EMERGENT THEMES FROM TOWN HALL AND OUTREACH MEETINGS ADDRESSING HEALTH CARE COST PROBLEMS AND SOLUTIONS.

The Minnesota Citizens Forum on Health Care Costs held twelve town hall meetings across the state, including four with specific invitations to Latino, American Indian, African-American/African-born, and Asian-Pacific Islander communities.

A separate document, *TOWN HALL MEETING SUMMARY, Issues from Edina, Mankato, St. Cloud, Rochester, Marshall, Moorhead, White Bear Lake, Clues, Duluth, Native American Outreach, and African American Outreach*, itemizes problems and solutions identified in the presentations. That information is organized under the four major topics of the Citizens Forum process – Health, Access, Financing, and Quality.

In contrast, this summary document takes the information from the town hall meetings and identifies themes that emerge from the information itself. The analysis identified three broad themes:

1. **There are a number of dynamics that increase the demand for more costly services or result in people not receiving appropriate health care. These dynamics raise the human and financial costs that result from the current health care and coverage system**. More and more people do not get the care and information they need to prevent future health problems or to treat existing problems. Lack of preventive care and action related to individual and public health causes graver problems later. These problems result in higher costs in two ways – more costly treatment for chronic conditions or higher human costs from lack of treatment. Presentations at the Town Hall meetings imply two consequences from this.
    - First, greater investment in prevention at the individual and public health levels will reduce demand for care and treatment for graver problems later on.
    - Second, if the barriers to good health care were removed, there would be an increased demand for care and treatment, resulting in better health.

2. **There are a number of dynamics which force individuals and families to either assume greater responsibility for the costs of health care, or to go without health care because they cannot meet the new costs. While this may lower the public costs of health care, it results in higher human costs – people going without treatment, financial stress on families, delayed retirement, and so on.** Many of these forces resulted from legislative action in Minnesota in 2003. Individuals are assuming a greater cost burden because of increases in co-payments, cost shifting, caps on care, and increasing numbers of people who are uninsured. The recommended solutions from the town hall meetings would result in lowering the human costs of the current system, but shift costs back to government.

3. **There are also forces driving up the cost to employers and government for health coverage or care.** The cost of insurance is proving more and more burdensome for employers. The cost of prescription drugs is too high. There are administrative and regulatory inefficiencies in the system.

The solutions offered in the town hall meetings are quite interrelated. For instance, recommended measures to lower the costs of insurance would result in people engaging in more prevention which in turn would lower the occurrence of chronic conditions and the costs associated with them. At the same time, some recommendations are in conflict with one another. For instance, some recommended reducing co-payment and cost shifting measures so that Minnesotans have better access to health care. Others recommended increasing co-payment and deductibles to lower the cost of insurance, shifting even more costs to the consumer. Many recommendations suggest investing in measures that will improve the overall health of Minnesotans. There is a routine call for systematic change.

<u>Theme 1</u>: Prevention and Barriers to Good Health.

Presentations at the Town Hall meetings identified a number of trends that result in increased demand for more costly care because there is not enough emphasis on prevention. Fundamentally the issues have to do with a lack of health care services or the cost of services that do exist.

> **"We spend 6 cents out of every health care dollar on prevention and 94 cents on services.** "
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> "**We pay for acute, episodic health care. We don't pay for education or prevention."**

- The system is far more concerned with disease than prevention.
- Because people cannot afford health care, they delay treatment and preventive measures, resulting in more complex problems later.
- Many different kinds of people face discrimination based on income, geography, race and ethnicity, and are denied good care. This results in more costly interventions later.
- There is a lack of information and education about good prevention and health lifestyle choices.
- People do not take responsibility for their health. They do not get the information they need to take responsibility. They overeat, don't exercise, and smoke.
- Illiteracy and cultural issues stand in the way of people getting the information they need.
- People avoid getting annual physicals, prostate exams, mammograms, etc. This is linked to the cost.
- People do not get good dental care because of cost and/or a shortage of dentists.
- Environmental hazards are not dealt with -- lead poisoning; poor air quality from industrial emissions, second hand smoke; poor water quality. Pesticides, preservatives, genetically modified foods, irradiation, and herbicides are affecting hundreds of thousands of people who have weakened immune systems.
- People end up in costly nursing homes because of avoidable loss of independence. Older people fall at home. Older people get depressed at home without support. Access to assistive technology and devices is blocked based on race, gender, and type of disability.

