

# Washington Landscape

- Think tanks and policy institutes
- Interests backed by big money
- Advocates for people-Families USA, Bread for World, Consumers Union
- Media
- Departments of HHS
- The US Congress



Extra! March/April 2008

## The Incredible Shrinking Think Tank

Third year in a row of declining citations

By Michael Dolny

# Citations of Think Tanks in Media

Think Tank	Political Orientation	2007	2006	% Change
1). Brookings Institution	Centrist	2,380	2,568	-7%
2). Council on Foreign Relations	Centrist	1,191	1,564	-24%
3). American Enterprise Institute	Conservative	1,171	1,429	-18%
4). Heritage Foundation	Conservative	1,168	1,390	-16%
5). CSIS	Conservative	1,068	1,388	-23%
6). RAND Corporation	Centrist	740	930	-20%
7). Kaiser Family Foundation	Centrist	706	1,023	-31%
8). Center for American Progress	Center-Left	673	687	-2%
9). Cato Institute	Cons/Libertarian	640	776	-18%
10). Urban Institute	Center-Left	558	472	18%
11). Hoover Institution	Centrist	472	567	-17%
12.) Manhattan Institute	Conservative	425	493	-14%
13.) <b>New America Foundation</b>	<b>Centrist</b>	<b>414</b>	<b>288</b>	<b>44%</b>
14.) Economic Policy Institute	Progressive	353	733	-52%

# Business Interests

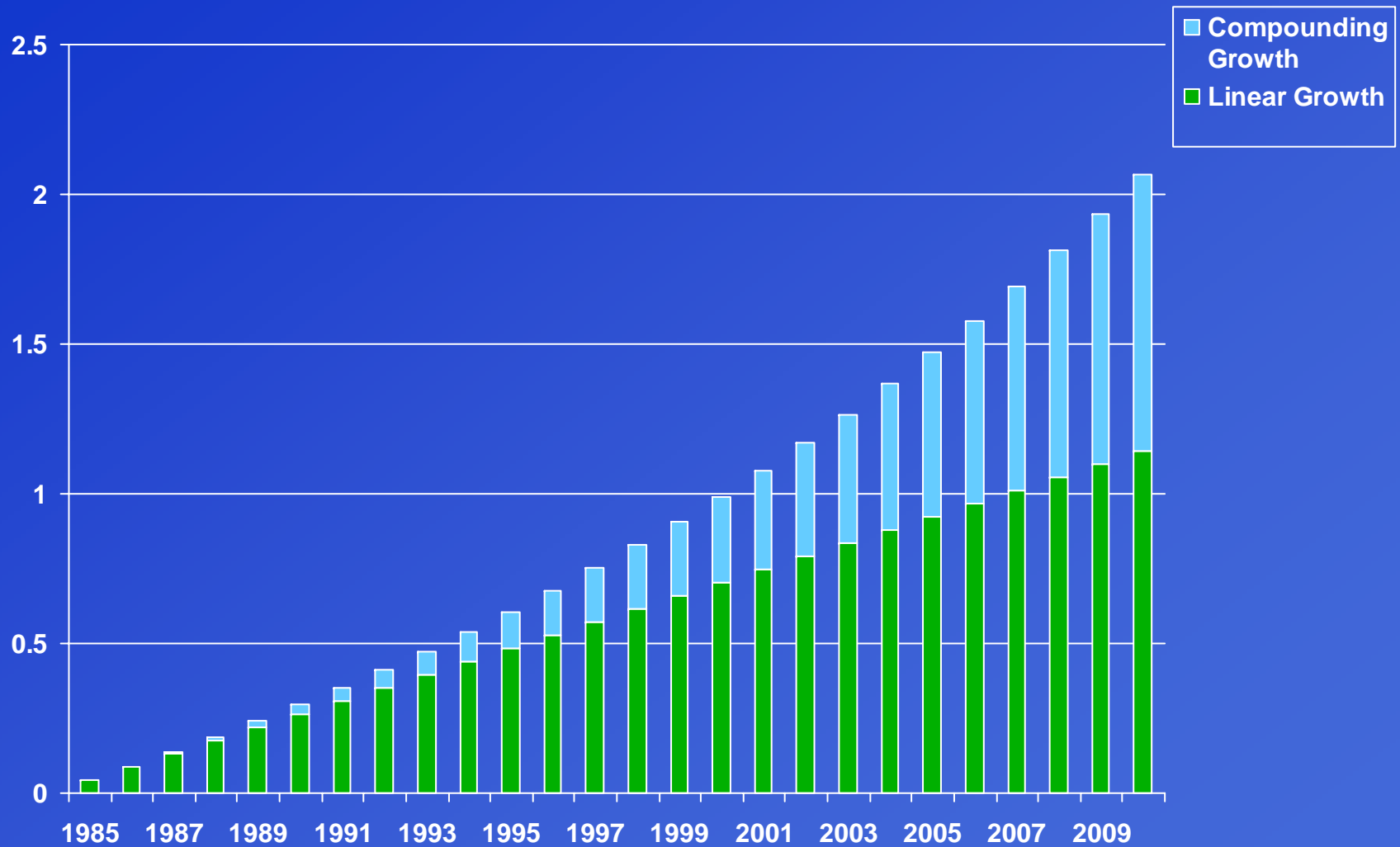
- Chamber of Commerce
- National Federation of Independent Businesses
- Business Roundtable
- National Association of Manufacturers

# Why Now?

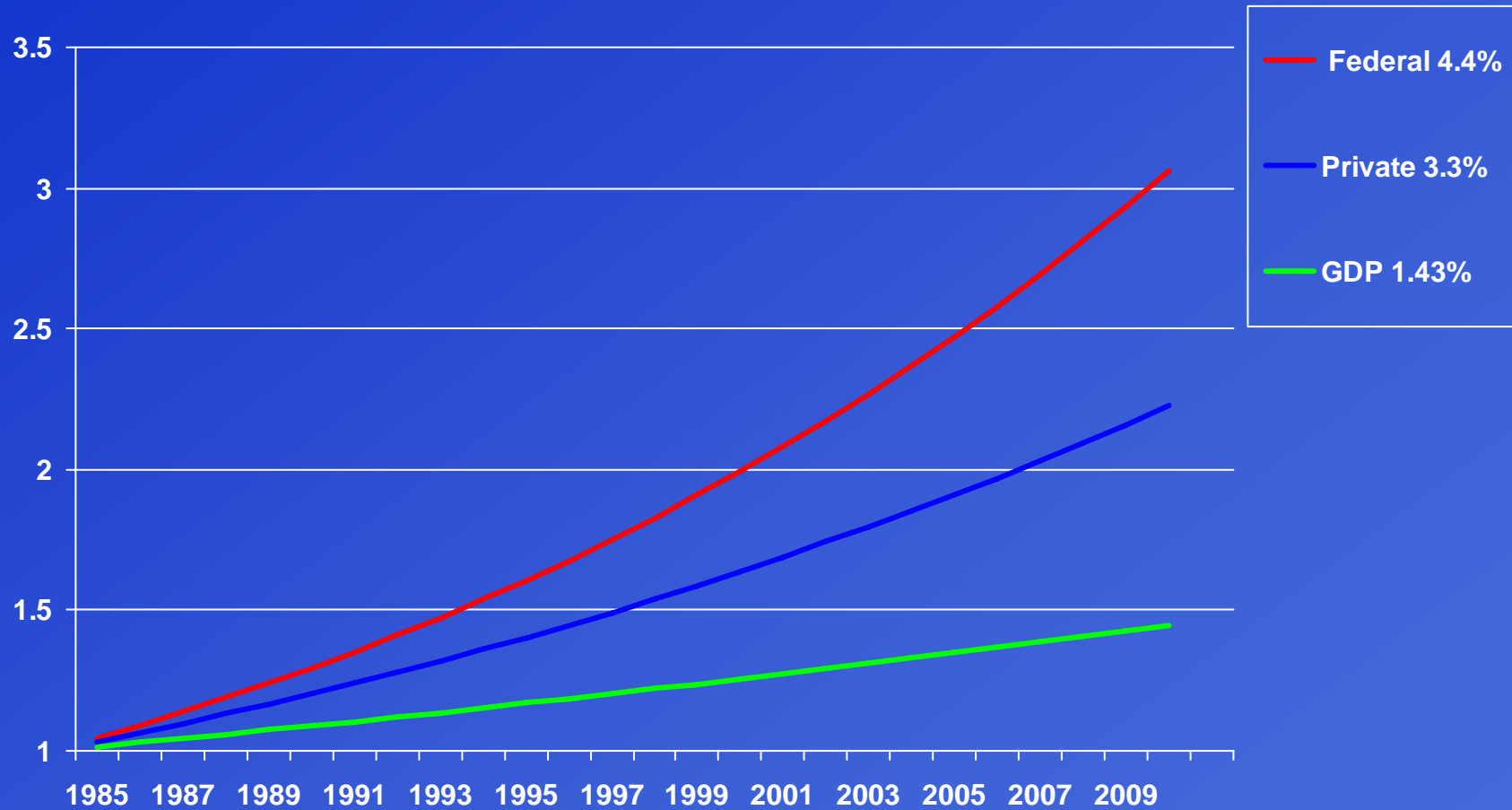
- We are at the wrong end of the compound interest curve

