices for health care. This is often documented for prescription drug and administrative costs, but is also true for hospital and physician services as well. Reducing the price that we pay in Vermont and in the U.S., as a whole, for essential medical services is a real option for reducing costs, and will be key to our long-term competitiveness in a global economy.

It is unlikely that any one thing will reduce overall health care costs as there are elements operating here that break the current model: utilization, expectations, and society’s demand for immediate gratification. However, given the opportunities outlined above, we should be able to “bend the cost curve”, in other words, to reduce the rate of growth to something closer to the general rate of inflation.

4. What is the appropriate design of the Vermont health delivery system to meet the needs of Vermonters in the future?

The current health care delivery system - our statewide network of hospitals, physicians and other care providers – gradually evolved over generations to meet past needs with the technology available at the time. Both those needs and the tools to meet them have changed rapidly in the last twenty years:

- Health care problems have shifted from acute, episodic illnesses, such as infectious disease, towards chronic illnesses, which must be managed over years, not days or weeks;
- The new inventory of tools has reduced the role of hospital stays and placed new emphasis on outpatient diagnostic and therapeutic services, as well as self-management and home care. If we were to design Vermont's health care system from scratch today, it is very unlikely that it would look anything like what is currently in place.

The system is evolving over time, but change comes slowly and the gap is large. The state legislature recognized this issue last session and passed Act 53, which calls for the development of a State Health Resource Allocation Plan over the next two years. This plan should provide a much-needed vision for the future Vermont delivery system and a better context for the public and private decisions on where to make strategic investments for capital and human resources.

However, a complete vision must include much more than the traditional components of hospitals, physician supply, and nurses. One of the missing conversations in the current health care debates is the role of a 21st century Public Health system. One hundred years ago, investments in public health to provide safe, clean water supplies played a lead role in controlling epidemics of infectious disease, which had caused infant mortality rates of 50% or more to be common. The improvements in health were aided by medicines and the professionalization of medical training, but the health problems at the beginning of

the 20th century could never have been by solved health care alone. Making investments in iron pipes in the ground to deliver clean water and dispose of human wastes solved them.

Today, at the turn of the 21st century, we face an epidemic of chronic diseases, not infectious diseases. A missing component of Vermont's health care system is a public health infrastructure designed to meet these new needs. That new public health system is still taking shape, but will clearly involve a network of community based resources to educate and support more engaged patients and to change patient behaviors. It will also require investments in integrated population based information tools, which can be used both to evaluate the effectiveness of the health care system, and to target interventions to specific people who need help. To be practical, this population level database must be fed automatically by the same tools used to both obtain patient encounter data and which provide "best practice" individualized guidance.

III. Moving Toward a Vermont Solution: Long Term Vision and Initial Steps.

Returning to the chronic illness analogy in the preamble, we must recognize that dealing with chronic illness, either in an individual or a health care system, is not easy.

Managing chronic care for a specific person requires a sustained effort and coordinated action on the part of many parties – patients, providers, families and community resources. Addressing a chronically ill health system is even more complex and more challenging. The following are our thoughts on some basic principles that should guide where to start:

Recommendations on Issue #1 ~ Universal Coverage

- a. Every Vermonter must be enrolled in a health insurance plan; mandated coverage should be provided either through the employer or a public program. Suggested actions include:
 - i. Newborns receive health cards, the way they currently receive social security cards.
 - ii. Insurance agencies provide current subscribers with their ‘license’;
 - iii. Any Vermont resident seeking care that is not insured must enroll at the time s/he seeks care.

- b. All health care benefit programs, either through a public or private model, should provide a common, basic benefits package to Vermonters. It should emphasize efficiency in administration, and utilize technology to reduce duplication of services. This standardization would serve to avoid any perverse incentives that would move people from “leaner” employer-based programs to “richer” publicly funded programs. Suggested actions include:
 - i. Preventative care – Periodic checkups will be included in basic coverage;
 - ii. Effective catastrophic coverage for major illnesses and accidents;
 - iii. A basic prescription drug benefit;
 - iv. Counseling – to improve healthy behaviors;

- v. Coverage for treatments that meet the Institute of Medicine's definition of quality care;
- vi. Individuals or employers may, at their expense, choose to offer programs above the basic benefit design. However, such programs should be standardized into a few common models to reduce administrative expense.

