TheHealthCareSuMMit

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Guiding Principles to Protect and Improve the Health Status of All Americans

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Introduction:

The HealthCare Summit is an organization of the general public, Non-Governmental Organizations, health insurance professionals, State Government and public service sector organizations. The membership is experienced in dealing with the costs and benefits of health care coverage.

The guiding principles of the HealthCare Summit are to protect and improve the health status of all Americans. The best solutions offer choice and flexibility to health care consumers by integrating the strengths of the public and private sectors. We recognize the necessity to expand essential health care coverage to all Americans and realize that any reform must include an emphasis on the uninsured. We believe the way to achieve significant reform is for all participants to accept their responsibility as providers, consumers, insurers and regulators of health care services and to embrace change that establishes measures to ensure a high quality, cost effective system that is financially viable, sustainable and fair. The public and private sectors must also address their responsibilities to provide a system that allows for consumer choice, and emphasizes wellness, prevention, education, and consumer empowerment.

The HealthCare Summit encourages policy makers to create an environment through which all Americans may obtain affordable health coverage utilizing public and private sector market forces. The United States legislative and business environment is conducive to a coordinated public/private system which encourages individual responsibility rather than mandated coverage.

Reform must promote ongoing and long-term innovations that enable the United State's health care system to adapt over time to the evolving needs of its citizens. The HealthCare Summit recommends reform in separate, but related areas of healthcare financing, operations and service based on five (5) guiding principles.

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The five guiding principles of reform are:

1. *Reform must address and reduce skyrocketing medical care costs.*
2. *Reform must include transparency of medical information, including cost that will enable treatment choices.*
3. *Reform must include public and private wellness promotion initiatives.*
4. *Reform must guarantee that all Americans have access to health care coverage, which includes health insurance and other alternatives; and must preserve or improve the current health insurance coverage or alternatives that provide benefits to 85% of Americans.*
5. *Reform must provide a source of coverage for the uninsurable populations of the United States.*

Guiding Principles - Discussion:

1. Reform must address and reduce skyrocketing medical care costs.

The key to the success of any health care reform plan is its ability to address the true underlying problem with our existing integrated public and private system—the cost of health care. True accessibility to health care and private health insurance coverage is dependent upon whether or not it is affordable. Constraining skyrocketing costs is a critical aspect of health care reform.

Statistical evidence supports what the National Association of Health Underwriters (NAHU) has observed relative to the economic impact of health care spending. In 2006, health care spending in the United States exceeded $2 trillion and accounts for 15.9 percent of the gross domestic product (GDP). This is an increase from $1.3 trillion and 13.3 percent of GDP in 2000 and health care spending is continuing to rise. Costs are projected to exceed $2.7 trillion and 17 percent of GDP in 2010. Furthermore, the annual increases in national health care spending consistently outpace both the rate of general price inflation and the average U.S. household income. According to a 2005 study by Hewitt Associates, LLC, health care cost increases have averaged 12 percent per year since 2000. During the same time, increases in the Consumer Price Index have averaged 2.7 percent and the U.S. household income 3.7 percent.

There are many reasons health care costs are skyrocketing, among them, uncontrollable issues like an aging population. New medical technologies and pharmaceuticals also contribute to rising health costs. However, today the

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majority of health insurance dollars are not spent to pay for health care services. Research by the Kaiser Family Foundation, Maryland Healthcare Commission, Office of Management and Budget, Harvard School of Public Health and others, documents that most of the health insurance dollars are spent to process money; develop provider networks; regulate, accredit, litigate and monitor services; and to pay for services proven not to be effective. These dollars are more than are spent to pay for the delivery of services that prevent, diagnose and/or treat illnesses and injuries, including payment for effective safety oversight.

The following areas are ones where if improved the U.S. health care system could achieve lower costs, greater efficiency, enhanced quality and provide better access.

