Healthcare Reform
From Problem to Crisis to Solution

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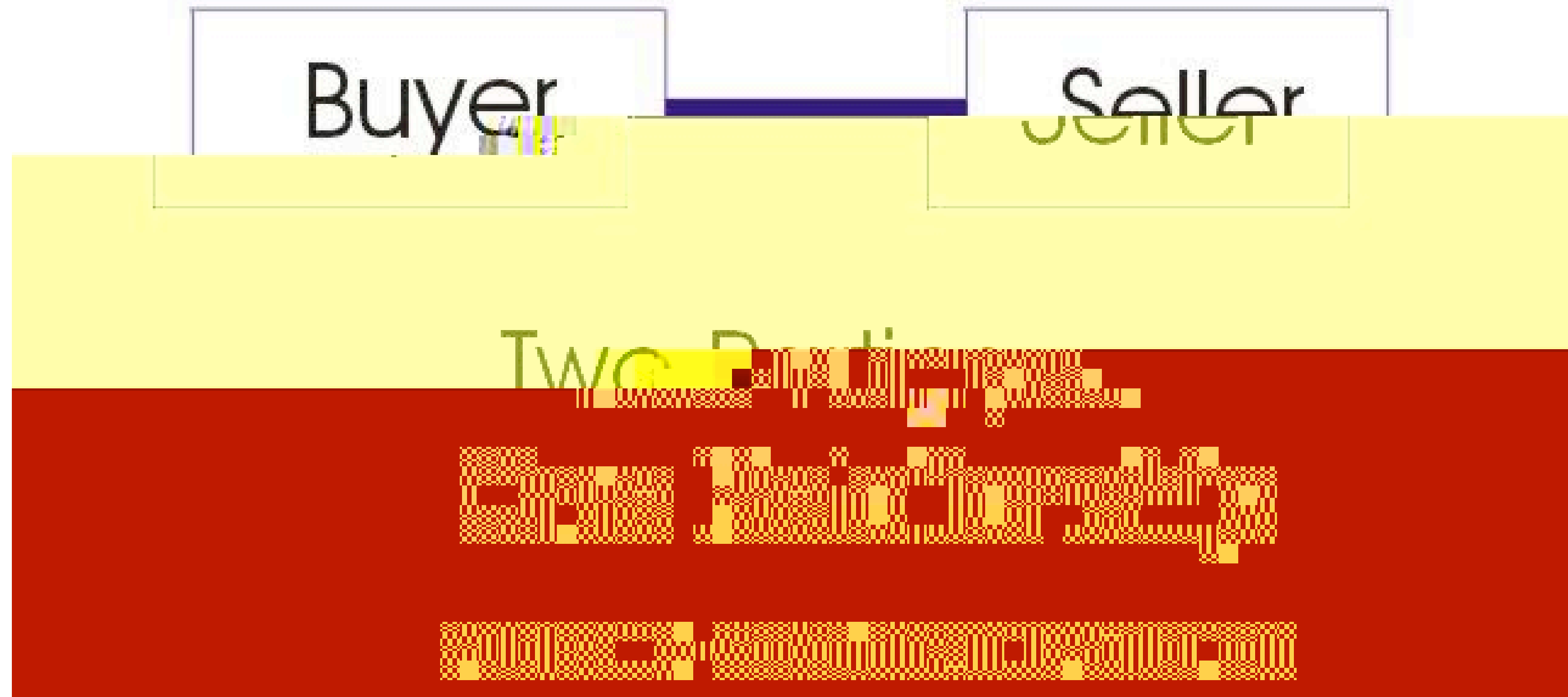
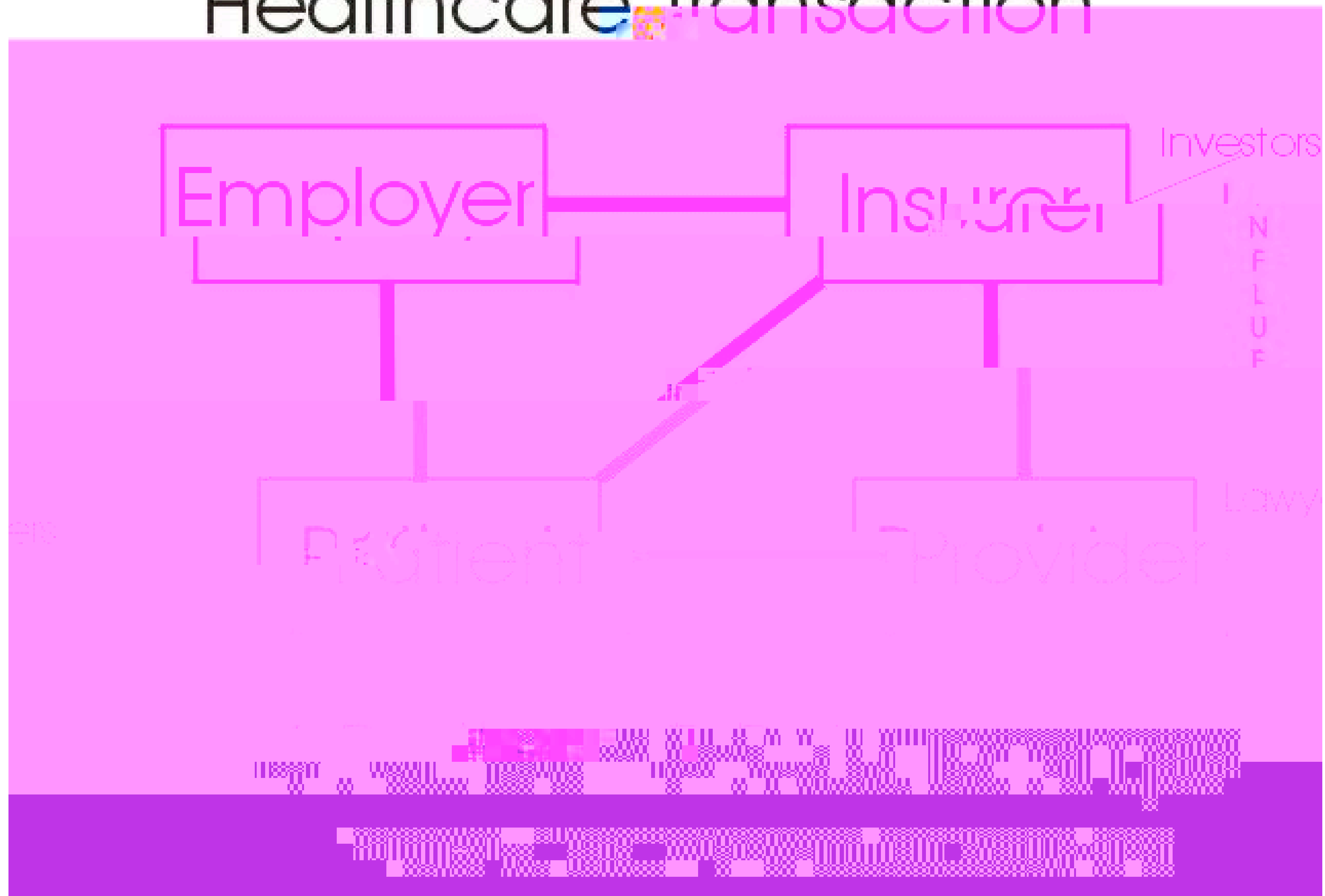
Healthcare in Crisis

