

DRAFT Legislative Concept

This document is intended simply to help organize our thinking and to provide a vehicle through which we can begin to incorporate the ideas and perspectives of the major stakeholders into a common framework. It is intended to serve only as the starting point for an ongoing discussion.

Relating to health care and the health of all Oregonians; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Preamble. The outdated federal policies enumerated in Section 4 of this 2007 Act were enacted over the past 50 years and increasingly jeopardize the health of our population, undermine the strength of our economy and put at risk the future of our children. It is the goal of this 2007 Act to maximize the health of Oregonians and the value of the public resources spent on health care by amending these policies to create a sustainable system which reallocates the public resources currently being spent on health care according to the principles described in Section 8 of this Act.

SECTION 2. Assumptions. For the purposes of this 2007 Act, the Legislative Assembly makes the following assumptions:

- (1) The objective of our health care system is health, not just the financing and delivery of health care.
- (2) We cannot achieve the objective of “health” unless all Oregonians have timely access to a basic set of effective health services.
- (3) Public resources are finite and therefore the public resources available for health care are also finite.

(4) Finite resources require that priorities be set to determine what will and will not be financed with public resources.

(5) As with most other services, those with more disposable income will always be able to purchase more health care than those who depend solely on public resources.

SECTION 3. Findings. The Legislative Assembly finds that:

(1) The current health care system is unsustainable due to outdated federal policies reflecting the realities of the last century, rather than the realities of today and based on a set of assumptions which are no longer valid.

(2) The ability of states to maintain the health of their citizens is increasingly constrained by these federal policies which were built around “categories” rather than a commitment to ensure all citizens have timely access to effective health services.

(3) These policies, which were established through three specific acts of Congress in the last century, were enacted separately at different times for different reasons and reflect no sense of common purpose.

(4) The economic and demographic environment in which these policies were created has changed dramatically over the past 50 years while these policies themselves continue to reflect a set of circumstances that existed in the mid-20th century.

(5) Any reform effort that fails to address the contradictions and inequities embodied in the federal policies enumerated in Section 4 and fails to bring them into alignment with the realities of the 21st century will also fail to achieve meaningful reform, perpetuating the status quo and the contradictions, inequities and consequences outlined in Sections 5 and 6.

(6) Any strategies for financing, mandating or developing new programs to expand access that fail to address what will be covered with public resources and how those services will be delivered will do little to stem escalating medical costs, make health care more affordable or create a sustainable system.

SECTION 4. Federal Policies. The federal policies Oregon seeks to amend in order to maximize the health of Oregonians and the value of the public resources spent on health care, include:

(1) **Employer sponsored coverage.** The Tax Reform Act of 1954 excluded the cost of employer sponsored health insurance from the definition of taxable income, thus granting a public subsidy to employer

sponsored coverage and creating the major private sector component of the current U.S. health care system.

(2) **Medicaid.** Medicaid was enacted in 1965 to improve financial access to health care for certain categories of poor citizens, primarily: poor women and children; those who are blind; and those with disabilities. Only those who fit into one of these categories are eligible for the program. In addition, Medicaid pays for the premiums, coinsurance, and deductibles for low income seniors who are covered by Medicare – as well as services like long term care which are not covered by Medicare -- giving these individuals “dual eligibility.”

(3) **Medicare.** Medicare was enacted in 1965 when poverty among the elderly was twice that of the general population and was intended to improve financial access to health care for older citizens. It is an entitlement program beginning at age 65 regardless of the income of the retiree and is financed primarily by taxes paid by those who are currently working. It covers acute care services but not long term care services.

SECTION 5. Federal Policies – Contradictions and Inequities

(1) Employer sponsored coverage.

- a) Since it was created over 50 years ago, the public subsidy of employer sponsored coverage has grown to over \$200 billion a year and is financed by all taxpayers including a growing number of workers who do not benefit from employer sponsored coverage.
- b) This subsidy is extremely regressive, meaning that it is more valuable to employees in higher tax brackets than to those in lower tax brackets.
- c) Since the creation of the system of employer sponsored coverage over a half a century ago, a highly competitive global economy has developed which increasingly puts U.S. businesses at a competitive disadvantage with businesses in other countries not burdened by the spiraling cost of providing health care to their employees.
- d) As the cost of health care continues to increase, the number of private sector employers offering health insurance coverage to their employees is steadily declining – currently at a rate of over four percent per year.
- e) As the cost of health care continues to increase, employers have shifted additional costs to employees through higher premium contributions, higher deductibles and other increases including co-insurance and co-payments, or have decreased benefit levels to help keep costs down.

f) Conflicts over the cost of health care are now a key element in virtually all labor disputes, often resulting in work stoppage and lost productivity.

