Alleviating the Pain

Searching for Health Care Solutions

By Tom Schuman

In an ironic twist of words, one of the outcomes of this roundtable discussion on health care reform is that everyone is going to have to experience the discomfort.

Dr. Edward Langston recalls former Indiana Gov. Otis Bowen saying he always knew he was close to a solution when "I've got everybody mad at me – and at about the same weight."

Fellow panelist Anne Doran claims, "We're all going to be unhappy at the end. Everybody has to give something up in order to create a better system, because the one we have right now certainly isn't working very well. I think that's the one thing we all can agree on."

Everyone includes hospitals, physicians, insurers, employers and the patients. The hope is that the short-term "pain" of adjustment will lead to a long-term system that proves more viable. The current health care payment structure serves few, if any, well and, all agree, is not sustainable.

But the "system is broken" recognition has been in place for many years and numerous smart people working very hard have been unable to come up with a solution. Now, the federal government is back at the table trying to lead the way. The unanimous reaction from our panel of experts: concern.

We're not able to offer an answer here for what ails us, but what follows is a most interesting discussion from a variety of perspectives. The participants are:

The panel includes:

- **James Dague,** president and CEO of Goshen Health System. With 36 years of health care experience, Dague has led five successful hospital turnarounds.
- **Doran,** a public affairs specialist with the Indianapolis-based Ice Miller law firm. She has represented health insurers and health plans in public policy areas since the late 1980s.
- **Langston,** a Lafayette-based physician, pharmacist and educator who, among many former and current industry leadership roles, is the immediate past chair of the board of trustees of the American Medical Association (AMA).
- **David Wulf** is vice president of administration for Templeton Coal, a diverse development, manufacturing and distribution company with its headquarters in Terre Haute. Wulf also serves as chairman of the Indiana Chamber's health care policy committee.

Out of order

To understand what needs to take place to fix the system, there must be a strong realization of what doesn't work. Easy question – but one with no simple answers.

From the hospital point of view, Dague offers, "Probably one of the most traumatic issues from my perspective is you can't give an 80% discount to Medicare and 85% discount to Medicaid, have it be 40% of your business, shift those costs to the employer community, where they provide benefits to their employees, and have that be anything other than a totally inefficient system and taxation without representation.

"As the federal government can't afford Medicare and Medicaid under their current funding mechanisms and keeps reducing the amount of reimbursements to hospitals, it just increases the cost shifting to the rest of the payer population. I think that accounts for a huge portion of the rising index in health care costs."

Langston shares that the AMA policy that has been advocated nationally and at the state level in recent years is "health care for everyone." The one in seven people who are uninsured, he says, is a daily issue with a "disproportionate share of the burden" on hospitals, overcrowded emergency rooms and "something our physicians share with us every day."

The association is calling for the three C's:

- Cash – Langston says individual tax credits became part of the discussion seven or eight years ago
- Choice – patients have clearly shown this is important and the AMA feels it should be addressed in any system
- Change – different insurance laws in the 50 states and other territories that are going to have to be looked at very carefully

"Within that choice, we advocate we ought to have a similar choice as the federal employees' health insurance package," he continues. "If it's good enough for my congressman, it's good enough for me. We think that coverage should be portable, and we should have individual ownership. Those are probably ideas you never thought you would hear from the AMA."

Wulf cites the longstanding disconnect "between the consumer of services and the payer of services. There's absolutely no incentive for an employee to manage this in any way like he would his household budget. There is no connection between the level of an employee's resources and the level of care he can buy. Everyone can buy the Cadillac or the Ferrari. Where we are today is we have quite a number of groups with different interests, all competing."

"Everyone wants to have certain items measured. The real dilemma is that even though there may be a measurement that has some connection to a medical issue, the question is whether that is the one that drives the outcome."

Dr. Edward Langston
American Medical Association

The players in the game, according to Wulf:

- Employers, who want to provide the lowest cost health care package possible for their employees
- Health care provider community, which has needs like other businesses
- Insurers, "sometimes held up as the poster child of evil, but they are really the agents of the employers and the individuals purchasing health care insurance"
- Litigators, sometimes "taking advantage of certain situations and driving up the cost of malpractice insurance"
- Physicians, with no connection between the quality of health care and the amount they're being paid

Experience tells us, Doran explains, that few are ready for the third principle described by Langston – change.