A. Administrative Overhead, Regulatory Expenses, Benefit Mandates, Unnecessary Services, Fraud:[i]

Research by the Office of Management and Budget shows that an average of 15% of health insurance premium is retained by insurance carriers to cover administrative expenses and an additional 6% is spent by health care providers to comply with the regulatory and accreditation requirements. Research by the Kaiser Family Foundation and the Maryland Healthcare Commission documents that an additional 5% of the premium is used to pay for mandated benefits not proven effective, for non-essential personal life-style choices and for non-patient care services. Price Waterhouse Coopers research documents that an additional 10% of premium goes to pay for litigation costs to process alleged malpractice complaints, including defensive medicine costs.

In addition, practice profile research suggests that an additional 10% of health insurance premium is spent on services and procedures not relevant to the prevention, diagnosis or treatment of illness or injuries. Office surveys confirm that an additional 3% of the premium is spent by providers for administrative expenses related to processing claims and contracting with carriers and provider networks. The White Collar Crime Division of the FBI reports that 10% of premium is spent on fraudulent claims and services.

The total of the above expenses is 59%. Controlling these costs via health care reform could potentially reduce many of these expenses significantly.

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B. Medical Malpractice[ii]

The amount health care providers must pay for medical liability insurance coverage is on the rise, which has directly impacted health care costs in this country. An additional costly side effect of rising medical malpractice insurance rates is the cost of defensive medicine (when doctors order more tests, prescribe more medication and make more referrals than they believe are necessary to protect themselves from being accused of negligence). Since 1975, when medical malpractice insurance data was first separated from other types of liability insurance, medical malpractice cost increases have outpaced other tort areas, rising at an average of 11.7 percent a year. In 2004 medical malpractice costs totaled over $28.7 billion, up from about $26.5 billion the previous year. Medical liability costs and defensive medicine combined, currently account for 10 percent of medical care costs.

Extensive independent research documents that:

- Negligent and substandard physician, other health professional and hospital acts occur. However, negligent acts are far less common and more difficult to identify than originally thought. In the largest study of hospitalized patients (30,000 patients studied by the Harvard Law School) adverse events occurred in 3.7% of the patients. However, negligence occurred in only 1% of the patients and physician, nurse or other hospital staff negligence occurred in only 0.3% of the patients (3 out of every 1000 cases).
- The malpractice complaint process is inefficient, ineffective and unpredictable. It takes an average of 4.88 years to process injury claims in America (2006). Sixteen times as many patients suffer an adverse event from negligence as receive compensation using the tort system. For every dollar award paid to successful malpractice claimants, litigation and administrative overheads consume 60%.
  Only 40% of every dollar is paid to the patient and only 29% of the patient's share is used to pay for medical expenses (11% of the total).
- There is no association between compensation and the occurrence of an adverse event due to negligence or an adverse event of any type.
- The size of the settlement or jury award is based on the severity of the patient's disability, not the occurrence of an adverse event or an adverse event due to negligence.
- The malpractice complaint process has serious unintended complications. Physicians order medically unnecessary procedures

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and tests believing that this will help in their defense. Some of these unnecessary procedures and tests cause the patient injury or illness. All of these procedures and tests add to the already high cost of health care.

- This fault based system which relies upon public, adversarial proceedings to address patient claims introduces anxiety, distrust and second-guessing into the physician-patient relationship which should be one of trust, confidence and patient involvement in the decision-making processes. Court actions for medical negligence take a considerable toll on the emotions and resources of both patient and provider.
- The tort system has not been successful in effecting meaningful improvement to the patient care process or accomplishing significant reduction in the incidence of patient injury. This is partly due to the random nature of medical malpractice litigation which signals to health care providers that the likelihood of being sued for medical negligence is related to statistical chance rather than the quality of health care rendered.

In conclusion, the current malpractice complaint process using the tort resolution option is expensive, lacks a nexus, and is inefficient and ineffective.

C. Service Delivery Inefficiencies and Quality Gaps:[iii]

Service delivery inefficiencies lead to unnecessary use of expensive emergency department services, poor communication, delays of diagnosis and treatment, adverse drug events, redundant medical test and medical errors, all of which increase morbidity, mortality and cost.

For example, the National Center for Policy Analysis (NCPA.org) reports that the total cost of unnecessary emergency room visits and unnecessary physician office visits is just under $31 billion annually, or about $300 per American household per year. They also note that “patient medical records are often handwritten and are usually maintained and stored separately by each physician, clinic or hospital used. Consequently, conditions affecting the patient may be unknown at the time of treatment. Because most patients see a number of physicians over time, care is fragmented, and doctors and other medical providers often must treat a patient with limited information. This lack of care coordination often leads to medical errors, adverse drug events and redundant medical tests.”

