WEATHERING THE ECONOMIC STORM

What Will Health Care Reform Mean for Your City?

By Lynn McNamara, City County Insurance Services (CIS)

The exponential rise in health care premiums in recent years has been matched by an increase in the amount of discussion about reforming the health care system. The current economic climate has added a sense of urgency to making reform happen.

While there are many points of view about what will make a difference, there are two areas of almost universal agreement: (1) something needs to happen, and (2) figuring out what the something is, is complicated.

It's not hard to understand why reform is necessary. Consider these projections in national health care expenditures (NHE) for 2008-18, prepared by the U.S. Department of Health and Human Services:

- Growth in NHE is expected to average 6.2 percent per year over the projection period (2008-2018);
- The health share of Gross Domestic Product (was) projected to reach 16.6 percent in 2008 and 20.3 percent by 2018;
- Medicare spending is projected to average 7.3 percent per year over the projection period;
- Medicaid spending is projected to average 8.4 percent per year over the projection period;
- Private spending is projected to average 5.3 percent per year over the projection period;
- Spending on hospital services was projected to grow 7.2 percent in 2008 to $747 billion. Average growth of 6.4 percent per year is expected for the entire projection period; and
- Spending on prescription drugs was projected to grow 3.5 percent in 2008 to $235 billion. Average growth of 6.5 percent per year is expected for the entire projection period.

All of these statistics talk about spending. None of them relate to whether or not people receiving services from these expenditures will be healthier, or live longer. Health reform efforts both in Oregon and at the federal level seek to connect health care spending to health care outcomes.

Whose Fault Is It?

If health care reform were simple, it likely would have happened by now. It's easy to place blame: it's the pharmaceutical companies. It's the insurance companies. It's the hospitals and doctors. It's the costs for the uninsured population. And it's us.

The health care debate is complicated for many reasons, not the least of which is that health care is personal. Each one of us will need health care in our lifetimes, and when we or our family members are sick, the natural inclination is to want the "best," regardless of cost. We also want to do what we want to: how many of us actually make the lifestyle changes—the diet, the exercise, stopping smoking, and preventive exams—that we know will improve our health now and in the future?

Here's an example of the "personal" effect, pulled from CIS Benefits claims data. Between June 1, 2008 and May 30, 2009, there were 1,758 claims filed for Lipitor, a cholesterol-lowering drug. Regence paid $320,140 toward the cost of these prescriptions. According to data developed by D2 Hawkeye, a national provider of health care analytics that works with CIS, if these prescriptions had been for Simvastatin, a generic cholesterol-lowering drug that studies have found to provide the best results for the least cost, the cost would have been $17,715… 94 percent less. The CIS data shows that the average cost per Lipitor prescription was $182.10. The average cost per prescription for someone taking Simvastatin (with 1,410 prescriptions filled) was $2.35.

So why isn't everyone who needs medication to lower cholesterol on Simvastatin rather than Lipitor? Certainly there are cases where the doctor has tried Simvastatin and determined that Lipitor works better for the patient. But how many patients have never been asked to try the lower-cost alternative? How many would feel comfortable asking their doctor about it? And in plan designs with relatively low copayments for prescriptions, how many would be financially motivated to do so?

(continued on next page)

And one more question for city officials: if your city's medical plan stopped paying for Lipitor unless Simvastatin were tried first, how many employee complaints about a "take away" would it generate?

Change is hard. But as we look at the current landscape for cities, it's clear that change has got to come.

The Current Landscape

After a few years of relief, health insurance premiums are creeping higher again. A claims trend factor survey of Oregon insurance companies prepared by The Partners Group, CIS' benefits consultants, showed a range of increases from 12.2 to 14.4 percent for preferred provider medical plans, and 9.2 to 13.7 percent for prescription drug claims. The actual premiums paid by employer groups may be higher or lower, based on their own claims experience, but the reality is that even if the medical increase is 10 percent, that's still 10 times the current rate of general inflation, and out of line with shrinking city revenues and other cost increases.

Oregon's Health Care Reform Efforts – HB 2009 and HB 2116

The Oregon Legislature made health care reform a priority in the 2009 session, and the result was HB 2009, the policy-making legislation, and HB 2116, the funding legislation.

HB 2009 takes a holistic view of health care reform. It's built on the recommendations of the Oregon Health Fund Board, created by the 2007 Legislature to make recommendations to the Legislature on ways to improve health care in Oregon. HB 2009 vests responsibility for all things health care in the Oregon Health Policy Board, a nine-member group to be appointed by the governor. Although much energy during the session was spent trying to develop specific solutions, in the end, funding realities resulted only in a requirement for the board to develop a plan for the 2011 Legislature to provide and fund access to affordable health care for all Oregonians by 2015.