"Everyone has to change somewhat, and I think there is a true reluctance to do so. At least that is demonstrated by the kind of legislation we get every year at the Statehouse," she confirms. "We don't treat health care as a regular commodity. It does not respond to traditional economics; supply does not equal demand. We have to be willing to make those choices; my experience at the state level says we're not willing to do that."

Changing course

Dague admits that hospitals are not exempt from the need for change. He does, however, provide more in-depth thoughts on others. Employers need to look beyond the best price and focus more on preventative aspects. Insurers, he goes on, should carry some of the risk (instead of transferring the responsibility to Medicare) as the population ages. Changes in financial incentives for doctors should include a type of salaried relationship with hospitals that execute proper quality control.

"If employers would not offer health insurance unless employees do preventative health measures … if insurers would say they were not going to insure you unless you offer those programs … if hospitals offer discounts for preventative measures … if litigators would just lay off for awhile," he contends. "Some of that is just part of the change we've got to start talking about for our country; otherwise, this is on a rail out of control and piecemealing it is not going to work in my opinion."

Doran says insurers as we know them today may not exist 20 years from now. She sees it becoming more of an administrative role that insurance companies take than one of actual risk, pointing out that more than 80% of the state's market was commercially insured 20 years ago.

"In other words, insurers assumed all the risks. Today, it is only about a third of that and it continues to decline," she explains. "Anyone that can self-fund is doing that and bypassing state regulations. And none of those plans are the same across the board."

Langston holds out hope that the economic downturn helps create a certain momentum.

"We do see changes coming. It's fascinating; it could be frightening," he states. "Physicians know that we have to address quality, we have to address patient safety. We're small businessmen. Over 50% of the practices in the U.S. are five physicians or less. Since 2001, there has been about a 4% raise on what I get paid for taking care of Medicare patients. I can't keep doing that in my small business. Right now, the insurance industry is the only one I know that

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James Dague
Goshen Health System

if the costs go up, you just raise your fees."

Doran counters, pointing out the cost shifting that occurs among providers

Wolf says, "The big bulk of where this cost of insurance is coming from is not the insurers, it's the health care community. I object to the provider community focus on the insurers being the driving force behind the cost of health care. Insurers are nothing more than a conduit, passing the costs from the health care provider to the payer, whether it be the employer or the government."

Federal fallout

The question is not one of who is in charge in Washington, but the fact that our nation's capital is the one preparing a remedy. Are you concerned?

Wulf terms it a "strong concern," citing as an example the recent expansion of the State Children's Health Insurance Program to families with incomes that are at three times the poverty rate. "In my view, that's simply an effort to draw more out of the privately financed system into the government financed system. And that scares me.

"We do have the best health care provider community in the world when it comes to providing services, but what we're basically moving toward is socialized medicine, at least socialized financed medicine. Where this is all leading is that services are going to be provided by the government, not by the private sector, and that will lead to rationing. Once we nationalize the system, there is no private system to cost shift to. We will see rationing of services, a cutback in compensation to the provider community, which will lead to less talent with our physicians."

Dague takes the level of concern from "strong" to "deep." He calls the templates of Medicare and Medicaid a third-class insurance system.

"I agree that we need a lot of radical change in the entire system, but the doctrine of incrementalism that is so prevalent in our Washington legislators probably dictates that we're going to get an extrapolation of Medicare and Medicaid," he submits. "We're not going to get the radical change that the industry does need so that all people are playing a bit of a different role. We're deeply concerned because we don't think they know what they're doing."

"I know that it is hard, but don't think sitting back and allowing Washington or whomever to decide this on their own without input from people actually paying the bill is going to result in an effective system."

Anne Doran
Ice Miller

Doran delivers the message of concern, but also provides a glimmer of hope. "If they're trying to create a universal Medicaid or Medicare system, it's going to be a failure in my estimation. But if they can implement policies that push creativity down to the state level and allow the states to expand their own systems, that could be something we would welcome."