Recommendations on Issue #2 ~ Funding of Coverage

- c. The delivery model for Vermont's health care system should be based on the existing employer-based, multi-payer model. The business perspective in this formula ensures that external controls will continue to apply market-driven pressures to achieve efficiency and cost-effectiveness. However, some businesses are reaching the point of not being able to continue offering health care. If current trends are allowed to continue, they will put into jeopardy the entire employer-based model. Suggested actions include:
 - i. All non-exempt employers will be required to offer basic insurance for an individual employee. The basis for non-exempt status is to be determined;
 - ii. All employees will be required to make a contribution to that insurance, in the recommended range of 20% or more, and funded through a variety of ways including payments that are proportional to payroll, a flat amount, or utilization charges.
 - iii. Employers may pay for additional coverage for recruitment or retention efforts;
 - iv. A Health Care Fund will pay basic coverage for underage and unemployed workers, based on a sliding income scale. No overlap with Medicaid, although Medicaid basic coverage should match that of this Health Care Plan;
 - v. The Health Care Fund will cover any basic care for the elderly that is not covered by Medicare.

- d. Health care programs must be affordable and sustainable. Low administrative costs, low error rates, and parity of basic coverage comprise the foundations of health care reform. Suggested actions include:
 - i. Reward or penalize providers for achieving best practices:
 - 1. Incentives to encourage adherence to evidence-based best practices in both chronic and acute care management of patients;
 - 2. Incentives for reducing error rates to zero;
 - 3. Incentives to achieve cost per case best practices; and,
 - 4. Incentives to achieve CMS endorsed clinical process indicators.

- e. All participants should pay for such coverage based on a means-tested scale of fairness. Incentives for good health and healthy behaviors will reduce the costs for qualified Vermonters. Suggested actions include:
 - i. Healthy behaviors that receive incentives must be validated in the medical literature.
 - ii. Incentives for cost effective health maintenance by:
 - 1. Avoiding risky behavior (i.e., smoking, excessive drinking, drug abuse, obesity, non exercise);
 - 2. Utilizing the most cost effective alternative for care; and,
 - 3. Compliance with provider-defined care plans.

- f. Government sponsored health insurance programs must have sustainable financing which covers their fair share of medical costs and eliminates cost shifting to the privately funded sector. If the funding is not sustainable, then either benefits or eligibility criteria must be adjusted.

Recommendations on Issue #3 ~ Improving Performance

- g. Vermont's health care system must significantly improve its reliability and quality of care as measured by the six STEEP aims that have been established by the Institute of Medicine and the Institute for Healthcare Improvement:
 - i. Safe
 - ii. Timely
 - iii. Effective
 - iv. Equitable
 - v. Efficient
 - vi. Patient-centered

- h. A proactive and efficient quality care management and treatment model, founded on evidence based medical practice, and a more efficient use of non-physician providers, should be applied to the provision of all health care services, especially to chronic care;

- i. Health care must become patient-centered, and patients and their families must be effectively engaged in health care and accept consequences for non-compliance as well as receive credit for wellness. Suggested actions include:
 - i. Incentives for avoiding risky behavior (e.g., cost savings) and consequences for continuing risky behavior (e.g., higher out of pocket expenses for coverage);
 - ii. Health Savings Accounts could accrue equity, which individuals could use for other purposes (e.g., retirement accounts), up to some percentage of the total value.
 - iii. Co-insurance and deductibles will be applied to create a continuing awareness of responsibility on the part of eligible Vermonters.

- j. Beginning with the youngest school children, all Vermonters must be educated about the importance of prevention and individual responsibility in the systematic management of their personal health and well-being. By teaching a core of behavior and having it reinforced over time, positive trends and benefits will impact the overall health indicators for Vermonters. Furthermore, realistic expectations of the health care system can be explained to them, which are also correlated to cost benefits.
- k. Administrative processes must be simplified and standardized to eliminate unnecessary hassles and costs. This includes the operations of both insurers and providers of care. For example, there is a major need to standardize and fully exploit the technology we have to achieve administrative efficiencies around billing and claims.
- l. As a state, we are under-invested in information systems technology that could have tremendous cost savings potential. Capital investments must be made in health care industry information technology to realize those gains. These technologies should, at a minimum, assure that both patients and providers have clinical decision support tools available to them on line. Special efforts would be needed to provide subsidies for rural areas, and national standards would ensure the interchangeability of these systems from site to site.

Recommendations on Issue #4 ~ Planning the Future System

- m. The Vermont Health Plan now under development should establish a vision for Vermont's health system, which is based on 21st Century needs and technology. This should include an assessment of the consequences of the shift toward chronic illness, the diffusion of medical and information technology to patients as well as providers, and an expanded role for public health and community based resources. Such a review is likely to result in a significant rebalancing of existing resources and capacity.

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