The situations faced by people in widely varying circumstances are seen as barriers to good health and good health care.

- It is very difficult for people who are uninsured to take many kinds of preventive action.
- There are technical exclusions of people from health care such as recent immigrants or the legality of citizenship
- Culturally and linguistically appropriate services, including interpreters and professionals from diverse backgrounds, are lacking.
- Illiteracy results in costly and inappropriate use of the system, such as going to emergency rooms for primary care, and not having information about good health practices.
- Native Americans, on and off reservations are going without essential health care services in many areas.
- African Americans and Latinos face discrimination.
- People with disabilities are unable to get services.
- The mental health system is overwhelmed.
- Urban and rural areas report shortages of nurses, pharmacists, dentists, doctors, psychiatrists and a variety of technicians. The crisis is looming even larger in the future.
- The cost of taking personal responsibility is high, including the cost of health care, exercise, and healthy eating.
- Home care is less expensive than hospitalization, but Minnesota is now on the low end of home health care users, second only to Hawaii.

The <u>SOLUTIONS</u> offered cluster in several areas – universal health coverage, increased prevention efforts, an emphasis on community care, addressing staff shortages, ensuring culturally and linguistically appropriate services are available, and equalizing access. It is thought that these efforts will be investments for the future, resulting in better health and lower demand for high cost health care.

- A health care system that places <u>priority on prevention</u> would include many elements – encouraging positive and discouraging negative lifestyle choices, individuals taking responsibility (and being able to take responsibility) for healthy lifestyles and practices, improved environmental quality, regular dental and physical examinations, on-going funding for prevention and early intervention measures, improved education and information to the public, and home and community care to prevent injury and dependence for older people and people with disabilities.
- Actions to <u>increase the availability of trained personnel</u> include improved recruitment (generally and in specific ethnic and racial communities), greater use of the right professional for the most effective and efficient health care (for instance, midwives, nurse practitioners, physician assistances) and education (for instance, relying on nurses instead of doctors) incentives to work in geographic areas where there are shortages, and enabling the licensing of foreign licensed professionals.
- Other efforts to <u>equalize access</u> include adopting standards for culturally and linguistically appropriate services, support navigators and advocates who can assist people to get what they need, stabilize funding to specific communities and populations (Native Americans, African Americans, Latinos, and people with disabilities).

- Increasing access to health insurance through a variety of means (discussed under Theme 3) is seen as a critical component in increasing prevention and equal access to quality health care.

<u>Theme 2</u>: Individuals and families are forced to bear increasing costs for health care and coverage, or go without appropriate care or treatment. The results in large numbers of uninsured and underinsured Minnesotans.

Time and again, presentations at Town Hall meetings focused on the growing number of people who are uninsured because of the escalating costs of health coverage. Insurance is linked to employment and coverage varies. As well, a number of legislative actions Minnesota during 2003 have led to shifting more of the costs to individuals and families. These and other dynamics result in good health care being denied or delayed, and thereby increasing the cost of interventions and the human costs.

> **"There are many people who do not have insurance, who cannot afford insurance, who wait for long periods, and who go to the ER…. This is a vicious cycle; it is reactionary and all we have are band aids for symptoms without fixing the root cause."**
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> "**There is a delay in getting Medicaid payments if the person is also eligible for Medicare. First you have to wait for Medicare denials before Medicaid pays. Waiting can lead to hospitalizations, use of the ER, or death."**
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> **"Home Health Care Companies are becoming used car salesmen trying to talk older people into placing liens on their homes in order to get in-home support."**
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> **"The Legislative actions that increased co-pays, deductibles, cut services, cut Minnesota Children with Special Health Needs (MCSHN), and reduced Minnesota Care are coming at too high a price. The price of no new taxes is too high; my life has not improved because of tax cuts."**

Directly and indirectly, the Minnesota Legislature has taken actions that have resulted in increased co-payments and reduced access to health care.

