

# Policy Perspective

By John Steen

## Massachusetts, California, Pennsylvania....

The states keep trying to be accountable for their residents' healthcare needs, but they lack the authority to implement the structural changes in healthcare delivery necessary to achieve their aims, and so they must deal with a market-driven system for which the rules are set nationally by the industries profiting from the market. And so each state comes up with its own plan that protects those industries, insurance key among them, and requires its own citizens to pay most of the costs. This despite numerous polls showing that a majority of Americans wish to have a universal single-payer system "like Medicare."

So, how to see what is going on in California? Well, just last August, the California legislature passed a true universal healthcare bill (SB 840) that would have created one state fund for all the healthcare Californians need. But Gov. Schwarzenegger vetoed it to protect the role of private insurance companies, choosing instead to model his plan on that of Massachusetts. Credit him only with attempting to include everyone, even illegal immigrants, in his plan, and imposing community rating and an 85 percent minimum loss ratio (which already applies to HMOs in California) on insurance companies. In fact, his plan will likely cost the state's taxpayers an extra \$12 billion per year. SB 840 would save nearly that much per year!<sup>1</sup> It is comprehensive in its coverage, and includes full coverage for mental health, dental, vision, and prescription drugs. The governor's plan does not require employers to offer any minimum benefit. And it has \$7500 out of pocket costs for individuals and \$10,000 out of pocket costs for families, while SB 840 has neither out of pocket costs nor deductibles. On February 27<sup>th</sup>, State Senator Sheila Kuehl introduced it for the third time, but that's unlikely to be the charm given the need for a two-thirds approval vote (for tax provisions to fund it) in the legislature.

In Pennsylvania, Governor Rendell announced a plan similar to those already enacted in Maine and Vermont that would, if it receives legislative approval, go well beyond providing universal health insurance. It too employs a limited form of community rating, and an 85 percent floor on loss ratios for small group plans, but otherwise would protect the insurance industry, and unlike Massachusetts and California, it would not mandate all its residents' purchase of health insurance. Its 47 initiatives include new laws and regulations addressing quality of care and cost containment that will require legislative enactment and federal endorsement. Most provocatively of all, a system of regional boards composed of volunteer representatives from academia, health care, and business and insurance groups would be created to oversee the review of spending projects at hospitals to ensure that expansions or major equipment purchases were necessary.<sup>2</sup> In the future, the governor said the state intends to stop paying hospitals for treatment stemming from medical errors or preventable complications. Pennsylvania's legislature considered legislation last year for a statewide single-payer plan (HB 2722 / SB 1085) that wasn't acted upon, but will be introduced again this year.

All these state efforts may be moot if, as in Maryland, federal courts find their employer mandates to be inconsistent with ERISA's preemption of employer funded plans.

### **The American College of Physicians on "Healthcare Reform"**

In January, the American College of Physicians, which represents 120,000 internal medicine physicians and medical students, issued a proposal to place internists and family doctors at the center of patient care where they could provide the coordination and oversight that has been missing in U.S. healthcare. "Expanding health insurance is essential. But it is equally essential that we reform the way that care is organized, financed and delivered in the United States," said Dr. Lynne Kirk, the group's president.<sup>3</sup> And Robert Doherty, who manages government affairs and public policy for the ACP, cited Commonwealth Fund studies like the one reported on in our last issue ("U.S. Rankings on an International Report Card," *Health Planning Today*, 4<sup>th</sup> Quarter, 2006, pp.7-8), saying, "It's being done successfully in other countries." He pointed to the studies as evidence that health care quality in the United States often falls short of that seen in countries with nationalized programs, such as Britain, New Zealand and Australia. In the United States, the Department of Veterans Affairs' used this model with success, Doherty said.

The ACP report, *A System in Need of Change: Restructuring Federal Health Care Policy to Make Patient-Centered Care Available to All*, accessible at [http://www.acponline.org/hpp/statehc07\\_1.pdf](http://www.acponline.org/hpp/statehc07_1.pdf), identifies primary care oriented countries with nationalized systems as "consistently associated with better health outcomes, lower costs, and greater equity in care." It states that, "the United States rates the poorest on all aspects of experienced care, including access, person-focused care over time, unnecessary tests, polypharmacy, adverse effects, and rating of medical care received." (p.6) In January, 2006, the ACP reported that the U.S. is facing a collapse of primary care medicine.

An excellent set of observations and recommendations, but I wonder, does the ACP really now favor the model they've cited... nations in which healthcare is mission-directed, not profit-directed, and physicians work on government salaries, i.e., socialized medicine? For example, in socialized countries like the U.K. and Sweden, the ratio of a physician's income to that of the average worker is 1.4 and 1.5, respectively. For Canada, which has a single-payer reimbursement system for physicians, the ratio is 3.2. In the U.S., it is 5.5. If we were to restore ethical medical practice here, we might once again have the kind of physicians we once had.

