

Is There a Role for Markets in Health Care?

Note: A "market" in this context refers to an environment where businesses are permitted to offer products and services to meet consumer preferences without overly restrictive government limitations on those preferences. Markets are dynamic, growing and contracting in response to demand. TPAs responding to the needs of their clients are perfect examples of markets.

Insights and forecasts you need to understand for your business.

SPBA's Anne Lennan recently attended a public policy symposium addressing the question of whether there is a role for markets in health care. The speakers were primarily from leading policy think tanks in the US, Canada, England and Europe. Below we highlight some of the comments made during the symposium with the intention of keeping SPBA members informed of discussion ideas circulating in the influential health care policy circles at the national level. There are two parts to this article. The first part explains emerging trends in health care and the need for payment structures and health plans to support these trends and allow them to flourish. TPAs should engage in some deep thinking about these trends and how their business practices should adapt in order to thrive in this new environment. The second part provides some disturbing facts about single-payer systems that will be helpful to TPAs as they shape public opinion in their local and regional markets. If your Congressional representatives begin singing the praises of a single-payer system, let them know these facts from well-respected research institutes located in countries with government-run health care systems.

Emerging Trends in Health Care

The keynote speaker, Mark McClellan, M.D., Ph.D., former Administrator for the Centers for Medicare and Medicaid Services (CMS) and former Commissioner of the Food and Drug Administration, opened the symposium with a broad-ranging introduction to some fundamental trends in health care that will shape health care and payment systems in the coming years. **Markets as opposed to a single-payer government system, according to Mark, have a critical role to play in achieving the goal of the best health care at the lowest cost. At the same time, there is a role**

for government in assisting vulnerable populations in taking advantage of the numerous choices that competitive forces create.

The first trend in health care is that **treatments will become more individualized for patients.** The new sciences, such as nanotechnology, genomics and biomedical advances, will open up new personalized solutions that are unique for each individual. **The second trend is that the range of medical treatments available is becoming increasingly diverse, complex and potentially costly.** Health professionals, rather than ordering procedures and dictating care, will be having dialogs with patients about the potential care options, carefully weighing the risks (including costs) and benefits of care. Mark emphasized that the new sciences have not yet had much of an impact, but they will.

The nature of care will be different in the future, with **much greater emphasis on wellness and prevention, as well as nutrition.** Traditional health care has not done a good job in emphasizing prevention. Too often the scenario has been: the wrong patient, the wrong treatment and at the wrong time. Treating problems after they become chronic is a losing game, squandering valuable health care dollars. The new driver of health care policy will be individualized prevention, catching diseases in the early stages and preventing them from progressing.

Payment Systems Must Change to Support Prevention

When Mark took the helm of CMS in March 2004, 90% of the dollars in fee-for-service Medicare were spent on disease and disease complications. Mark heard from doctors who had made changes in their practices to emphasize wellness, prevention, and personalized care, as well as to reduce duplicative tests and office visits. While these strategies were saving the overall system money by keeping people out of the hospital, the medical professionals who had implemented these changes were having a hard time financially. Basically, it simply did not make economic sense for these medical people to save the system money when these efforts were not rewarded by Medicare. Medicare pays more when there are complications, duplicative tests and numerous office visits. **Medicare was punishing the very type of care that it should have been supporting.** A patient population with robust health should not be economically devastating for a

physician's practice.

Mark noted that the **same kind of backward incentives are at work in third party payment systems**. The cost incentives are not functioning in a way to support preventive treatments that will save the individual payers and plans health care dollars, as well as the overall health care system.

The twentieth century style of health care that focuses on disease treatment must be replaced with the new model of prevention.

Mark reminded the audience that **health care costs = price x quantities**. **The current prices are not increasing as much as the quantities (utilization) are throughout the world**. **Innovative strategies are needed to reduce quantities and improve health care value.**

One physician at the symposium gave his personal experience with the health care reimbursement system in the US. He noted that for certain conditions if he keeps a patient in the hospital more than 3 days he will not receive any payment, despite the fact that the patient needs additional inpatient care and will require hospitalization a few weeks later with a more expensive complication; for other conditions if he fails to keep the patient in the hospital for at least 7 days, he will not receive any payment, despite the fact that the patient no longer needs inpatient care. Rigidity in payment methodologies is very costly.