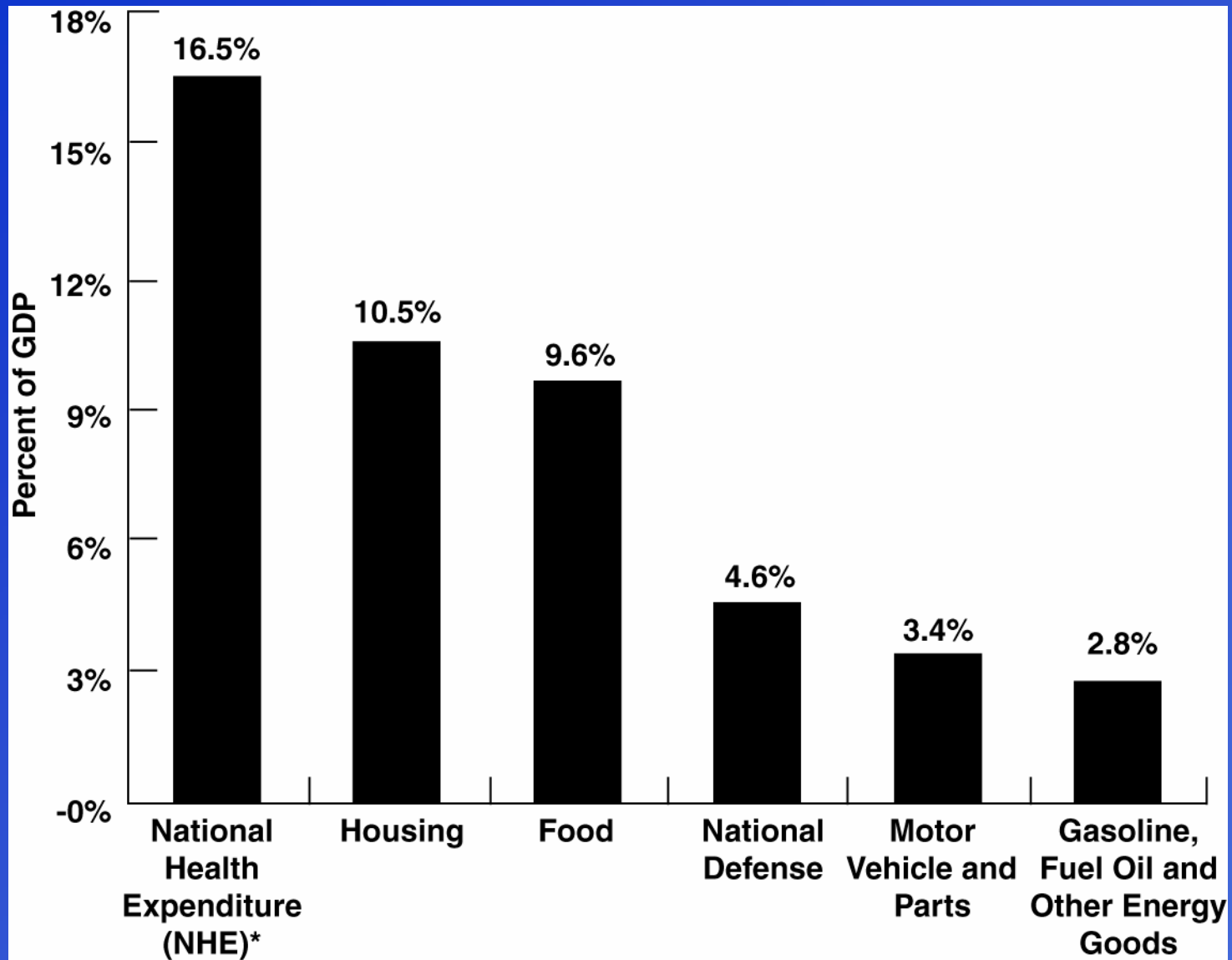
# Why Now?