- There are increased costs to private pay residents in nursing homes.
- There are caps on oral health care, mental health care, and so on. Individuals cannot afford the additional costs.
- For people with disabilities, funds have been eliminated (Minnesota Children with Special Health Needs), parental fees have increased dramatically, the employment situation of adults means they fall in the coverage cracks between Minnesota Care and Medicaid. Families are under financial and emotional stress. For instance, parents cannot pay TEFRA fees so that they are reducing or stopping therapies, postponing surgeries, and not purchasing medications.
- People with HIV/AIDS are less able to afford critical medications.

- People with diabetes have less access to supplies and are using more expensive emergency room services.
- The Legislature exempted medications for children and mental health from any co-pays but the pharmacies do not know about these exemptions.

There are other pressures and issues related to shifting the costs to individuals and families.

- There is less Medicaid and Medicare in rural areas so cost shifting occurs.
- To the extent that insurance is linked to employment, if someone or a member of their family has a pre-existing condition, then this might well not be covered if the employment changes. This becomes a very serious problem if that pre-existing condition carries high costs and those become the responsibility of the family.
- Older people are working past retirement age because of health care benefits. After retirement, insurance is taken out on an after-tax basis. Before retirement, it is a pre-tax basis.
- Over 280 million people do not have any coverage for long term care for people who are disabled or aging. **"Something is wrong, when you have to be impoverished before you can get help with long term care.**"

Most of the <u>SOLUTIONS</u> recommended to counter rising pressure on individuals to cover costs require reversing the 2003 legislative actions. Presentations called for the following:

- Take away this surcharge (private pay residents in nursing home), the elderly deserve our care.
- Reverse this action (caps and co-pay increases) in 2004.
- Restore MCSCHN funds by having the 2,000 enrollees pay $50 a month in premiums or $34 a month if 3,000 enroll. Use existing administrators for Minnesota Care to handle the paperwork.
- Reduce parental fees.

Such recommendations are in marked contrast to some others which call for raising co-payments. "**We have spoiled people with 5 – 10 percent copays; we need to increase personal responsibility. The consumer is disengaged."**

The more overriding recommendation is for universal coverage to reduce the numbers of people who are uninsured.

<u>Theme 3</u>: The cost of insurance, medications and administrative inefficiencies and regulations are consistently cited as the reasons for escalating costs to employers and government for health care and coverage. The recommended solutions focus on universal coverage or a more competitive market, reducing prescription costs, and improving efficiencies, both in administration and purchasing power.

Many of the other dynamics identified in the Town Hall meetings are also related to increasing costs -- lack of emphasis on prevention, lack of emphasis on home care,

institutional care rather than community care, increasing burdens on individuals and families to cover costs, and funding cuts to essential programs. To the extent that these dynamics result in the need for more health care and more expensive interventions, they put pressure on government to reduce its costs and are used to justify increasing insurance premiums.

> **"Employer sponsored health care is breaking down. Approximately 800,000 people are on Minnesota publicly funded programs. If we add in all government employees, then 40 percent of health care is paid by government payers. "**

One result of the rising cost of health insurance is the burden on employers and government, as an employer.

- Employers are collapsing with the rising costs. For instance, small businesses with 10 or fewer employees have experienced premium increases of 15 percent.
- As health insurance rates rise, they become unaffordable and a higher percent of operating costs of business is consumed by health care.
- Employers cannot pay for individualized plans but must buy group coverage.

The rising costs of prescription medications is seen as a major issue. People differ in why they think this happens.