The pricing practices of the medical industry depart sharply from the competitive norm . . . It is clear from everyday observation that the behavior expected of sellers of medical care is different from that of business men in general. These expectations are relevant because medical care belongs to the category of commodities for which the product and the activity of production are identical. In all such cases, the customer cannot test the product before consuming it, and there is an element of trust in the relation. But the ethically understood restrictions on the activities of a physician are much more severe than on those of, say, a barber. His behavior is supposed to be governed by a concern for the customer's welfare, which would not be expected of a salesman.

-- Kenneth Arrow, recipient of the 1972 Nobel Prize in Economics<sup>4</sup>

And what should be even more provocatively relevant to the right solution to our need for a true healthcare system is how satisfied its beneficiaries, the general public, are with it. The best working systems for us to use as models in designing one are the many European healthcare systems, and among all of them, which one gets the highest marks from its own people? Denmark's<sup>5</sup>... a socialized system.

### **Updated Quality Indicators**

State health regulators will wish to take note of the January 2007 updating of quality indicators issued by the Agency for Healthcare Research and Quality (AHRQ). The ones they will find most relevant to their state health plans, licensure, and CON criteria are those covering Coronary Artery Bypass Graft (CABG) volume and mortality rates, Percutaneous Coronary Transluminal Angioplasty (PTCA) volume and mortality rates, and Bilateral Cardiac Catheterization rates.

For CABG volume:

[http://www.qualitymeasures.ahrq.gov/summary/summary.aspx?ss=1&doc\\_id=8869](http://www.qualitymeasures.ahrq.gov/summary/summary.aspx?ss=1&doc_id=8869)

For CABG mortality rate:

[http://www.qualitymeasures.ahrq.gov:80/summary/summary.aspx?ss=1&doc\\_id=8875](http://www.qualitymeasures.ahrq.gov:80/summary/summary.aspx?ss=1&doc_id=8875)

For PTCA volume:

[http://www.qualitymeasures.ahrq.gov:80/summary/summary.aspx?ss=1&doc\\_id=8870](http://www.qualitymeasures.ahrq.gov:80/summary/summary.aspx?ss=1&doc_id=8870)

For PTCA mortality rate:

[http://www.qualitymeasures.ahrq.gov:80/summary/summary.aspx?ss=1&doc\\_id=8876](http://www.qualitymeasures.ahrq.gov:80/summary/summary.aspx?ss=1&doc_id=8876)

For Bilateral Cardiac Catheterization rate:

[http://www.qualitymeasures.ahrq.gov:80/summary/summary.aspx?ss=1&doc\\_id=8893](http://www.qualitymeasures.ahrq.gov:80/summary/summary.aspx?ss=1&doc_id=8893)

For area rates as well as all other quality indicators, see AHRQ's *Guide to Inpatient Quality Indicators: Quality of Care in Hospitals – Volume, Mortality, and Utilization* (February 20, 2006) at

[http://www.qualityindicators.ahrq.gov/downloads/iqi/iqi\\_guide\\_v30.pdf](http://www.qualityindicators.ahrq.gov/downloads/iqi/iqi_guide_v30.pdf). This Guide includes many specialized surgical procedures, indicators for 55 of which can be found at the AHRQ website: <http://www.qualityindicators.ahrq.gov>.

Quality measures are essential as a basis for limiting the capacity of services and equipment, and a 1999 *JAMA* article well documents the harm resulting from overutilization: <http://www.dartmouth.edu/~cecs/downloads/jsc80266.pdf>.

And the American Public Health Association has a new searchable Health Disparities Database containing projects and interventions aimed at the challenges presented in trying to improve the quality of healthcare and increasing the health literacy of the poor and of racial and ethnic groups and other underserved communities. It covers creating tools/assessments/audits to improve health care, creating private/public partnerships to fix health care disparities, and creating healthy communities by ensuring adequate infrastructure and resources:

<http://www.apha.org/programs/disparitiesdb/>.

## **Is Urban Healthcare Endangered?**

Observers have increasingly been noting the boom in new hospital construction in affluent suburban areas while inner city hospitals are closing. As hospital construction costs escalate, hospitals must secure an ever higher proportion of well-paying patients in order to make that construction financially feasible. A 2005 study in the *New England Journal of Medicine* found that 16 percent of city-based public hospitals were lost between 1996 and 2002.

Meanwhile, President Bush's proposal to reduce the rate of growth in Medicare and Medicaid spending has the potential to severely strain hospitals that serve large numbers of poor and uninsured patients. Medicare spending will grow at an annual rate of 6.7 percent rather than 7.4 percent if there were no downward adjustment.

