



## Addressing Health Care Costs

It's election time again, and candidates are traveling their states and districts, making promises. Some of them will win—only to face the question Robert Redford made famous in *The Candidate*: “What do we do now?”

As they settle into office the vast majority will discover that there's no money to fund their many promises. Despite rapidly rising tax revenues, the cupboards are surprisingly bare.



In my state, Massachusetts, we're still balancing the budget with \$550 million from the Rainy Day Fund—a true mark of insanity, at the top of the business cycle. We should be replenishing the Rainy Day Fund, because one of these years it's going to rain.

As I have argued before in this letter, I believe the fiscal crisis is more or less permanent, thanks to skyrocketing health care and pension costs as people live longer and the baby boomers begin to retire. Health care now eats up 20 percent of all state and local spending (33 percent at the state level, where we pay for half of Medicaid), and since 2000 it has grown at double digit rates. Next year the Governmental Accounting Standards Board will require governments to disclose the true cost of their future commitments to retirees for health insurance, and the numbers will be staggering.

After health care and pensions take their bites, there's precious little new revenue to fund other things that matter: education and training, transportation, the environment, public safety, and economic development. What's a poor leader to do? I'll devote my



next two letters to some answers, in the form of an open memo to candidates across the land.

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**Sept 29, 2006**

**To: All Candidates for Public Office**

**From: David Osborne, Senior Partner at the Public Strategies Group**

**Re: Health Care Spending**

Until global warming really heats up, skyrocketing health care costs are probably the single greatest threat to our future prosperity. For four decades, they have marched upward at 10 percent a year. Employers are cutting back on health insurance, employees are paying higher portions of their premiums, higher co-pays, and higher prescription drug bills, and millions of Americans are losing health insurance altogether.

In the public sector, health costs are busting budgets from New York to California.

Smaller local governments can't do a lot about this, but large jurisdictions can. The most promising strategies I've seen are electronic health records, investments in prevention, and creating large purchasing pools that use price competition among insurance plans to keep costs down and quality up. Let's take these strategies one by one.



## **Electronic Health Records**

According to a 2004 report by the President's Information Technology Advisory Committee, one of every five medical tests must be repeated and one in seven hospitalizations is ordered because records are missing or information is unavailable. The cost is enormous.

Fortunately, a solution has come from surprising quarters: the Veterans Health Administration has developed an electronic health records (EHR) system that virtually eliminates both problems. Between 1995 and 2005, while the rest of the country suffered through doubling health care costs, the VHA's cost per patient remained level. With 10,000 fewer staff, the VHA more than doubled the number of patients it served.

The VHA's EHR system is the most advanced in the world. A few months ago it won a prestigious Innovation in American Government Award. Leaders from Britain, Germany, and other countries seeking to create EHR systems visit to learn about it, and the government of Mexico is installing it in its largest health care provider system.

How does EHR work? Every VHA physician is linked by computer to the system. He or she has access to every patient's entire medical record, including all x-rays, CT-scans, and test results. The doctor enters all notes and prescribes all medications electronically.

The VHA has mined the data the system has accumulated—and other sources of medical knowledge—to develop best practice guidelines, which the system provides physicians through timely reminders. For instance, it might remind a doctor that a patient



with diabetes is due for a retinal exam, or that an older patient should be immunized against pneumonia. If a doctor is prescribing a medication that will interact with another drug the patient takes—or to which the patient is allergic—the computer will flag it.

The system costs the VHA \$78 per patient per year: less than the cost of repeating a single lab test. It has saved billions of dollars while helping to drive quality up. Errors on prescriptions, which are bar coded, not handwritten, have fallen from the national average of five percent to a fraction of one percent. Study after study has concluded that the VHA's quality of care is superior to private sector care. Not surprisingly, customer satisfaction has soared: on surveys done using the American Customer Satisfaction Index, the VHA now outscores private sector health care providers.

EHR is not the only reform responsible for these improvements, but it has had a huge impact. And believe it or not, the VHA's software is available to anyone who wants it, free of charge. Every state government should work with private health care providers to encourage widespread adoption, using the huge population they pay for—state employees, retirees, and Medicaid recipients—as leverage.

If states can create public-private consortia willing to adopt the system, the potential is enormous. To extend its reach, one wrinkle might be to put a patient's entire medical record on a smart card they could keep in their wallet that could be read by any computer—so if they showed up at an emergency room or doctor's office that didn't use the system, their record would still be available.

The next step is to build a billing component in, so different insurers begin using the same forms and codes. Because our system is so fragmented, with physicians' offices



and hospitals filling out forms from dozens of different insurers, 20 percent of all health care dollars now go to overhead. EHR systems would be a big step in reducing this vast waste of money.

### **Investments in Prevention**

We all know that an ounce of prevention is worth a pound of cure, but our we invest most of our money in cures. By funding more prevention, we can make the system more cost-effective.

Four big factors determine the health of a population: personal behavior, genetic predispositions to disease, exposure to hazards in the environment, and access to health care. Personal behavior accounts for *50 percent* of the outcome, while access to health care accounts for only 10 percent. But according to studies, we spend 88 percent of the money on care and only *4 percent* on changing personal behavior.

Campaigns to lower the rate of smoking—many of which were gutted during the recent fiscal crisis—should be fully funded, by raising cigarette taxes. We should launch similar campaigns to lower alcohol consumption and drunk driving and encourage healthy diets and exercise.