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According to research published in The Journal of the American Medical Association, during a 20-minute office visit, physicians spend less than one minute planning treatment on the average. In addition, more than two-thirds of the public (72 percent) think 'insufficient time spent by doctors with patients" is one cause of preventable medical errors, and three-fourths (78 percent) think that the occurrence of medical errors could be reduced if physicians spent more time with patients. Unfortunately, according to 2007 research published in The Healthcare Economist the authors conclude that "while time spent by the patient and physician on a topic responds to many factors, time of the visit overall is much less malleable". The authors further conclude that financial compensation is a factor directly affecting the time of the visit.

Quality gaps costs lives and money according to the National Committee for Quality Assurance (NCQA). In their 2006 report the NCQA states that "low quality care leads to an estimated 64.7 million avoidable sick days; the equivalent of 270,000 full time employees and to $10.6 billion in lost productivity. In the same report the NCQA states that yearly unexplained variation in care in the treatment of selected measures and conditions results in between 37,600 and 81,000 avoidable deaths and between $2.6 billion and $3.6 billion in unnecessary hospitalization expenses.

2. Consumers must have transparency of medical information, including cost, that will enable treatment choices.

Americans are consistently using health care services more and more, which has a tremendous impact on health insurance premiums. In a report prepared by PricewaterhouseCoopers on behalf of America's Health Insurance Plans entitled *The Factors Fueling Rising Healthcare Costs 2006*, "higher utilization of services accounted for 43 percent of the increase, fueled by factors such as increased consumer demand, new and more intensive medical treatments and defensive medicine, as well as aging and unhealthy lifestyles." Americans need to become more engaged as consumers. Informed shoppers are more efficient consumers and efficient consumers spend less money.

3. Reform must include public and private wellness promotion initiatives[iv].

Unhealthy behavioral and lifestyle choices contribute significantly to the cost of health care. Research shows behavior is a significant determinant of health status with as much as 50 percent of health care costs attributable to individual behaviors such as tobacco, alcohol, and drug use, poor diet and a lack of exercise.

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Increasing numbers of Americans are obese, often starting in childhood as a result of poor eating and exercise habits. According to the National Center for Health Statistics, 30 percent of adults (more than 60 million Americans) are obese, a 10 percent increase in the past decade. Research has also shown tobacco use is responsible for approximately 7 percent of total U.S. health care costs. These behaviors lead to many serious chronic health conditions such as cancer, diabetes, heart and cardiovascular disease. Consumers are seeking medical solutions for these lifestyle issues rather than correcting unhealthy behavior.

4. Reform must provide programs for uninsured Americans, while preserving the current health insurance programs that provide benefits to 85% of Americans[v].

In 2006, 85% of Americans had health insurance coverage, leaving 15% uninsured. Demographic information reveals that 19.4% of the uninsured in America have incomes between 100% and 200% of the federal poverty level (FPL). Therefore most of this segment of uninsured are eligible for Medicaid, but not enrolled. While mass enrollment may be challenging, attempts to identify and cover this population is extremely important. If coverage for all is the goal, then locating, enrolling and funding for this population must be achieved.

Other segments of uninsured include the Low Wage Workers (LWW) defined as working individuals earning between 60% and 250% of FPL and the "irresponsible uninsured" who have the access and income to purchase health care coverage, but do not (39% of America's uninsured have income levels above 200% of FPL, $40,000 for a family of four).

The largest percentage of the uninsured, 58.2%, are young adults ages 18 to 44. This population is arguably the healthiest segment of our society. Because this segment also spans all socio-economic categories, any meaningful reform must address this population.

5. Reform must provide a source of coverage for the uninsurable populations of the United States[vi].

The uninsurable populations in the United States are persons who cannot qualify for health insurance because of a physical or medical condition. This group includes individuals who lost their coverage through reasons other than failure to pay their premium, certain individuals who move from state to state and individuals who have acquired disqualifying illnesses or injuries.

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