## Federal Cost Growth--The Miracle of Compound Interest (4.4%)



# Compounding Growth Rates

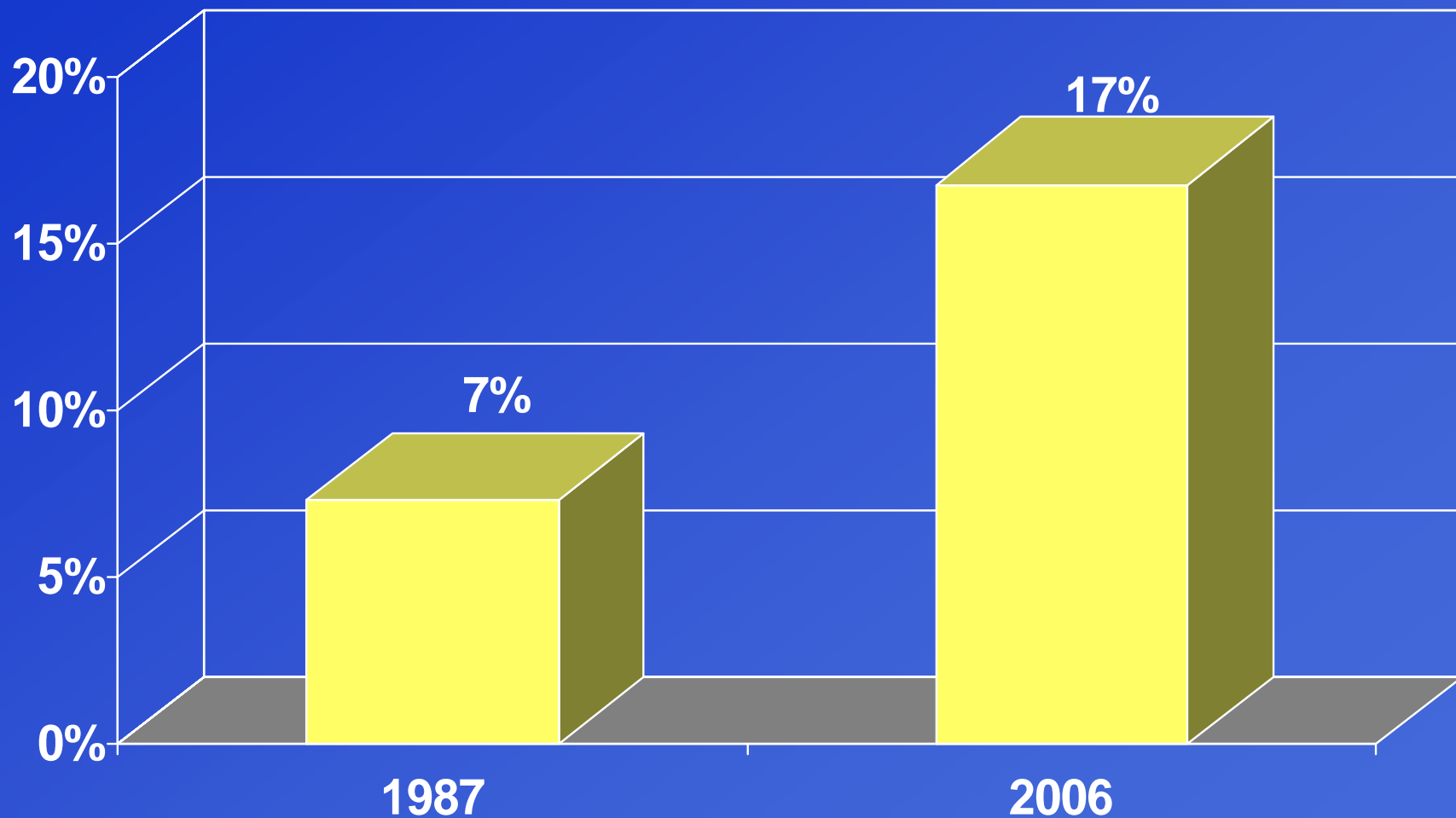




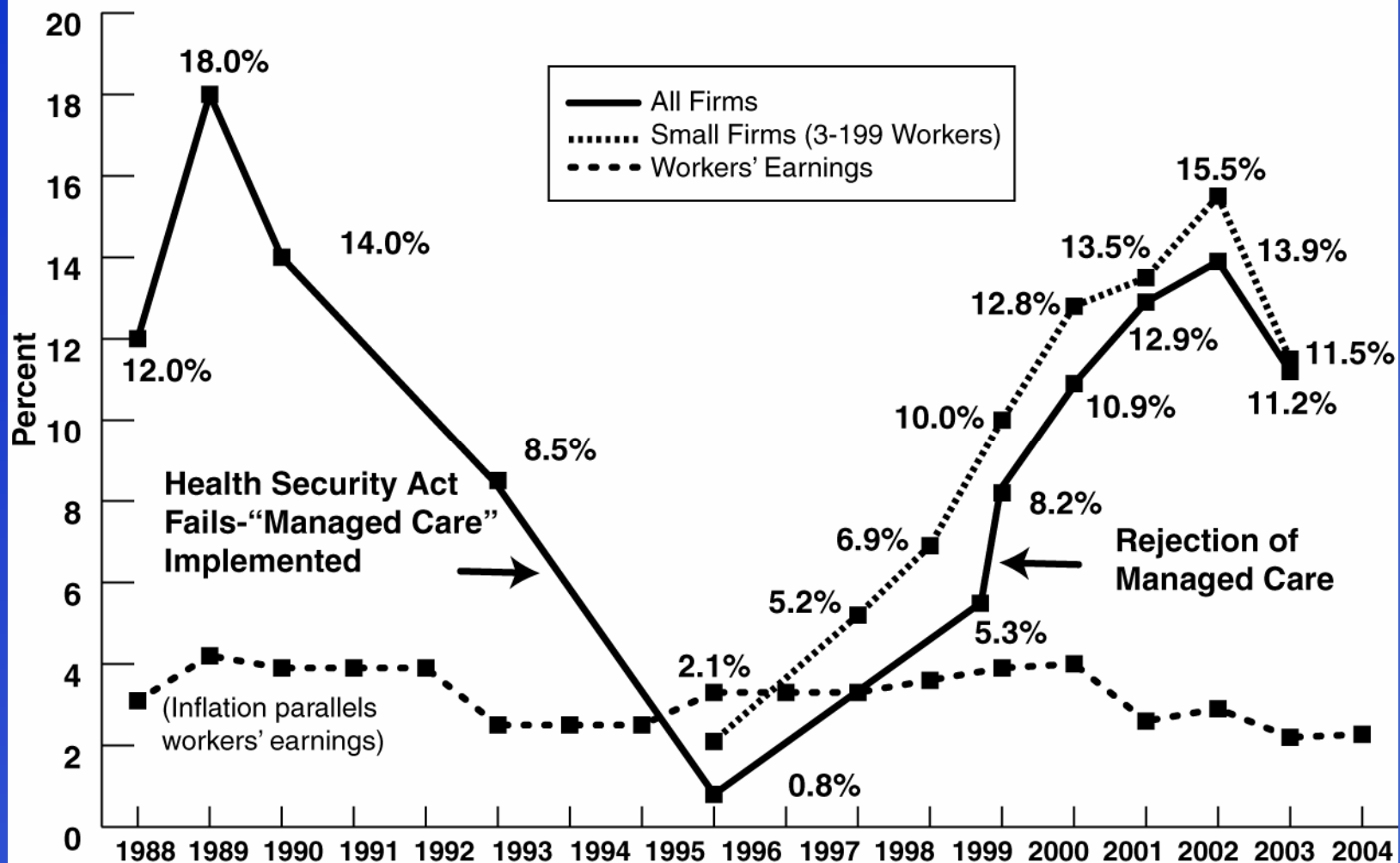
# Why NOW?

- Premium / income is higher and growing

# Percent of median family income required to buy family health insurance



## Premium Increases by Firm Size Since 1988



Source: Fronstin P. Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2004 Current Population Survey. EBRI Issue Brief No. 276, December 2004.

# Increased cost produces increased uninsured

- 
- 2000-68% of small businesses offer coverage
- 2007-59% of small businesses offer coverage\*\*
- Healthcare cost/ minimum wage=\$2.21/\$6.55\*\*\*