Customized Plans Needed to Transform Health Care

Mark referenced his experience with the Medicare Part D program as an example of how market competition and the ensuing choices offered by private companies resulted in a government program that is currently 30% to 40% below the original cost projections – unheard of for a government program. Medicare beneficiaries found the plethora of choices for Part D plans frustrating, but the result was that people were able to choose the type of plan that was right for them. No one selected the standard plan originally envisioned by the government; instead, Medicare beneficiaries examined their needs and chose plans to satisfy those specific needs. The emphasis on transparency of drug prices in local pharmacies also was instrumental in helping people lower their costs by switching to generic drugs.

One of the lessons learned from the Medicare Part D program is that a single standard set of benefits does not work near as well as abundant choices that give personalized options. Choices result from market competition, not a single payer.

Another lesson learned from the Medicare Part D program was the role of reinsurance in addressing adverse selection. The government used reinsurance mechanisms to limit the exposure of private companies that created Part D programs that would attract costly risks. Companies with programs attracting primarily healthy 65-year-olds received far less payments than those with programs attracting 85-year-olds with multiple chronic ailments.

In answer to the question: Is there a role for markets in health care? Mark gave a "qualified yes." **A mix of government involvement and market competition will be essential in shaping a new health care delivery system, as well as a new reimbursement structure that supports individual choice and delivers value.**

Note: Many TPAs are already laying the foundation for the transformation in health care by designing and implementing innovative wellness programs. The SPBA Fall Meeting in Salt Lake City, Utah, September 26 -28, will explore these new programs.

Alert to Stop-Loss Community

Policy thinkers in both political parties are carefully watching the effectiveness of the risk adjustment mechanism in the Medicare Part D program and potentially are looking to broaden this approach into other insurance markets. Stop-Loss companies and TPAs should be thinking about market-based ways to better handle adverse selection.

Warnings Heard for Single-Payer Systems

Canadian Perspective

Brett Skinner, Director of Health and Pharmaceutical Policy Research, The Fraser Institute in Canada, provided the Canadian perspective.

Key points from Brett's presentation follow.

>> Canada's single-payer health system is sick and Americans should avoid it like a plague.

>> The Canadian experience shows that a single-payer health insurance system will damage the quality and availability of medical care in the US, just as it has in Canada.

>> Health care only appears to cost less in Canada than in the US. This is because Canadian public health insurance does not cover many advanced medical treatments and technologies that are commonly available to Americans. Canadian patients do not get the same quality or quantity of care as American patients. On a comparable basis, Canadians have fewer doctors, less high-tech equipment, older hospitals, and obtain fewer advanced medicines than Americans.

>> Since the 1990s, thousands of Canadian-trained and previously active physicians have left Canada for better opportunities & working conditions in the US. American doctors do not leave to work in Canada.

>> If Canadians had access to the same quality and quantity of health care resources that American patients enjoy, the Canadian single-payer health insurance system would cost a lot more than it currently does.

>> In 1993, Canadian patients waited on average 9.3 weeks between the time they saw their family physician and the time they actually received specialist treatment. By 2006, that wait time had nearly doubled to 17.8 weeks. Median wait times in Canada are almost double the wait times that physicians consider clinically reasonable.

>> The Canadian government does not publish the number of patients who wait and are not able to get necessary medical treatment within each year. But in 2005, a survey of Canadians showed that, of the patients who finally did get access to health care services within the year, 11 percent waited longer than three months to see a specialist; 17 percent waited longer than three months to get necessary non-emergency surgery; and 12 percent waited longer than three months to get necessary diagnostic tests.

>> Americans concerned about health care costs should know that the Canadian single-payer system is not financially sustainable. There is a growing consensus among government and private-sector researchers in Canada that because public-health spending is growing so much faster than public revenue, every one of Canada's 10 provinces is on a path to fiscal disaster.

>> American health professionals should be afraid of a single-payer system. After adjusting for the purchasing power of the currencies, Canadian nurses earn only two thirds as much as American nurses and Canadian physicians earn only 42 percent as much as American physicians. After adjusting for inflation, average income for physicians in Ontario (Canada's largest province) has actually declined to 75 percent of its peak 1972 level. Canada's public monopoly exploits the services of medical labor by holding down wage rates below what they would normally be if there weren't a single-payer system.