The Health Policy Board also is supposed to start implementation of some specific initiatives that are aimed at reducing costs and improving health care quality. These include a statewide registry of Physician Orders for Life Sustaining Treatment (POLST); promotion of the use of electronic health records and data exchange; the creation of the Statewide Health Improvement Program, "to support evidence-based community efforts to prevent chronic disease and reduce the utilization of expensive and invasive acute treatments;" the establishment of a Healthcare Workforce database; and the development of evidence-based health care guidelines for use by health care providers, consumers, and purchasers of health care in Oregon.

Cities are specifically mentioned in one section of the bill, which creates a Public Health Benefit Purchasers Committee. The committee, which explicitly includes individuals from city government who purchase health care, focuses on benefit plan design as a way to achieve best practices and consolidated purchasing, if possible.

The committee is charged with:

- Identifying and making "specific recommendations to achieve uniformity across all public health benefit plan designs based on the best available clinical evidence, recognized best practices for health promotion and disease management, demonstrated cost-effectiveness ,and shared demographics among the enrollees within the pools covered by the benefit plans"; and
- Developing a plan for ongoing collaboration to implement the uniform designs the group develops and, "shall leverage purchasing to achieve benefit uniformity if practicable."

These changes are supposed to minimize the cost shift to individual public purchasers, while not shifting costs to the private sector.

HB 2116 imposes a one percent assessment on the gross amount of premiums earned by an insurer from health policies between October 1, 2009 and September 30, 2013. The Public Employee Benefit Board (PEBB), the insurance program for state employees which is about to become self-insured, also will pay one percent of its medical claims and their associated administrative cost. The funds are to be used to expand health care coverage for Oregon children, and to provide grants to community health centers and safety net clinics. It's reasonable to assume that the cost of the assessment will be passed on by insurers in their rates, as the legislation explicitly allows them to do so.

Apart from meeting the public policy goal of health care for all Oregonians, the rate increase HB 2116 applies is based on the supposition that you have to spend money to ultimately save money. The cost of "uncompensated care"—the emergency services that health care providers, primarily hospitals, provide to uninsured individuals—is ultimately passed on to the insured population through higher provider rates. The theory is that if those individuals have access to regular medical care, illnesses will not result in costly emergency treatment.

And at the National Level…

At this writing, it appears that a national health care reform bill will emerge in the relatively near future. However, Congress and President Oboma are still wrangling over its terms. The House has passed a bill; a Senate committee has its own plan. There are significant questions to be decided about funding—e.g., will the value of employer-provided insurance become taxable? Will there will be a "public" plan to compete with private insurers?, etc.

(continued on page 18)

Health Care Reform

continued from page 17

A recent publication from the American Association of Retired Persons (AARP) summarized some of the areas of agreement at the national level, even if the details remain to be worked out. They include: the maintenance of employer-provided health care; some form of mandatory health coverage for everyone; the need for control in the increase of health care cost; more federal regulation of the insurance industry; and improvement in the quality of care, and in health outcomes.

What CIS is Doing

Since 2002, when the CIS Board of Trustees first decided to invest in the wellness program that became Healthy Benefits, CIS has focused on giving city employees enrolled in its medical plans the resources to take charge of their health and avoid high-cost claims. The result has been claims trends that are lower than the Regence BCBS statewide trend, and in one year, an actual rate reduction.

This year, the Healthy Benefits program has evolved to provide local resources for health coaching, weight management, tobacco cessation, and worksite wellness. This fall, the same services will be offered to spouses for the first time. CIS also plans to use its new data analysis tools to create plan designs that provide incentives for employees to engage in healthy behaviors and keep chronic illnesses from becoming major episodes. And, CIS will work with the League to stay involved in the work of the new Public Health Benefit Purchasers Committee.

What City Officials Can Do

There's no need to sit back and wait for reform to happen. CIS member cities can take action now by supporting employee participation in CIS' Healthy Benefits program, while non-members can start their own program. CIS provides worksite wellness and health screening grants to many member cities.

For cities involved in collective bargaining, now is the time to begin discussions on making changes. "Cadillac" plans are not the best use of scarce resources for employers or employees, and communicating that reality has to start now. Even though it's too early to know what the final options will look like, avoid locking yourself in to specific benefit plan designs that may not be available under a reformed system, or even during the transition years. It's always easier to bargain over what the city will pay toward benefits than to arbitrate changes in coverage. The Local Government Personnel Institute (LGPI) can provide guidance in this area.

What will health care reform mean to your city? The hope, in the long run, is a healthier population and lower costs. How quickly the hope becomes reality is the question at hand. But in the meantime, remember: like charity, health reform for each of us begins at home. ■