\*Cowan and Hartman, Health Care Financing Review, 2005

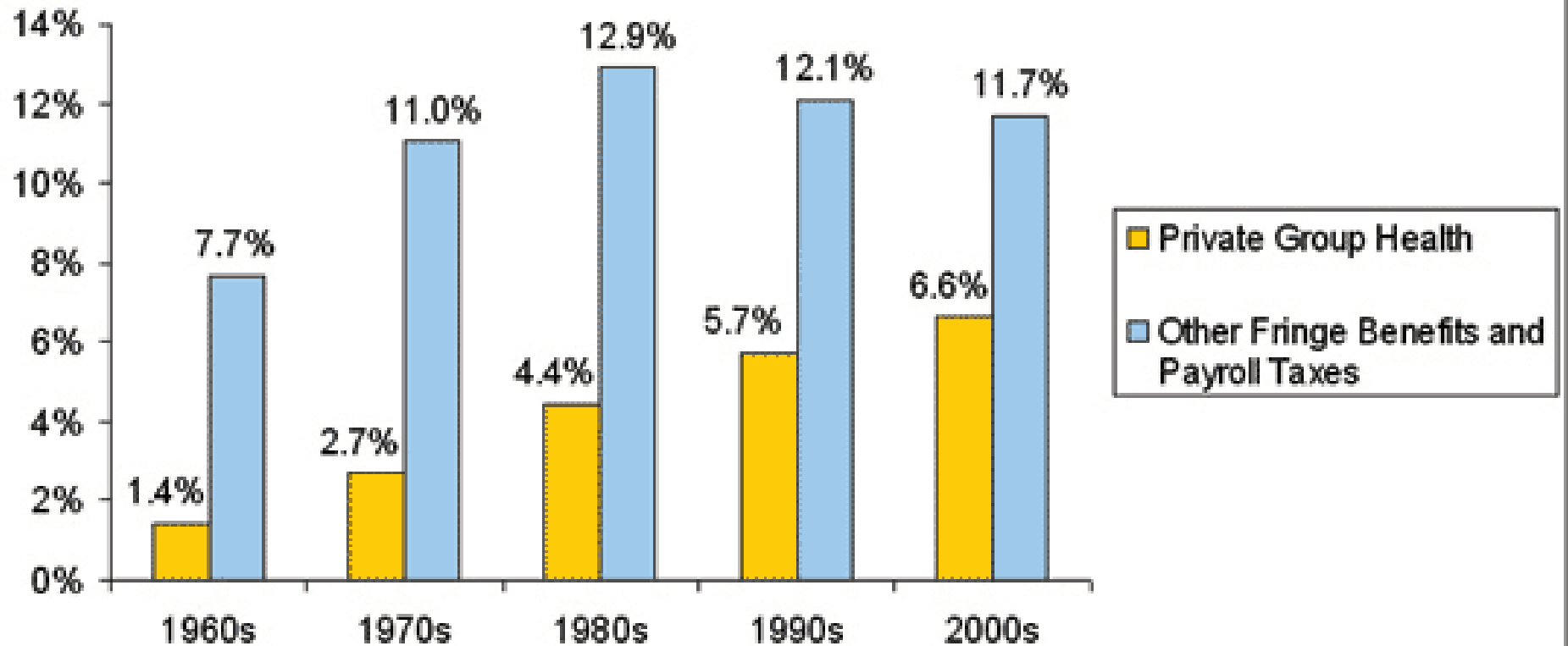
\*\*Kaiser Family Foundation

\*\*\*US Department of Labor

# Why NOW?

- International competition is more pervasive

**Figure 3: Benefits as a Share of Total Compensation for Selected Time Periods, 1960-2006, NIPA**

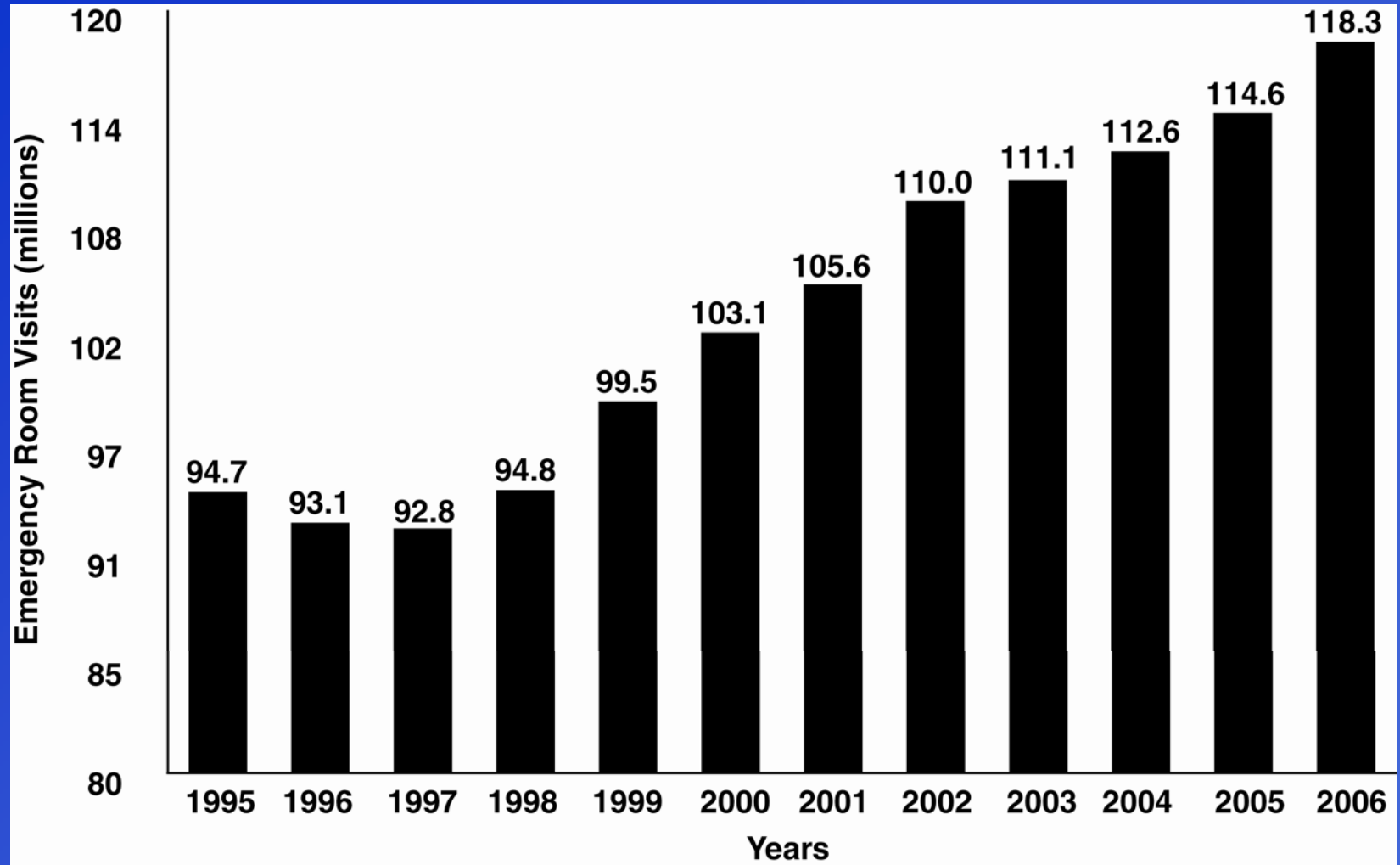


## Employer Contribution Rates and Hourly Cost of Health Benefits, Selected Top Trading Partners

Country (rank in total trade with the US, 2005)	Employer Contribution Rate	Hourly Pay, Manufacturing U.S. dollars	Hourly Cost of Health Benefits, Manufacturing US dollars
United States	11.3%		
	13.0% for Manufacturing	\$18.32	\$2.38
Canada (1)	4.5%*	\$19.21	\$0.86
Japan (4)	3.74%	\$18.06	\$0.68
Germany (5)	6.65%**	\$25.53	\$1.70
United Kingdom (6)	1.92%***	\$20.91	\$0.40
France (9)	12.8%****	\$16.93	\$2.17
Weighted avg.	4.9%	\$19.79	\$0.96

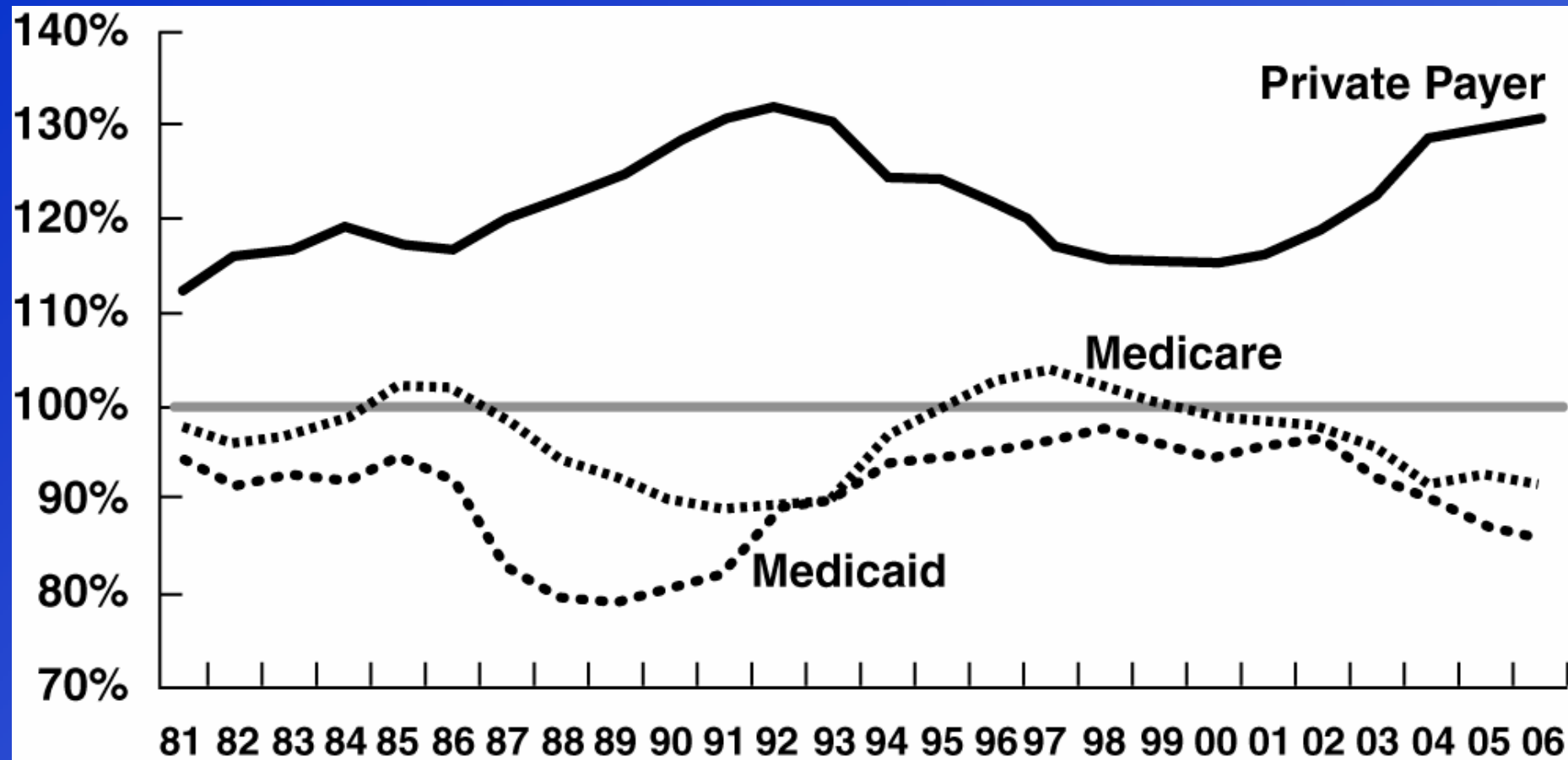
# Why NOW?