For these and related reasons, state regulators are challenged to find ways of maintaining a full-range of adequate hospital services in urban areas, and regionalization of specialized services in major urban centers with sufficient volume is a win-win situation for the public interest in such areas. It can at once both improve outcomes and enhance revenues for the urban centers. But what about rural hospitals? A recent study<sup>6</sup> in New York State looked at what will happen to smaller rural hospitals if patients needing "high-risk" operations are transferred or directed to larger medical centers. Small hospitals were defined as less than 50 beds, and high-risk operations included 6 procedures for which there is a documented volume-outcomes association: abdominal aortic aneurysm repair, carotid endarterectomy, colectomy, cystectomy, esophagectomy, and pancreatectomy. Estimated average contribution to hospital net revenue for all procedures was approximately 2 percent, nearly all attributable to colectomy. The study authors concluded that small rural hospitals would not experience an unsustainable economic loss with a shift of high-risk operations to larger hospitals.

## **Specialty Hospitals**

Regulators have been suitably critical of the establishment of specialty or "boutique" hospitals as selectively treating lower risk patients, raising concerns about patient safety and quality issues due to their lacking a full ED compared to general hospitals, their impact on the revenues of general community hospitals, and their effects on service utilization with its cost implications. A recent observational study of outcomes showed that Medicare patients who underwent coronary revascularization procedures at specialty hospitals had no outcome advantage over those treated at general hospitals, after adjustment for patient characteristics and hospital procedure volumes. And several studies have documented the validity of all of those concerns save for the last. Now an article<sup>7</sup> in *JAMA* shows the cogency of the last concern. It highlights the effects within specialty-hospital regions of physician financial incentives and growth in procedure rates at nonspecialty hospitals due to new competition.

The authors analyzed data from 1995 through 2003 on Medicare beneficiaries in three types of hospital referral regions: 13 where new specialty cardiac hospitals opened during that period, 142 where new cardiac programs opened at general hospitals, and 151 where no new cardiac programs started. In 1995, rates of both coronary artery bypass grafting (CABG) and percutaneous coronary intervention (PCI) were statistically similar among the three types of regions. From 1995 to 2003, the rate of total revascularizations grew significantly more in regions with newly

opened specialty cardiac hospitals than in the other two types of regions. Within 4 years after specialty hospitals opened, the relative increase in revascularization procedures within those regions was 19.2 percent, compared with 6.5 percent and 7.4 percent in each of the other two types of regions. This significant difference was reflected in both the relative decline in CABG over time (–4 percent in regions with new specialty cardiac hospitals vs. about –19 percent in the other regions) and in the relative increase in PCI (+35 percent vs. +23 percent); the latter was due entirely to PCI in non-emergency patients without acute myocardial infarction (+42 percent vs. +24 percent).

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<sup>1</sup> See the Lewin Group analysis at <http://singlepayernow.net/sb840/summary.pdf>.

<sup>2</sup> Maine's 2003 plan included a greater cost containment role for CON through the imposition of a state spending cap against which applications are reviewed.

<sup>3</sup> In March 2007, the National Association of Community Health Centers released a report that found that 56 million Americans lack access to basic medical care because of a local shortage of primary health physicians. The report, *ACCESS DENIED: A Look at America's Medically Disenfranchised*, found that 52 percent of uninsured Americans are without a primary health care provider, but most Americans who don't have access to a primary health care source actually do have health insurance. For the press release: <http://www.nachc.com/press/03162007accessdenied.asp>.

<sup>4</sup> "Uncertainty and the Welfare Economics of Medical Care," *The American Economic Review*, 53 (5), December, 1963, 949-950.

<sup>5</sup> E. Mossialos, "Citizens' Views on Health Care Systems in the 15 Member States of the European Union," *Health Economics*, 1997, 6:109–16.

<sup>6</sup> Chappel AR, Zuckerman RS, Finlayson SR. "Small Rural Hospitals and High-Risk Operations: How Would Regionalization Affect Surgical Volume and Hospital Revenue?" *J Am Coll Surg*. 2006;203(5):599-604. Only 14 small hospitals were included in the study which covered the years, 1998-2001.

<sup>7</sup> Brahmajee K. Nallamotheu, Mary A. M. Rogers, Michael E. Chernew, Harlan M. Krumholz, Kim A. Eagle, John D. Birkmeyer. "Opening of Specialty Cardiac Hospitals and Use of Coronary Revascularization in Medicare Beneficiaries," *JAMA*, 2007;297:962-968. <http://jama.ama-assn.org/cgi/content/abstract/297/9/962>