1. **What makes health care complicated?**
2. **Is there a health care crisis?**
3. **How do we work to reform health care and resolve the crisis?**

Usual Business Transaction



Healthcare Transaction



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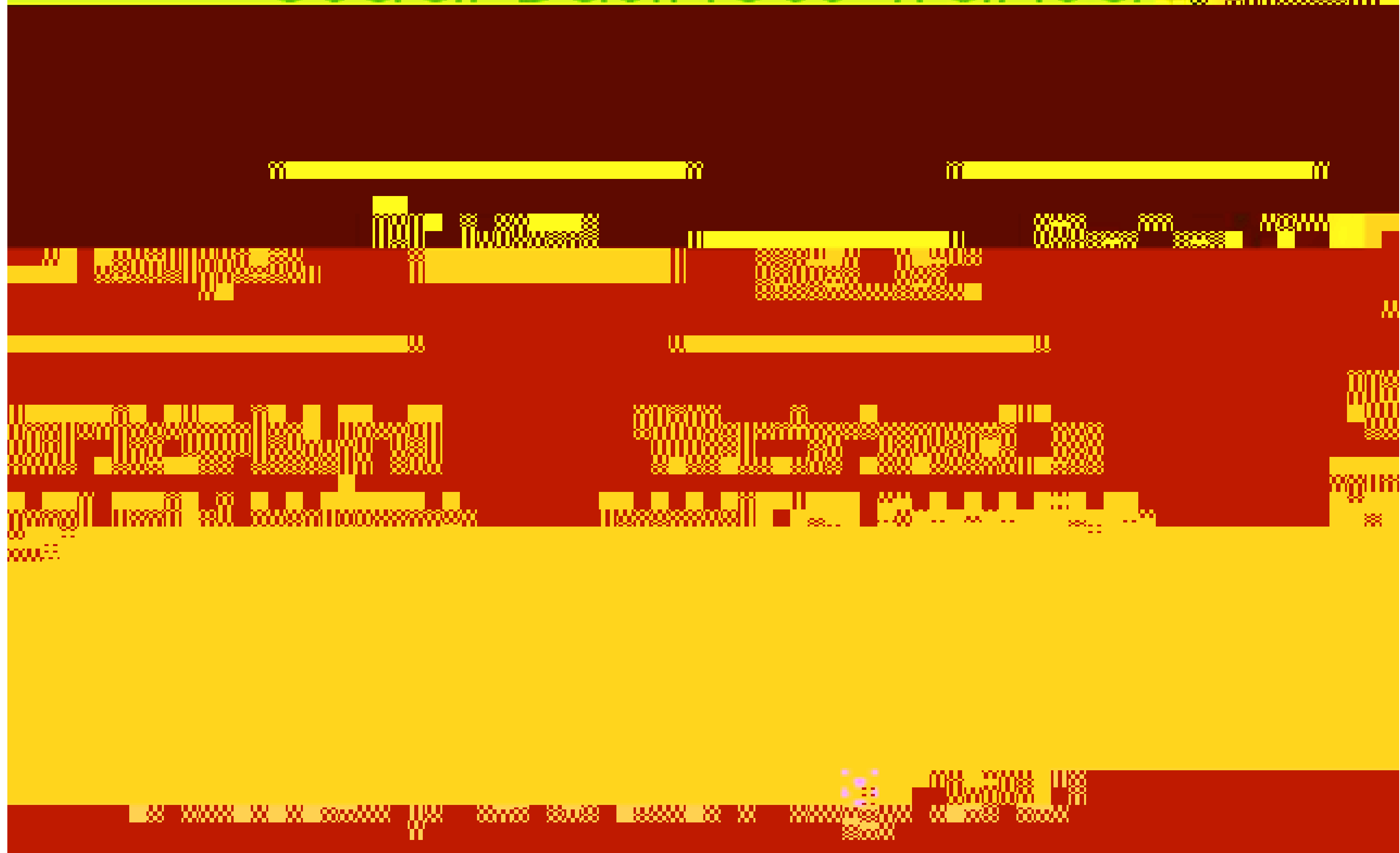

Insurer Practices That Sabotage Healthcare Financing

Insurers:

- Collect money in advance, yet hold it as long as possible
- Randomly delay and deny payments for services rendered
- Arbitrarily decide what to pay for services already provided
- Refuse to provide prospective payment information (even when asked in advance)
- Collect premiums and retroactively deny patients coverage
- Exclude “prior conditions” in an overly broad way
- Make premiums too high for some people to afford coverage

Insurer Medical Loss Ratio (MLR) Payments made for healthcare

- The MLR creates a euphemism for healthcare payments to make paying for care sound like a bad thing.
- MLR = payments made for healthcare service / premiums
- When MLR is high, most money is going for patient care
- As MLR shrinks, less money is going for patient care
- Insurers brag to their investors when they minimize their MLR
- Insurer stock prices rise when MLR goes down, i.e. when insurers pay for less care

Representative California MLR Data

Insurer	Insured Lives	2005 MLR	2001 MLR
Aetna	295,000	78.7%	87.9%
Blue Cross of California	4,550,000	78.9%	76.4%
Blue Shield of California	2,780,000	83.4%	83.6%
CIGNA	300,000	93.4%	82.2%
HealthNet	2,000,000	85.7%	83.6%
Kaiser Permanente	6,500,000	93.0%	95.6%

Several small plans spend <95% of premium

The 1975 Knox-Keene Act required health plans to spend 85% of premium on health care. For-profit insurers decided that their profits were an expense to come from the provision of care and no one has forced them to change. Requiring Blue Cross and Aetna to satisfy the Act and spend 85% of premium on care will raise over $700 million for care. At a May PRI (Pacific Research Institute) policy event, a health plan lobbyist was explaining how the MLR is under 70% for some products in some states and that was a good thing. How sad for them.

Characteristics of Quality Care

- **Timely**
- **Beneficial = Benefit > Risk**

Barriers to Timely Care

Barriers to Beneficial Care

Cost Pressures

- Population living longer with more chronic diseases
- New technologies
- New Drugs
- Direct-to-Consumer Marketing
- Emotional decision-making (especially doing "everything" when comfort measures are best)
- Lack of personal responsibility - the "it's free" syndrome
- Poor patient choices coupled with the belief that the medical profession not only can but is obligated to fix the problems the patient created
- Unreasonable malpractice verdicts
- Doing tests "just in case" or to reduce the chance of lawsuits

Payment Limitations

- Patients do not want to pay for their care
- Employers do not want to pay for healthcare
- Insurers do not want to pay for healthcare. As discussed, insurers benefit by refusing to pay for care, so they seek ways to illegally or unethically take money from patients or providers, e.g. by denying valid claims randomly (knowing that the cost to pursue is greater than the amount to be collected)
- Government insurers have the ability to mandate what amount providers can charge, even when it is below the cost to provide care, even when the provider has no contract (e.g. Medicare, MediCal, Champus, CMSP, Healthy Families)

Defining Our Healthcare Crisis

We have been in a healthcare crisis for more than 5 years. Will we remain blind to the crisis until a friend or family member suffers? Even then, will we blame it on a person, a healthcare provider, or will we recognize it is the fault of the broken system?

Some of the facts:

- Provider costs have risen much faster than provider receipts
- Health insurance premiums paid by Providers have increased much faster than payments from those same insurers
- Government insurers pay at or below the cost of care. We pay cost+ in Iraq but pay cost- for Americans' health here at home
- The number of uninsured Americans continues to rise
- Uninsured and underinsured patients delay seeking care until they are sicker, increasing cost and decreasing effectiveness
- Delaying care increases the cost and decreases our success
- Thus we persist in a downward spiral spending ever more and get progressively worse results

Defining Our Healthcare Crisis

Some of the facts:

- Payor mix determines whether an ER can be self-sustaining:
  - Uninsured patients in our rural ER - 25%
  - Government insured patients in our rural ER - 65%
  - Only 10% of our ER patients have private insurance
- In 1999, OSHPD reported 43% of ER patients were privately insured
- Nationally, most ERs loses money
- In 2002, 80% of California ERs lost money; $80 per visit on average
- By comparison, in 2005, "only" 40% of New Jersey ERs lost money
- California ER and Trauma system Losses (aggregated):

1997	1998	1999	2000	2001	
$300	$292	$316	$325	$390	millions of dollars

- Physicians treating those emergency patients lost $100 million
- From 1995-2003 65 ERs closed - in our rural area one of two ERs closed
- From 1996-2003: 126 Medical Groups closed, displacing over 3 million patients. Some groups had been in business over 60 years. They didn't suddenly become incompetent, their costs rose faster than their income.