States, cities and counties could also require or incent health insurers to provide premium discounts for those who exercise regularly, maintain a healthy Body Mass Index, and don't smoke. Patients who comply with best practices in disease prevention and care—getting immunized, following prescribed treatments, exercising regularly at a gym—could be rewarded by eliminating their co-payments.



Our leaders should also do everything possible to drive childhood immunization rates higher, to prevent diseases.

### **Increasing Competition Among Health Plans Based on Price and Outcomes**

States and large cities, counties, and school districts pay for health insurance for tens of thousands of employees and retirees. Most already ask multiple plans to compete based on price, and some give their employees a choice of plans. But few have built regional consortia of multiple jurisdictions to enlarge the pool and thus get better deals, and fewer still have added medical outcomes to the mix.

Wisconsin asks all insurers to make offers to cover state employees, then ranks them into three tiers, by price and quality. Lower price but high quality plans (tier one) are available to all employees for a low monthly share of the premium, but if employees want to pay more they can purchase the higher price plans. This creates incentives for employees to buy the most cost-effective plans, which in turn encourages the plans—and the networks of doctors and hospitals they put together—to compete by improving quality and controlling costs. The state recently announced that it had held cost increases to single digits for the third straight year.

Measurement of medical outcomes, while not always easy, is growing more sophisticated. If states could create large enough purchasing pools, they could then require plans bidding for their contracts to measure and report outcomes. They could purchase the most cost-effective plan or plans—or give the information to their employees and let them choose their preferred plan based on the price and outcome data.



Either way, HMOs, PPOs, and health insurance plans would have a powerful incentive to improve their outcomes and control their costs. If you doubt they could do much, consider how dramatically the Veterans Health Administration has improved its cost-effectiveness.

### **Universal Coverage**

You've probably noticed that I've stayed away from the other big health care issue, universal coverage. The solutions here still elude us. But I suspect that the best way to control costs is to create a universal system. Within one system, state governments would have far more leverage to require or encourage electronic health records, preventive services, competition based on price and outcomes, and other measures to control costs.

Maine is trying to move toward universal coverage with its Dirigo Health Plan, a comprehensive approach with a number of attractive features. But insurers and the Chamber of Commerce have challenged it in court, and progress on shrinking the number of uninsured people in the state has been painfully slow. I fear that Maine's laudable effort will be swamped by rising health care costs and business opposition, as Massachusetts' much-ballyhooed effort under Governor Dukakis was.

Massachusetts' new effort to create universal coverage appears no more promising than its last one. In some ways its strategy is laughable: If low-income working people can't afford health insurance, we'll just force them to purchase it. That ought to fix things!



To be fair, the plan does promise sliding-scale subsidies for those earning up to 300 percent of the poverty line. But trial balloons floated by the state suggest that few of the working poor will be able to afford the subsidized rates. Subsidies large enough to work would require money the state doesn't have. And with health care inflation raging in Massachusetts—something the reform barely addresses—subsidies will get more expensive every year.

Personally, I expect the plan to go the way of Dukakis's effort, particularly if our tax-cuts-at-all cost lieutenant governor is elected governor this fall. Dukakis' health care bill helped no one but his own presidential campaign, and I suspect Mitt Romney's will do the same.

Other state efforts to expand coverage have also been swamped by rising health care costs. For instance, Tennessee's TennCare program—basically a dramatic expansion of Medicaid—was neutered in recent years due to fiscal problems.

The most promising plan I've seen is one that Republican Curt Gielow and Democrat Jon Richards recently introduced in Wisconsin, though it has a long way to go before passage. It builds on the experience of state government and the city of Milwaukee in using managed competition to lower growth in premiums, which I described above.

The Wisconsin Plan would levy taxes on employees (two percent of social security wages) and employers (3-12 percent of total wages, depending upon the size of their payroll) to pay for a "premium credit" for every resident under 65. A new nonprofit Health Insurance Purchasing Corporation would seek bids from HMOs, PPOs, and



insurance companies and rank them into three tiers, as the state already does. All plans would cover medical care, hospital care, and prescription drugs, plus a modest dental benefit for children.

The premium credit would be worth the price of the first-tier plan. To enroll in a more costly (tier two or three) plan, participants would need to supplement the credit with their own dollars. Regardless of which tier the plans were assigned based on their risk-adjusted prices and quality measures, the benefit package would be the same. All plans would have a deductible of \$100 for children and \$1200 for adults, followed by co-insurance of 10-20 percent. The maximum in total annual costs would be \$500 per child, \$2,000 per adult, and \$3,000 per family. To help pay the cost-sharing, all adults would get a Health Savings Account of \$500 per year.

The Wisconsin plan is based on the work of Stanford Professor Alain Enthoven, a pioneer of managed competition in health care. Its sponsors believe that insurers would strive to provide lower cost and higher value plans than their competitors, health care inflation would moderate, businesses would spend less in taxes than they do now to purchase health insurance, and every resident would be covered. (For more information, visit [www.wisconsinhealthplan.org](http://www.wisconsinhealthplan.org).)

Health care is an extremely complicated subject, but that's a shorthand version of my advice to candidates about our biggest fiscal problem. Next month I'll turn to two other key issues: education reform and the challenge of squeezing ever more value out of every tax dollar.