- Drug prices skyrocketed because the HMO/insurance companies have been abject failures. No one cared 15 years ago what meds cost so there was waste. Now the waste has caught up with us.
- Drug mark-ups occur because there are eight distribution centers before the drug arrives at your local pharmacy.
- Marketing of drugs has become obscene.
- The drug discount card is the worst approach because the discount comes from local pharmacies not the drug companies.
- The taxpayer pays for the research and development costs of pharmaceutical companies; we are suffering by their inflated prices and ads that drive consumption.

> **"You must do something about drug pricing because I have people who are elderly who cut their pills in half, take their pills every other day, and choose between food and pills. The Medicare legislation just passed by Congress will not solve the problem."**

Charges of inefficiency are laid at health care providers, the insurance industry and government. Administrative costs are too high. One person stated that the current system costs $200 billion in administrative costs. Examples of various types of inefficiencies or excessive administrative costs include:

- Insurance has 30 percent administrative costs and Medicare has 3 percent administrative costs.
- State and federal regulations are often duplicative.

- The problem is government. HIPAA is burdensome. Medicaid requirements are onerous. There are conflicts between CDC telling us to use disposable equipment while the next day EPA comes in and says reduce your waste.
- Can the Department of Human Services shorten the preauthorization process?
- Professional credentialing is costly and inefficient. Smaller providers have to pay $250-$400 per doctor on staff or in consulting capacity to verify credentials every few years. This can be done less expensively.
- Short cuts such as drug treatment without proper diagnosis or hurried visits prevent appropriate treatment.

Some cites a lack of personal responsibility among Minnesotans as a driver of increased costs.

- No society can provide everything for its members. Some people seek maximum treatment at the end of their life because "everything must be done." Expectations are too high.
- We have spoiled people with 5 – 10 percent copays; we need to increase personal responsibility. The consumer is disengaged.
- People go along with doctor's recommendations even if the treatment is excessive.
- Third party providers are hiding the real costs. Inform consumers of costs and encourage them to ask for less expensive drugs, make fewer office visits, etc.

The <u>SOLUTIONS</u> offered in the Town Hall meetings to reduce the cost to employers and government are varied:

- **Universal health coverage (to varying degrees)**
- **Use the combined purchasing and negotiating power of larger pools**
- **Shift more costs to the individual**
- **Reduce the costs of prescription medications**
- **Reduce inefficiencies**
- **Enable personal responsibility.**

Many presenters called for universal health coverage.

- It is suggested that this will mean respectful care. It will enable more money for care, because the root cause of problems is not delivery, but funding. Eliminating health disparities will bring costs down. The savings from a single payer approach would offset the costs of covering everyone.
- Some suggested the first priority should be universal health coverage for children.
- A universal system should be portable and not linked to employment.

"The Lewin group studied three states and they concluded that all people could be covered, costs would decrease, and fairness would increase if we had a universal system. There are multiple studies including PNHP, GAO, CBO, and Institute for Economic Policy that support universal coverage."

"Minnesota should take the initiative, be progressive, and pursue universal coverage. How can we be this rich and not have health care for all? It is unconscionable."

Some, however, suggested cautions in terms of a single payer system. They suggested there will be a huge impact of dislocated workers, reduced wages, higher unemployment, reduced social security, and so on. “Single payer” can have a steep price. For example, the Mayo plan is similar to single payer, but the costs are $9,282 per person per year. On average, the US plan costs $5,938.

There were also recommendations to increase the size of private employer and government purchasing pools. These would ensure better insurance rates and drug costs.

- Let all employers get into larger purchasing pools. Encourage purchasing pools for small businesses.
- A number of government purchasing pools were recommended – all levels of government; the 200,000 employees of 350 school districts; all county, city, school, and state employees; joining forces with neighboring states.

Others recommended actions consistent with an open market approach -- expand competition; increase employer based insurance and/or individual responsibility for insurance.