Defining Our Healthcare Crisis

- Gridley ER recently averted closure when the rural community voted for a new ER-specific tax
- ERs are overburdened and cannot see patients quickly
- ER waiting times have been rising. ER beds and staffing have been rising in an attempt to keep up.
- ER wait time for admission to our rural hospital:
  - 2000 37% waited > 2hrs
  - 2001 69% waited > 2hrs, 29 nurses, 25 ER beds
  - 2006 avg wait > 7 hrs, 60 nurses, 25 beds + 10 “hall” beds + 12 “overflow”
  - includes time in ER waiting for a hospital room
- Diversion rapidly increased in the prior 3 years and was eliminated in 2007
- A nearby community (Colusa) is at risk of losing ambulance service
- Doctors are leaving medicine, cutting back, retiring, or moving out of California to lower cost, higher payment states
- The first publicized ER death has been followed by many more reports
- It is likely that other deaths and disability are due to the ER wait but go unrecognized
- Despite starting nursing salaries averaging over $50,000, 1.2 million nursing positions remain unfilled nationally
- The Institute of Medicine estimates national economic gains of up to $130 billion per year from insuring the uninsured, possibly enough to pay for insurance for all

Describing the Healthcare Solution

- Acknowledge the complexity of the problem
- Change public perceptions and expectations with education
- Recognize that if we allow each of the four parties to pit policies and desires against those of the others, we will accomplish nothing.
- Create a basic foundation for discussion which identifies the key principles to which all the parties can agree
- Balance the policy requests and desires of the four parties based upon our defined principles (not who spends the most money or yells the loudest)

Principles for Healthcare

1. Everyone now living will die someday
2. Regardless of how much money we spend, we cannot change the first principle
3. The goals of healthcare should be:
   - Promote positive lifestyle choices
   - Prevent preventable illness
   - Screen for early treatable disease
   - Promote effective therapy
   - Provide comfort when treatment is not an option
   - Allow people to die in a dignified and comfortable manner
4. There is a fixed amount of money that can be spent upon healthcare, even if we choose for it to be 100% of GDP
5. We must optimize our healthcare budget in support of the goals of healthcare
6. Money collected for healthcare should maximally be spent on provision of effective healthcare services

Principles for Healthcare

7. Every Californian should be able to access a minimum level of healthcare services
8. No one should be precluded from paying for healthcare services that they choose to obtain in California
9. Patients should have some responsibility for their healthcare choices, so long as they are legally competent
10. Allocation of limited healthcare resources should be done in the most rational fashion that supports our goals
11. No party may dictate to another party what they may charge for their services
12. Sellers of services shall be paid by buyers (or payors) at the agreed upon rate or the seller's price when no agreement exists
13. Buyers (or payors) who were forced to obtain services in an emergency which limited their ability to investigate other options may seek a neutral third party to negotiate a reduction in a seller's price

Principles for Healthcare

14. Provider pricing should be transparent
15. In recognition of the critical need for trained healthcare workers, some resources of the healthcare industry (insurers and providers) should be directed to support education and training for the development of the next generation workforce
16. To ensure that a healthcare system endures in perpetuity, there must be:
    - Adequate financial resources to support education and training of the healthcare workforce
    - Enough clinical positions open to enable trainees to complete their practical training
    - Strong incentives to encourage those capable of becoming healthcare workers to apply to do so