>> In a 2005 case challenging the province of Quebec's government-run health insurance monopoly, the Supreme Court of Canada struck down the single-payer system as a violation of patients' rights to preserve and improve their own health because of long waits to get treatment. A similar case is currently underway in two other Canadian provinces where the plaintiffs are seeking to expand the Quebec precedent on the basis of nationally applicable constitutional rights.

>> Canadians are currently witnessing the failure of their health insurance system and are beginning to reject it. The Canadian experience shows that a government-run single-payer monopoly is the worst way to achieve universal health insurance coverage.

British Perspective

Helen Evans, Ph.D., provided the British perspective. Helen is a senior nurse with nearly twenty years experience in the National Health Service (Britain's government-run health system) and is director of Nurses for Reform, which campaigns for more consumer-oriented and sustainable health care systems in Britain. Helen also holds a Ph.D. in health economics.

Key points from Helen's presentation follow.

>> Britain's government health care system has proven to be one of the greatest public policy failures in modern history.

>> After nearly six decades of epic Soviet-style failure, the National Health Service finds itself in a perilous state. Britain has about one million people on its waiting lists and another 200,000 people trying to get on them.

>> Due to the waiting lists, Britain has seen the emergence of a private health care sector. Today, more than 6.5 million people have private medical insurance, 6 million have private cash benefits, and 8 million pay privately for a range of complimentary therapies.

>> In 2000, Tony Blair's government signed an agreement with Britain's private hospitals, allowing, for the first time, state funded patients to receive treatment and care in private hospitals.

>> Recently, the government has stated that it encourages all NHS hospitals to return to the private sector as Foundation Trusts, allowing them to attract capital and investment.

>> The National Health System is governed by a body that seeks to provide a scientific basis for the rationing of drugs and other forms of treatment. The criteria by which this agency makes its decisions are kept secret from the general public. No one knows how it makes its decisions or the value judgments that guide the process.

Swedish Perspective

Johnny Munkhammar, M.Sc., the program director at Timbro, a Swedish policy research institute, provided the Swedish perspective. He is the author of four books on economic policy and has published numerous reports and papers on economic issues.

>> During the decades following World War II there was a general belief in Western Europe that a centrally planned economy would be efficient. Today, we know the opposite to be true. In building the welfare state – or the “social model” – politicians found a great task that would win elections for them.

>> One often stated aim of having health care run by and paid for by the state has been to ensure universal access to health care, particularly the poor. In fact, the result has been the opposite. Due to lack of competition, monopolies have no incentives to be efficient, adapt new technology or reorganize. Consequently, the taxpayers get less for their money. And since tax pressure has definitely hit the ceiling in Western Europe, there will be no expansion of health care funding despite such services being highly in demand. Health care is in effect being rationed. This rationing will only get stricter.

>> It is patients who suffer from European government's ideological attachment to centrally planned health care. In Sweden, this attachment has recently resulted in some perverse outcomes. Patients have been sent to veterinarians in order to circumvent waiting lists, since veterinarians are private and there is a large supply. Many people go to neighboring countries for dental care, despite having paid taxes to the public system for this care. The number of consultations by a patient per doctor has fallen from, on average, nine per day in 1975, to four per day in 2001. Doctors devote 80% of their time to administration.

National Provider Identifier Numbers Available (these are NOT TINs)

Background

The final regulations on the National Provider Identifier (NPI) require health plans to be able to use the NPI of any health care provider that has been assigned an NPI on HIPAA EDI “standard transactions” no later than May 23, 2007 for non-small health plans and no later than May 23, 2008 for small health plans. A plan is a small health plan if the total medical expenditures of the plan for the last fiscal year are under \$5 million. Stop-loss premiums or reimbursements are irrelevant in the computation. For fully insured plans, only the premium cost counts (the source of the premium payment, whether paid by the employer or employees, is irrelevant). In early April 2007, the Centers for Medicare & Medicaid Services (CMS) announced a contingency plan for non-small health plans and other “covered entities” that will not meet the May 23, 2007 deadline. Under the contingency plan, “covered entities” that have been making a good faith effort to comply with the NPI provisions, may, for up to 12 months, implement contingency plans that could include legacy provider numbers on HIPAA standard transactions.

Will the NPI replace the taxpayer identification number?

No. Plans will have to maintain two separate numbering systems, one for IRS purposes and one for CMS purposes.