- System stresses appear more unsustainable to more people
  - ER waits + diversions, generalized access problems
  - Can't find a primary care doctor.
  - Un-insurance, unstable insurance, and insufficient insurance is moving into the middle class.



# Why Now?

- More awareness of LINKAGES among problems
  - poor quality
  - consequences of being uninsured
  - uninsured and ER failure
  - Cost shifting.



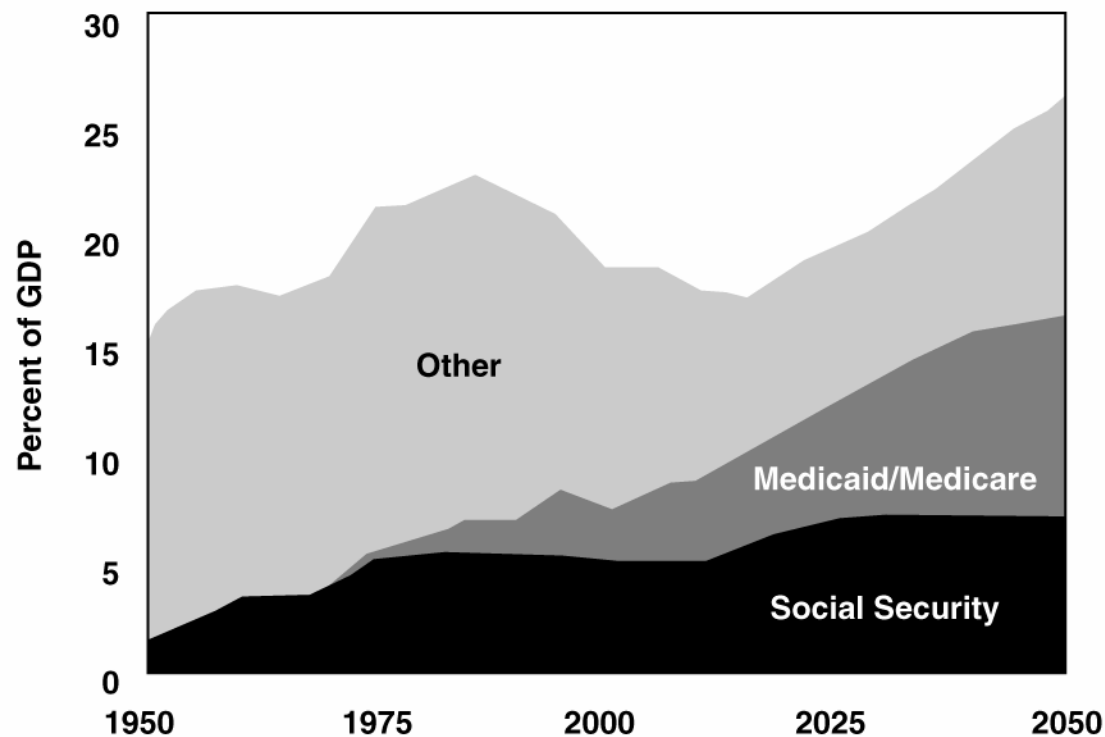
# Let the States do It

•	CA	TX	UT	MN	MA
<b>Uninsured</b>	21%	28%	17%	10%	12%
Medicaid- per capita /per enrollee	\$957/ \$2520	\$834/ \$3371	\$581/ \$3268	\$1108/ \$6376	\$1509/ \$5312
<200% FPL	67%	71%	60%	56%	56%
ESI coverage rates	63%	62%	69%	79%	78%

# Competing Visions

- Each Man for Himself – Individualism
  - Consumer-centric-demand side reforms
  - Tax neutrality
  - Individual market
  - NO regulations (or Shadegg-DeMint, which is the same thing)
- Government for all – Socialism
  - Equity-centric
  - Government sole payer
  - Population health management
- Practical Idealism – Realism
  - Result-centric (cover all in *sustainable* system)
  - Markets are powerful but flawed and need smart regulation)
  - Purchase requirements make markets work better
  - Electronic information system, comparative effectiveness , re-aligned incentives are keys to Efficiency and Justice

## Federal Outlays by Category as Percentage of GDP



*Adapted from: A 125-Year Picture of the Federal Government's Share of the Economy, 1950-2075.  
Congressional Budget Office, July 2002*

# The Good News

- Dems have discovered markets and the importance of value enhancement/cost-growth control
  - Model proposal had regulated private insurance markets, purchase requirements\*
  - Emphasize delivery system reform through information systems and comparative effectiveness, some payment reforms
- Repubs have acknowledged that many cannot afford health insurance as we know it
- McCain discovered supply-side incentives are important, too
- Huckabee stressed behavioral change
- Romney created and “owned” Massachusetts reform model

# Meanwhile, Back in Washington...

- Massachusetts and California got noticed
- “Strange” coalitions formed in 2007
  - BHCT, Divided We Fail, strange bedfellows
- Vision of many trade groups remarkably similar to modal Dem proposal
  - FAH, ERIC, CED, Advamed (save Comp. Effectiveness)
- Wyden-Bennett (S. 334) has 14 co-sponsors
  - Bennett, Gregg, Grassley, Alexander, Coleman, Crapo, Corker
  - Wyden, Nelson (FL), Stabenow, Lieberman, Carper, Landrieu, Inoyue
  - Has mandate, new markets, subsidies, phases down employer financing, uses existing tax \$
  - Emphasizes delivery system reform as well
    - “Health Home,” FDA reform, etc.

# Common Themes To Expect

- We Cannot Afford It (whatever “IT” is)
- Trust, but Verify
  - Transparency of price and comparative quality info
  - Market outcomes will need to be monitored
  - Government programs will need to be evaluated
- Shared Responsibility *is* the American Way
  - Individual responsibility is central
  - Community responsibility is to make it possible for each individual to take responsibility for himself or herself
  - Part of shared responsibility is making system sustainable, i.e., stewardship
- Cost of doing nothing is high