- Each citizen should be required to carry insurance similar to the requirement for carrying vehicle insurance. Everyone should be required to carry major medical insurance with a $1,000 deductible.
- Go to community ratings not individual ratings because employers are probably looking at employees unfairly with this type of cost discrepancy from $150 to $1000 based upon individual ratings
- Expand employer based insurance and expand individual purchasing of insurance.
- Expand the use of Medical Savings Accounts and tax credits to enable lower income people to purchase insurance, cover certain costs and major medical coverage for disabilities.
- Allow employers to buy individual plans not group coverage.
- Individuals should be able to join purchasing pools.
- Open up Minnesota to other insurance companies not just the existing three companies.
- Increase deductibles and co-pays. (For instance, we need everyone to pay the first $1,000 or $2,000 in health care costs and the price will come down.)

There were a variety of strategies recommended to lower prescription drug costs, including:

- Create one large purchasing pool and negotiate better prices.
- Import drugs from Canada. (Others cautioned against this.)
- Try a Dell-direct model for selling drugs.
- A price control board.
- Minnesota and North Dakota need to work on drug pricing together.
- If insurance companies can bargain and dictate with doctors, why aren’t they doing that with drug companies?
- Individuals shop for bargains.
- Reduce the length of time for intellectual property rights to get to generic drugs faster.

Similarly, there was considerable variety in the recommended ways to reduce administrative and regulatory inefficiencies, including:

- You must regulate the regulators.
- People feel powerless because there is no one place to focus anger. People who commit this much waste and mismanagement should be indicted and convicted.

- Can we cut the administrative costs by streamlining processes?
- Insurance companies need to agree on medical coding and modifiers. Use a common software system that allows insurance plans to talk to each other.
- Use standardized forms to reduce administrative costs.
- Use administrative caps (but then people might spend up to the cap).
- Have every person carry a "smart" card that holds all personal records to reduce paperwork, and thus reduce paper records.

- Have the Department of Human Services shorten the preauthorization process?
- Reduce duplicative costs of equipment and inappropriate competition (seven MRIs in one city).
- Adopt nine regional boards of governance rather than have 87 counties.

Town Hall presentations did not recommend the use of Evidence Based Medicine as a way to reduce costs to the system. A number of cautions were raised.

- Its political nature because Medicare decides what is evidence based and Medicare is the federal government;
- It may harm people with significant disabilities or those who are regarded as outliers;
- Different disciplines have different definitions;
- Not every condition needs evidence based surgery (sometimes nutrition works as well).
- Alternative medicine (or integrative medicine or healing) should be included in the larger picture
- Evidence based medicine means standardizing protocols to drive toward error free medicine. It means computer-assisted diagnoses.
- Where are we getting the evidence? From the pharmaceutical companies that are producing the drugs and producing the results and making profits 3 to 5 times greater than S&P companies? The most recent evidence is hormone replacement therapy that leads to heart problems, stroke, and breast cancer.

In closing, there is a thread in the presentations at the Town Hall meetings that points to the <u>need for systematic change</u> that looks at health in a comprehensive way and recognizes the interconnections among components in the system.

> "The World Health Organization defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."
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> "If you use a social determinant model of health, then you look at issues differently. For example, the life expectancy of a black male in Washington

DC is 57, in Ghana it is 59 years, and in Bangladesh it is 60 yet the US spends 200 times more money."

"Flu vaccines are in short supply because there wasn't enough profit. There is no incentive to prevent fires in our system. We pay well for patching up people and taking out organs, but we do not pay for prevention. "

"We don't have a health system, the system isn't equitable, fair, cost effective nor are we working together. We would never create the system we have. This is Rube Goldberg-complex, discriminatory, expensive."

"Past Health Care reforms have failed because reform has not been systemic. Please do not give us a box of band-aids."

"We need to pay taxes to cover people who are uninsured."

"Provide access to health care for all who need it."

"It is the 21st Century, we need comprehensive and systematic reforms that include delivery, regulation, and financing at all levels and the how's and the where's."

"Break the monopoly of access and financing a hospital-based health care system that is acute and episodic. Seek a different model."