(2) **Medicaid.**

- a) Because eligibility for Medicaid is based on “categories,” not strictly on financial need, current federal policy has created a distinction between the “deserving poor” – those who fit into a category; and the “undeserving poor” – those who do not. As a consequence, many poor citizens are ineligible for Medicaid even though they are deeply impoverished.
- b) There is a huge administrative cost involved with determining who is eligible for the 28 different Medicaid categories which exist today.
- c) Those who have “dual eligibility” in both Medicaid and Medicare account for only 13 percent of Medicaid enrollment but over 43 percent of program cost, making them the most expensive part of the Medicaid population. As the population ages, the number of those with “dual eligibility will increase substantially, driving up the cost of the program.
- d) Medicaid has become a backstop for the decline in private sector employer sponsored coverage. Twenty years ago 75 percent of those enrolled in Medicaid were receiving welfare, while today less than one fourth are receiving public cash assistance – most of them are workers and their families who simply have medical needs which they cannot afford.

(3) **Medicare.**

- a) Whereas 40 years ago those over the age of 65 constituted the single poorest segment of the population, today they constitute the single wealthiest segment, followed by those between 55 and 65. Yet all retirees are entitled to publicly financed health care paid for primarily by current workers, many of whom cannot afford health care for themselves and their families.
- b) Since Medicare does not cover long term care, those in need of such services must spend themselves into poverty in order to become eligible for Medicaid (“dual eligibility”) at which point their needs compete directly with those of poor women and children.
- c) Certainly there are many frail, elderly citizens who need and deserve publicly subsidized health care; but there are many children and working citizens who deserve exactly the same thing, but are eligible for nothing.

SECTION 6. Federal Policies – Consequences.

(1) The federal policies enumerated in Section 4 of the 2007 Act have resulted in the following consequences:

a) Misaligned Incentives

The incentives in the system are aligned to finance health care rather than to produce health. These incentives reward the use of procedures and technology to treat the medical consequences of disease and disability rather than to prevent it in the first place; encouraging the over utilization of resources with little regard for the health benefit produced, particularly from a population standpoint.

b) Rising Health Care Costs

Misaligned incentives, an aging population, a growing incidence of chronic disease, a financing structure which shields the true cost of treatment decisions from both providers and consumers; and advancing technology has led to dramatic medical cost inflation. Since 1998 the cost of health care has grown on an average **five times** as fast as general inflation, dramatically exceeding the growth in state revenues. The U.S. now spends over **two trillion dollars** on health care each year, **over \$5,200 per person** which far exceeds the amount spent by any other country in the world, many of which have far better population health statistics than does the U.S.

c) Cost Shifting

As cost increases, both employers and states are forced to drop people from insurance coverage, steadily driving up the number of uninsured citizens who cannot afford the cost of care. Many of these people delay seeking needed treatment until they are very sick and need higher and more costly levels of care, and then turn to hospital emergency rooms where federal laws require that they be seen and treated. The resulting uncompensated cost is then simply shifted back to public and private third party payers -- to government health care programs financed by taxpayers and to those employers offering health care coverage to their workers -- forcing them to drop more people from coverage, repeating the cycle.

d) Increasing uninsured

Over **18 percent or approximately 600,000 Oregonians** do not have health insurance. These individuals receive less care and receive it later than those with coverage – often when they are very sick – so on average they are less healthy and less able to function effectively in their daily lives. This pattern of delayed treatment shifts costs to those