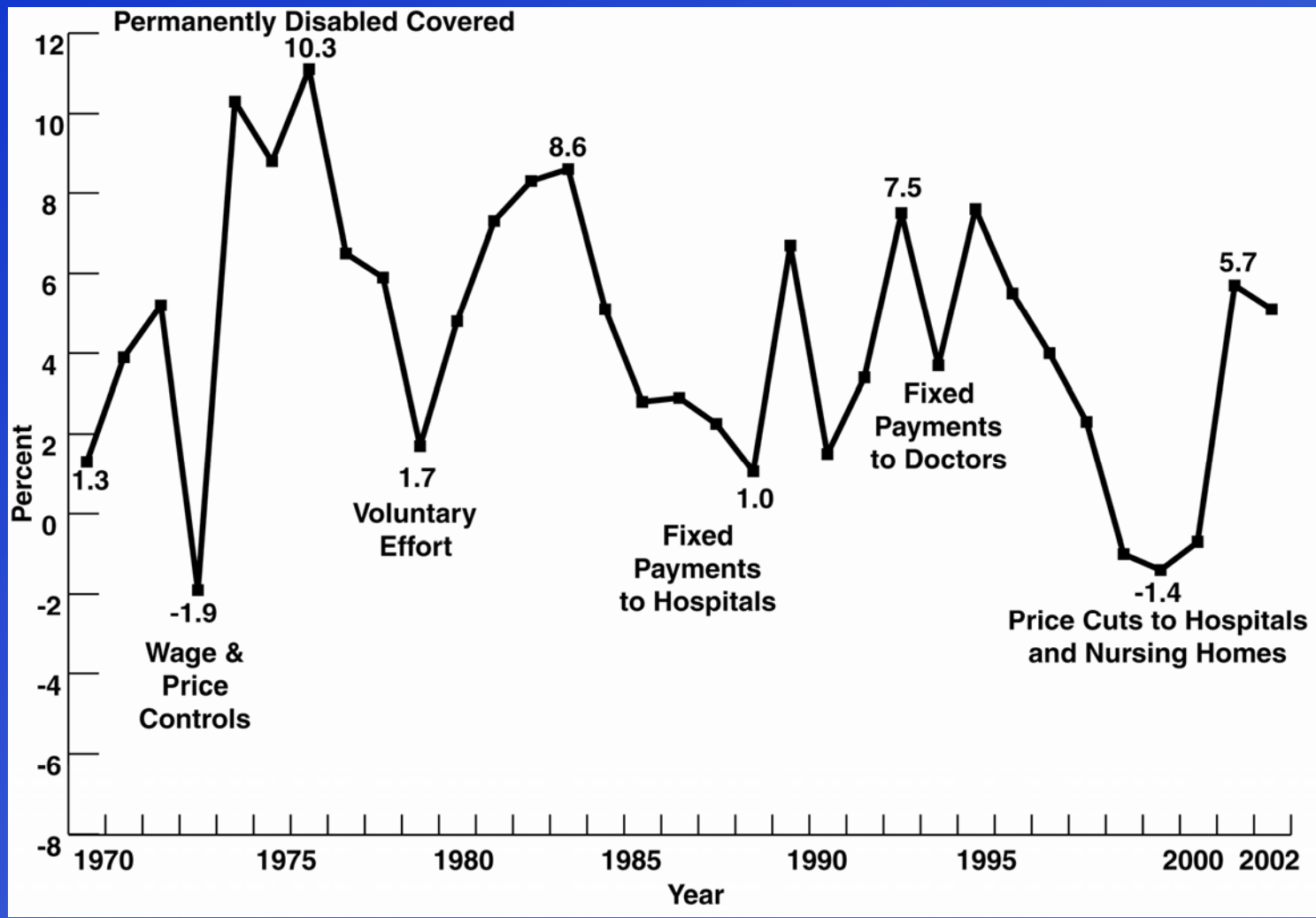
# Cost and Coverage Equation

- We are not willing to cover everyone with current system trajectories
- We must cover everyone, or risk yet more social segmentation
- It will be harder to extract inefficiency when cost shifting hides it.

# Core Cost Problem

- The unexamined delivery of medical interventions in a fee-for-service payment system
- Fee-for-service medicine has to go so that there is a business case for efficiency.

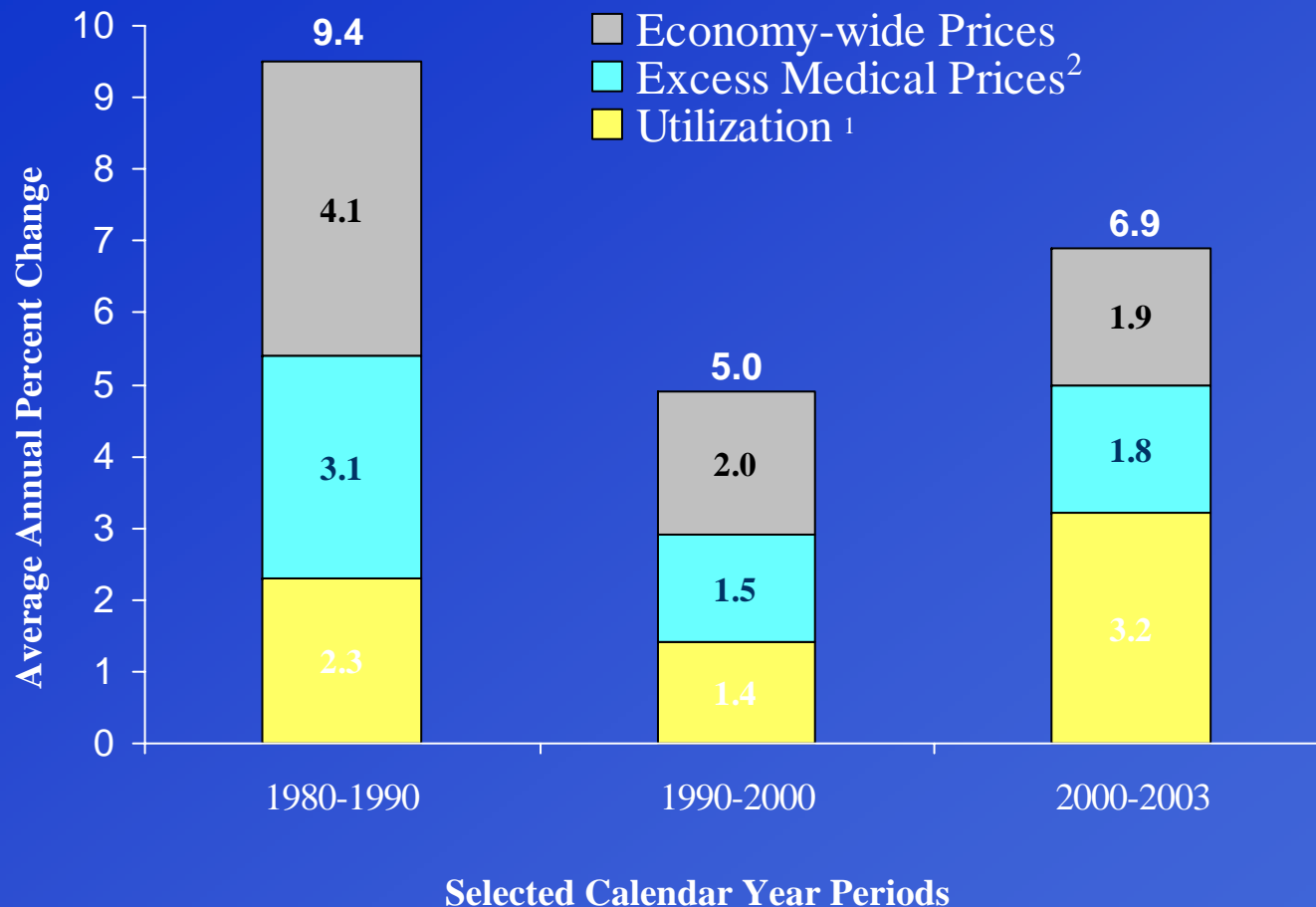
# Average Annual Change in Medicare Spending per Beneficiary with Federal Actions-inflation adjusted



# Futility of Price Controls without Managing Utilization

- Sustainable Growth Rate and Doctors
- “Physician volume effect”
- Rehabilitation and Long Term Care Facilities
- Imaging payments

# Factors Accounting for Growth in Personal Health Care Expenditures Per Capita



<sup>1</sup> Utilization includes quality and mix of services. As a residual, this factor also includes any errors in measuring prices or total spending.