Langston concludes, "I think there is always concern when the government gets involved and yet, on the other hand, they're already paying half the tariff in the United States. We've been very supportive of the states having the opportunity to try different methodologies because it's the laboratory that gives you some answers."

Quality counts

Consumerism, making individuals more accountable for their health care decisions, has been one of the more common trends of recent years. Wulf says his company has experienced success with Health Savings Accounts as a control on routine expenses, but that consumer education and choices have little impact on the large claims that are driving up insurance costs.

At the center of any consumerism debate is the availability or absence of quality measures. That topic, for providers, raises the question of how high is the quality of the quality data.

"The published quality standards are just the tip of iceberg," Dague suggests. "We see those, inside the industry, as not measuring much that is useful. But if you boil it down, the patient is going to go where they are considered in-network; they don't want to pay an out-of-network premium just for quality."

Wulf agrees that consumers make decisions based on comfort and bedside manner, with part of the reason being a lack of access to quality data. "Consumers have to gain access to quality information, which is closely guarded, or insurers have to have that access and seek some

sort of incentive to reimburse the higher quality doctors at a higher level to try and drive people toward higher quality health care."

Langston says there is no doubt that you cannot address quality unless you measure performance and that substantial progress has taken place.

"But we're getting what we call 'measure burden.' Everyone wants to have certain items measured. The real dilemma is that even though there may be a measurement that has some connection to a medical issue, the question is whether that is the one that drives the outcome. That's the next level, that's where we're going."

Dague believes there is much more quality information available than most people realize. "That's why we feel so heavily regulated. Part of what I object to is insurance companies coming in to tell us 'this is our quality measure'; they're not quality measures, they're insurance company measures that help optimize their profit, not necessarily produce quality for their patient."

Doran takes exception, countering that Indiana's status as an "any willing provider" state (insurers must accept any qualified provider willing to agree to the terms and conditions of the plan) is a major factor.

In addition, "any time we try to move in a direction of higher payment for quality, there is constant pushback that we can't do that because we are an any willing provider state," she continues. "If we have the expectation that down the road it is going to be better, it has to be driven by data. When that data comes up that we have providers that perhaps are not meeting that quality standard, provider (groups) are going to have to step up and say 'you're done'."

Langston's experience with such programs is that, "I may get graded on things over which I have absolutely no control because I'm the designated primary care physician." He offers the example of someone who receives a test from another provider. "When we use billing data, it is just so inaccurate."

Wulf says that it will take a database that everyone will trust and accept before true progress can be made.

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David Wulf
Templeton Coal

Parting advice

Our experts are asked to conclude with their message to small employers, those that have pulled out all the stops to try and keep offering an insurance program for their employees. Where they can turn for hope that improvement is on the way?

"A big part of it is to work with their insurers, particularly those that steer them into preventative medicine, and staggering the premiums that employees pay," Dague reiterates. "Those (employees) that are high risk and don't do anything about it will pay more than those that have a healthy lifestyle. Encourage insurance companies and hospitals to offer those programs, and then give them some preference in network for purchasing. We need to play for the long-run benefits."

Langston cites strength in numbers, both in stating your case to lawmakers and being part of a larger insurance pool that minimizes the impact of one or two costly employee conditions.

Transparency and activity are two keys for Doran.

"Share with employees the fact of what health care is costing. There has to be greater participation by employees in their own health; there has to be an emphasis on wellness and a number of insurers are doing that in their programs," she maintains. "Finally, as a small business person, you need to become active. I know that it is hard, but don't think sitting back and allowing Washington or whomever to decide this on their own without input from people actually paying the bill is going to result in an effective system."

Wulf concurs, with a strong emphasis on involvement at the General Assembly. He knows firsthand that the Chamber is always looking for people from the business community to spend a few minutes talking to legislators, testifying.

"The state Chamber offers a voice. Right now, legislators are insulated from the whole thing," he asserts. "They pass laws, mandates that only affect 33% of the state, but they keep piling it on and piling it on. It's driving small employers down. The statistics show that small employers under 50 (employees) are dropping health care plans at an alarming rate. All of our good intentions of expanding health care in the state through mandates simply lead to more and more uninsured."