- who do have coverage, creating a cycle that increases costs and makes health care unaffordable for even more Oregonians.
- e) Impact on Individual Oregonians
Rising health insurance premiums are far outpacing inflation and wages, which has caused wage growth to lag, thereby reducing take-home pay. In addition, nearly two in five adults now have difficulty paying medical bills – and nearly half of all individuals who file for bankruptcy do so due to medical expenses.
- f) Impact on the Health of Oregonians
Oregon falls short in maximizing the health of its citizens as federal policies have created a system where resources are continually focused on acute care. This neglects the significant contribution of prevention activities that improve quality of life, reduce of the burden of chronic illness, and reduce of the costs of acute and chronic disease management.
- g) Impact on Oregon Business
Employers have been faced with spiraling premiums or, in the case of large self-insured employers, unrelenting increases in medical claims costs. These increases have reduced the profitability and competitiveness of many employers and the wages they may pay their employees. Their response in many instances has been to reduce benefits or contribution levels, to pass the additional costs on to their employees through cost sharing, or to drop coverage for their employees or their employee dependents. According to the Medical Expenditure Panel Survey data, from 1996 to 2004, the number of private sector Oregon employers offering health insurance dropped from 61.5 percent to 52.7 percent.
- h) Impact on Oregon budget
Rising health care costs have had an increasing impact on the state's budget. While enrollment grew in the Oregon Health Plan during the 1990s, state revenues did not keep pace with the costs of providing health care services to an expanding population. During the recession and the subsequent budget crisis in the early part of this decade, the state was forced to cut or reduce essential health care coverage to thousands of Oregon's most vulnerable residents because it lacked the resources to pay for that coverage or competing priorities required the allocation of public resources to other areas. Many of those who lost coverage because of these actions ended up in the emergency room – often when they were very sick and needed more costly care – and the uncompensated cost was then shifted back to the state.

(2) Unless the federal policies enumerated in Section 4 of the 2007 Act are fundamentally changed, they will lead to the following consequences in the future:

a) Medicare Insolvency

The pending insolvency of the Medicare program is being driven by a huge demographic shift. Since 1900 the U.S. population has tripled while the population of those over the age of 65 has grown ten times and the population over the age of 85 has grown 30 times. Today 13 percent of the population of the U.S. is over the age of 65 but by 2030 20 percent will be over the age of 65. The fastest growing segment of the U.S. population is people over 100 and the second fastest is people over the age of 85.

Very high proportions of elderly persons and very high dependency ratios accompanied by continuing low fertility and very low mortality have profound social and economic consequences.

In 1957 a woman had, on average, 3.8 children. Today she has 2.0. During the last half century an extraordinarily large generation has been followed by an extraordinary small generation.

In March of 2005, the board of trustees for Social Security and Medicare warned that the Medicare trust fund will become insolvent in 2018. Trustees also reported that Medicare's expenditures will surpass Social Security's by 2024 -- and double them by 2079. Medicare's total unfunded liability was shown at \$65.4 trillion, with the new prescription drug benefit accounting for \$18.2 trillion. In 2004, Medicare accounted for 8 percent of all federal income taxes. This is estimated to rise to 19 percent in 2015, 32 percent in 2025, and more than 90 percent by 2075.

b) Currency Crisis and Loss of Self-Determination

The U.S. national debt is now approaching \$9 trillion and is escalating even as the population ages and while Congress is preoccupied with the solvency of the Social Security system, the real challenge is Medicare. The Social Security gap is around \$5 trillion but, by comparison, when baby boom generation reaches 65 the unfunded entitlement in Medicare will exceed \$65 trillion.

This staggering deficit is being financed largely by selling U.S. securities to China and to other countries still willing to purchase

them. If these nations decide to stop underwriting U.S. deficit spending we will face a currency crisis, a stock market crash and soaring interest rates. And while this may not happen in the immediate future because these other nations want our economy to remain strong so U.S. consumers can buy their goods and services – it is no longer our decision to make. We have handed much of our financial future over to some of our major international competitors.

b) Growing Market Instability

Over the last 12 years, the national percentage of private sector employees offering health benefits has dropped 32%, and the deterioration is accelerating. Between 1991 and 2000, the average erosion rate was 2.4%, but during the recent recession this erosion rate almost doubled, to 4.5%. In 2003, only 45% of private sector workers had coverage and current dynamics will make this number continue to decline.

Private sector coverage has largely cross-subsidized publicly-financed coverage over the past few decades, and the escalation of health care costs is forcing states and the federal government to cut back on Medicare and Medicaid allocations creating a growing conflict between the increasing demand for services and declining resources.

Private sector coverage alone provides about half of all health care dollars. As employer sponsored coverage continues to decline there will be a steady decline in the total amount of money available to buy health care products and services. Over time this will adversely affect the financial outlook of health care companies, negatively impacting their margin, stock price, market capitalization and credit. And because health care spending accounts for one out of every seven dollars and one out of every 11 jobs in the U.S., these disruptions in the nation's health care economy will cascade to the larger US economy, generating growing market instability.

(3) In order to maximize the health of our population and the value of our health care investments, Oregon must take immediate action.