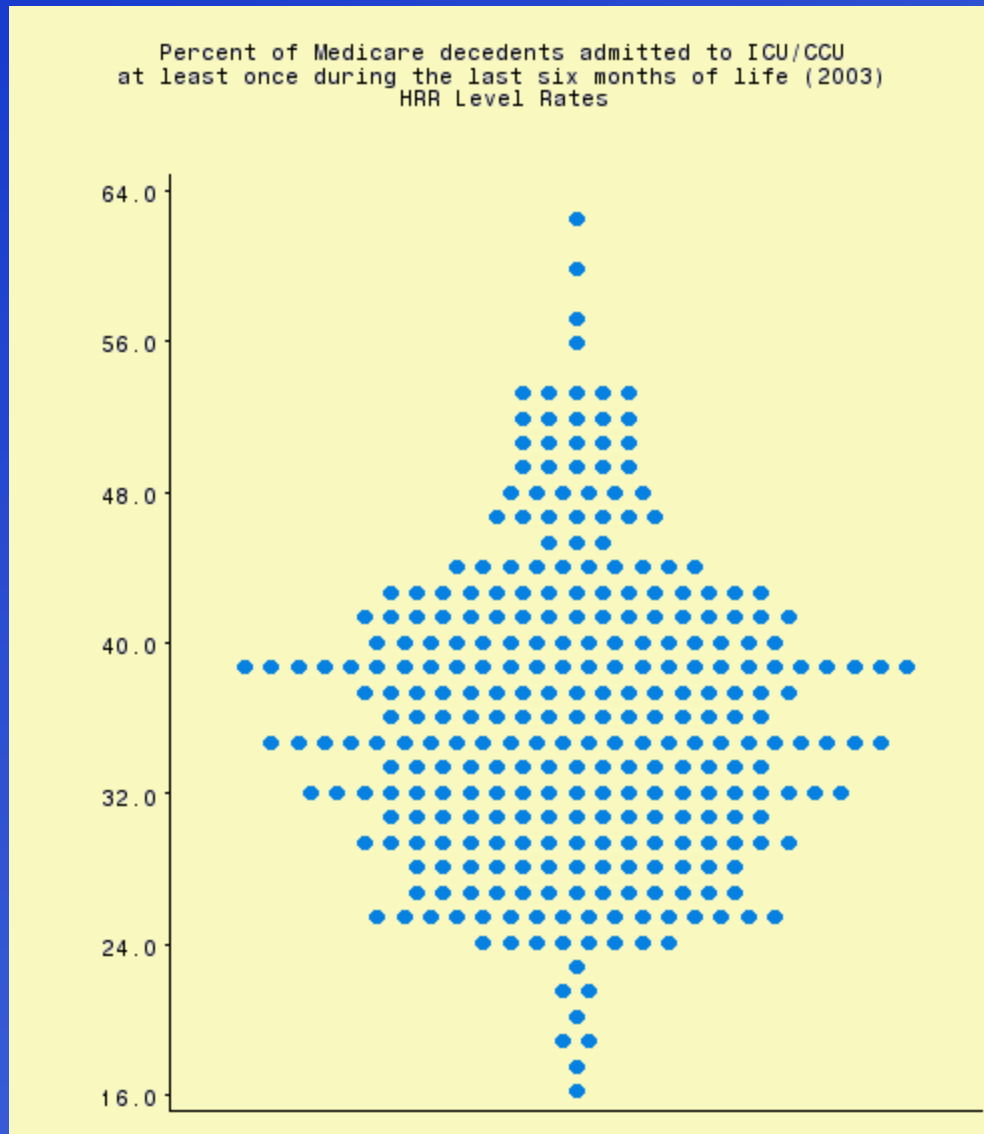
<sup>2</sup> Excess medical prices are calculated using the personal health care chain-type index constructed from the producer price index for hospital care, nursing home input price index for nursing home care, and consumer price indexes specific to each of the remaining personal health care components.

SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

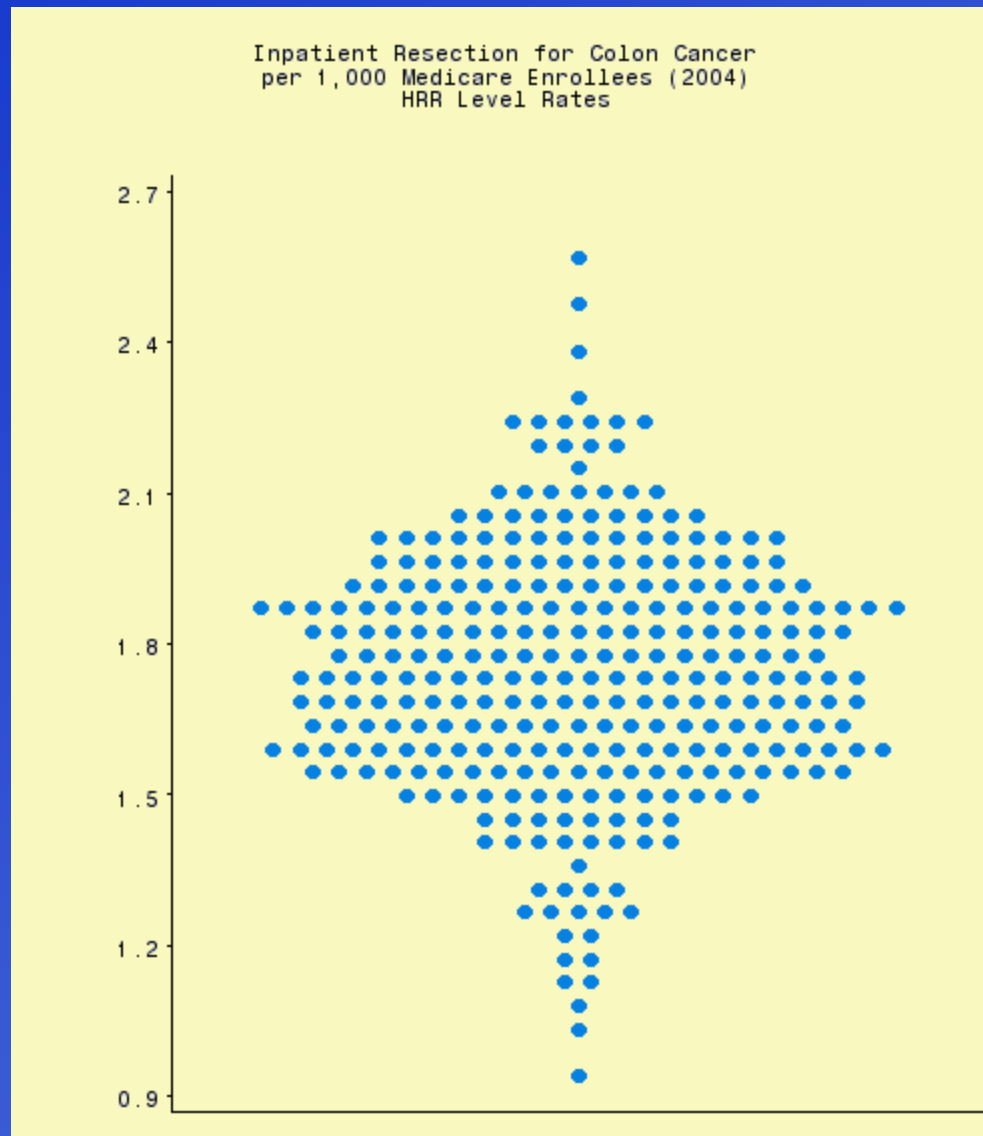
# Five Sources of Waste

- Poorly managed chronic disease
- Unwanted end-of-life care
- Unnecessary procedures
- Excess diagnostic testing
- Over-priced drugs of little benefit