SECTION 7. Request for Congressional Action. In order to meet the goal set forth in Section 1 of this 2007 Act, the Governor shall request from Congress authority for the State of Oregon to reallocate the public dollars currently being spent on health care within the state to create a

sustainable system which will maximize the health of Oregonians within the context of the principles described in Section 8 of this Act. The request for this authority shall be submitted within 180 days of legislative approval of this Act.

SECTION 8. Principles. The request to Congress described in Section 7 of this 2007 Act shall include a description of the contradictions and inequities of current federal policies; the consequences of these policies for the State of Oregon; and the following principles which will provide the context for reallocating the public resources currently being spent on health care:

- 1) Eligibility and Equity. All Oregon residents will be eligible for and have access to at least the same set of effective health services.
- 2) Population Benefit. Within the constraints of available public resources, the public will set priorities to maximize population health, seeking the greatest health benefit for the largest number of people.
- 3) Individual Responsibility. Individuals will have a responsibility to be wise stewards of limited public resources and be encouraged to actively participate in activities to keep themselves well and be involved in decision-making about their health.
- 4) Effectiveness. The relationship between health services and the desired health outcome will be backed by unbiased, objective medical evidence.
- 5) Efficiency. The administration and delivery of health care will use the fewest resources necessary to produce the highest quality
- 6) Explicit Decision Making. The criteria for decisions will be clearly defined and open to the public, including clear lines of accountability for the decisions themselves.
- 7) Transparency. The evidence used to support decisions about the prioritization of health services; the determination of quality; the measures of performance and outcomes; the prices paid for services; and the flow of resources will be clear, understandable and observable to the public.
- 8) Economic Sustainability. Expenditures of the publicly financed component of the health care system will grow no faster than the growth in general inflation.
- 9) Realigned Financial Incentives. Financial incentives will:
 - a) Encourage the coordination/integration of care and the use of best practices to improve outcomes and reduce inefficiencies.

b) Encourage practitioners to put their training and skills to the highest and best use. * [see p. 11]

c) Encourage the delivery of care to be appropriately matched with the training and expertise of the providers involved. ** [p.11]

d) Maximize the transferability of information.

10) Community-Based. The delivery of care will be organized to take place at the community level, emphasizing collaboration and coordination among the care systems, unless outcomes and/or cost can be improved at other locations.

SECTION 9. Implementation.

(1) Upon Congressional approval, the Governor shall direct the Oregon Health Policy Commission [or some other entity] to develop a plan for implementation consistent with the principles in Section 8.

a) The process of developing this plan must formally include, but is not limited to, the participation of the following stakeholders: [list]

b) The plan shall detail the administrative and governing structures of the new system on both the state and community levels, the process of benefit determination and performance measures.

c) The plan shall include a transition period detailing the changes, timing and resources necessary to implement the new system.

(2) Upon completion of the plan, but before its implementation, the Oregon Health Policy Commission [or some other entity] must conduct public hearings to allow the stakeholders and the public at large to compare the new system with the current system. These hearings must include, but are not limited to, an examination of:

a) The adequacy of the benefit level

b) The performance measures

b) The impact of the new system on employers

c) Transparency

d) Economic sustainability

e) The impact of implementing the new system on:

1. hospitals,

2. physicians

3. employers,
4. consumers, including those currently on Medicare,
5. insurers and health plans

f) Add

g) etc.

- (2) Following the public hearings, the Governor shall submit the plan to the Legislature. To implement the new system, the legislature must vote affirmatively to accept the plan and to authorize the release of funds required for implementation.

SECTION 10. Emergency Clause. This Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this Act takes effect July 1, 2007.

** This is an acknowledgement of the fact that many of the financial incentives in the current system are not aligned with the highest and best use of highly trained providers. For example, an endocrinologist should manage the endocrine needs of an entire community (say 50,000 people) rather than seeing uncomplicated diabetics in their office. They should be making sure that the best care is being delivered in the primary care offices. They should serve as team leaders, e.g. conducting group clinics for diabetes; evaluating the disease/case management system; seeing the most difficult patients; doing the strategic planning for the system; etc.*

*** This is an acknowledgement of the fact that in the current system, a lot of things being done by specialists can be done by primary care docs and a lot of things being done by primary care docs can be done by mid-level providers. Given the predicted provider shortage related to the looming increase in demand associated with the aging of the baby boomers, an effort will be made to utilize providers in a way which most appropriately utilizes their training and expertise.*