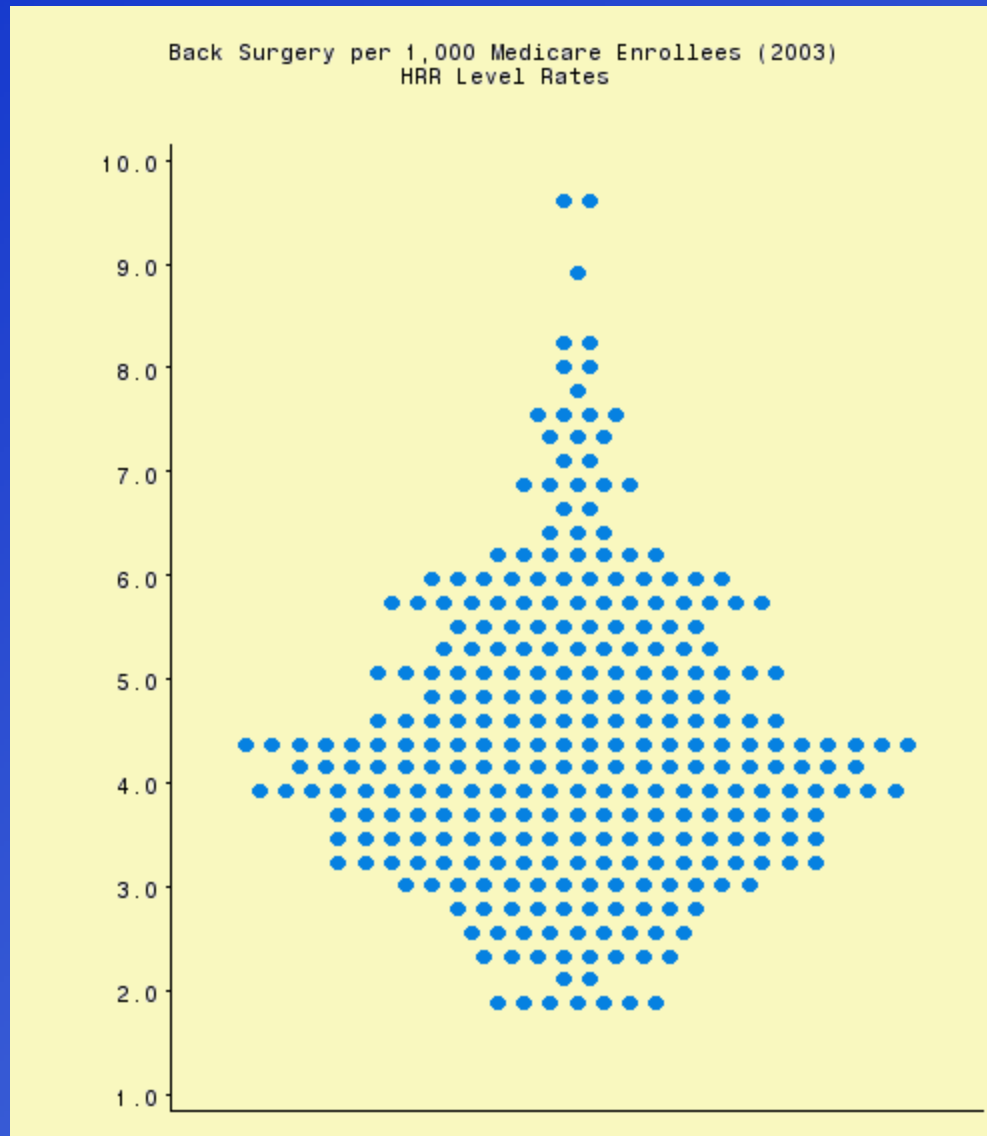
# ICU Care at End of Life-4x

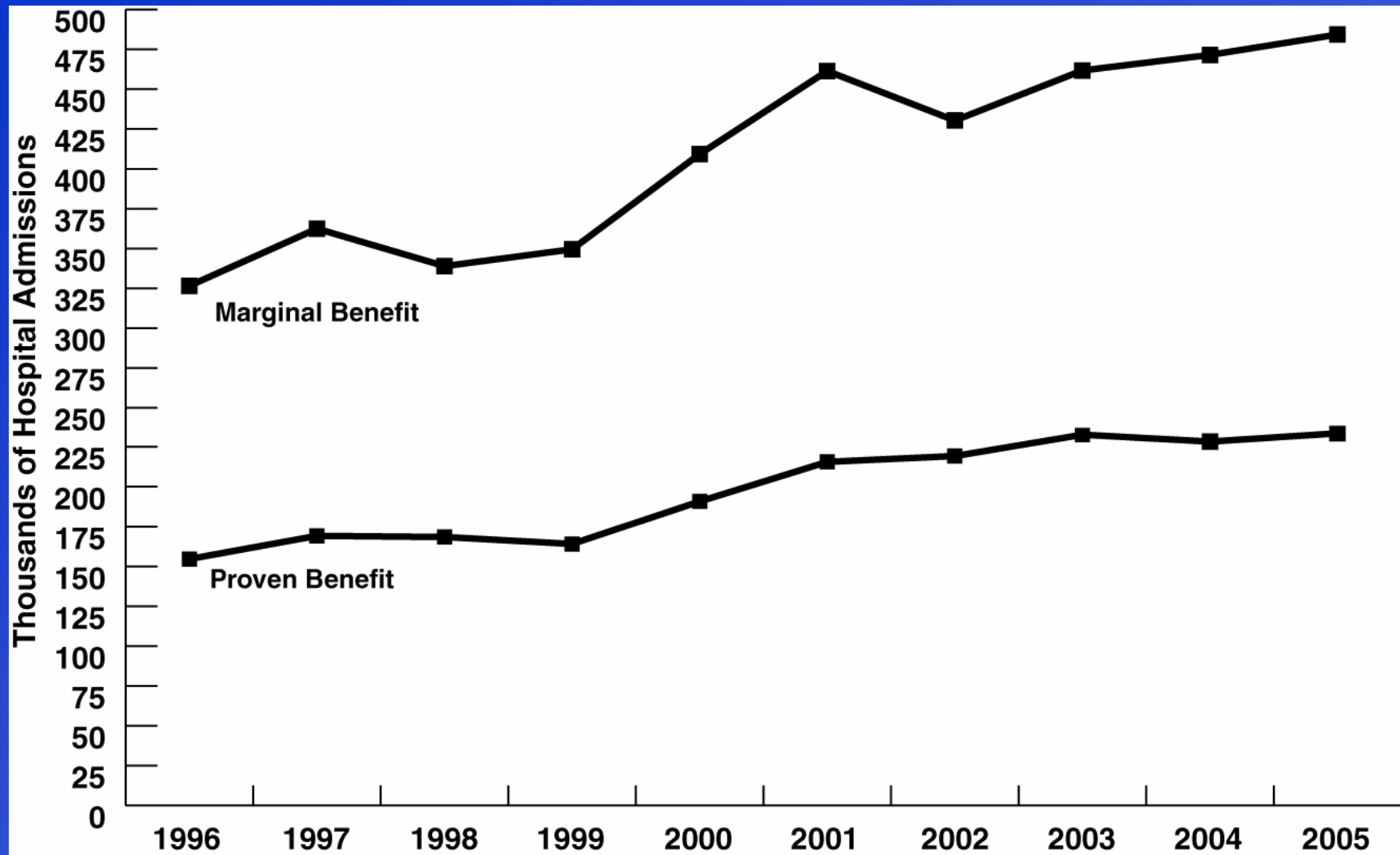


# Colectomy for Colon Cancer-2.5X



# Back Surgery-5x





# What Americans Won't Tolerate

- No one between doctor and patient
- Someone else picks their doctor
- Reorganization of medical practice.

# Principles of Cost Reduction

## Reduce Variability

1. Establish standards
2. Reduce variability around a standard

## Share savings

1. Doctors and hospitals paid only for efficient care
2. Patients share cost of marginally-effective treatments.

# Sharing Savings with Generalists

- Primary care is in rapid decline.
- Chronic disease management has never been physician-driven.
- Fee-for-service medicine provides no business case for efficiency (low use of IT).

# Promising Examples

- Sumner Clinic in Gallatin, Tennessee
  - Protocols plus nurse care coordinator
  - But sans payment reform, would turn savings over to Medicare
  - Struck incentive deal with MA plan (HealthSpring)
    - All quality measures exceeded 90%
    - ER down 23%
    - Admissions down 16%
    - Loss ratio fell from 87% to 77%, now down to 69%
  - Quality, income, and profits up, costs down

Source: Guy Clifton, *Flatlined: the Resuscitation of American Medicine*, Rutgers Press: (forthcoming 2008)

# Sharing Savings with Hospitals and Specialists

- Pay specialists, hospitals, and ASCs one lump sum for an episode of care.
- Eliminates gaming of rehabilitation and LTCHs and aligns hospital and physician incentives.
- In 1992 Texas Heart Institute offered CABG for \$27,040 against a national average of \$42,370.

# Promising Examples

- Intermountain Health Care using information and protocols
  - Brent James studied variations within LDS hospital
  - Shared info, let specialists develop own protocols
  - Care improved, savings achieved
  - Much turned back to Medicare, health plan created/expanded to help capture savings

Source: Guy Clifton, *Flatlined: the Resuscitation of American Medicine*, Rutgers Press: (forthcoming 2008)

