Oregon Business Council
Healthcare Task Force
December 6, 2004

A New Vision for Health Care

We have a serious problem in Oregon: our healthcare system is not working. The "symptoms" of the problem are apparent to everyone: rising costs, inconsistent quality and limited access to care for many Oregonians. There is an urgent need to take action to address these problems. As a first step to developing a "treatment" plan, we need to clearly understand the nature of the problem – the "symptoms" and the "diagnosis", or root causes of our problems. The purpose of this paper is to summarize our understanding of the problem, articulate a vision for the healthcare system, and recommend initiatives to move us toward our long-term goals. We hope that this will stimulate dialogue and collaboration and be a catalyst for change.

"Symptoms" – the problems we face

The healthcare system in the U.S. and Oregon is not delivering value. The U.S. spends much more than other developed countries, and costs have been increasing rapidly. The quality of care in the U.S., however, is inconsistent and often inadequate. Furthermore, our healthcare system leaves many people without access to care.

A few critical statistics demonstrate the magnitude of the problem:

- The U.S. spends 14% of GDP on healthcare vs. an average of 8% in other industrialized nations.[1]
- Health insurance premiums nationally rose 11.2% nationally in 2004. Although this was somewhat lower than the 2003 increase (13.9%), it was the fourth consecutive year of double-digit increases and far exceeded overall inflation rates. [See Figure 1]
- If costs continue to increase at 10% annually, the average cost per employee per year in the U.S. will rise from $6000 in 2004 to over $10,000 by 2010. [See Figure 2]
- The annual rate of increase nationally in total healthcare costs (not health insurance premiums) was 7.4% in 2003 vs. 10% in 2001. While this offers an indication of a slowdown, the rate of increase is still unsustainable.[2]

- Life expectancy at birth in the U.S. is 77 years – ranking 21st among OECD countries (n=30)[3]
- The Institute of Medicine estimates that 44,000 – 98,000 patients die in U.S. hospitals annually due to avoidable medical errors.[4]
- A recent study estimated that only 55% of recommended care – treatment guidelines based on scientific evidence -- is received by patients.[5]
- In a recent survey, more than half of consumers (55%) say they are dissatisfied with the quality of health care in this country -- up from 44% who were dissatisfied in a similar survey conducted four years ago.[6]
- In 2003, 45 million people in the U.S. were uninsured, an increase of over 5 million since 2000. The current total represents 16% of the total U.S. population. In Oregon, 562,000 were uninsured in 2003, an increase of 178,000 since 2000. The current total represents close to 16% of the total Oregon population.[7]

Why this is Important to the Business Community

The Oregon business community has identified healthcare as one of the most serious cost problem they face. The high cost of health benefits:

- Makes it more expensive for Oregon businesses to compete in a global market
- Reduces funds for business investment
- Dampens economic recovery and job growth
- Reduces funds available for cash compensation to employees.

The lack of consistently high quality care also is a serious concern. Employee productivity is reduced, and – much more importantly – lives are being lost. In addition, the lack of access to care for many Oregonians is unacceptable in our society.

In response to these concerns, the OBC Taskforce on Health Care was commissioned in the Spring of 2004 to understand the healthcare problem and determine if and how the OBC wanted to move forward on a healthcare agenda. [See Appendix for list of Task Force members.]

The Task Force had four primary objectives:

- Understand the healthcare problem in Oregon and the impact on businesses and the community
- Educate business and the community regarding the problem and its impact

- Develop a long-term vision and principles
- Develop and prioritize short-term proposals and a long-range plan that are consistent with the vision

Overview of the Healthcare System

In order to analyze the nature of the problem, it is helpful to understand the basics of the U.S. healthcare system. A few key facts:

- We spend $1.8 trillion on healthcare annually in the U.S.[8]
- The largest % of healthcare costs are spent on hospitals (31%) and physician services (22%). [See Figure 3]
- Those 65+ use 3-5 times more healthcare services than those under 65. [See Figure 4]
- The sickest 10% use 69% of all services. [See Figure 5]

"Diagnosis" – the root causes of the problems

The healthcare system is badly broken and needs fundamental change. The system is fragmented and filled with the wrong economic incentives. The system has limited incentives to improve efficiency or quality, and it is not clear who has responsibility or accountability for making it better.

From one perspective, the system does provide exactly what it is "designed" to do: compensate physicians, hospitals and other providers for providing units of service, and protect people from the potentially high costs of medical care. From another perspective, however, the healthcare system isn't really a "system" at all. It has evolved incrementally without an overarching design. As a result, incremental change won't work; we need to change the fundamental "rules of the game".

The healthcare market is not structured to deliver good value. In a well-functioning market, consumers would be cost-conscious, knowledgeable and active in demanding ***value***: access to high quality care at an affordable cost. Providers -- physicians, hospitals and other providers -- would have strong economic incentives to deliver value to consumers. Why does the healthcare market not produce good value? To answer this question, one possible approach is to identify the "villains" who are responsible for the problems in healthcare: increasing costs, poor and inconsistent quality, and deteriorating access to care. We believe it is more productive to understand how the system works and what incentives exist for the key actors.

The problems can be traced to issues on both the demand side and supply side of the healthcare system.

Demand-side Factors

Much of the increase in healthcare costs is driven by demand for services. Several critical factors are fundamental drivers of this increase.

For most consumers, healthcare costs are covered by employer-based insurance coverage. These benefits are usually quite comprehensive with relatively low employee cost sharing, especially in large employers. This is true for the costs of insurance premiums as well as costs at the point of service. (Although more cost-shifting is now occurring from the employer to the employee, this is seen primarily in the small employer market.) The comprehensive nature of employee benefit plans is driven by the tax favorability for employer-based health benefits, competition to hire and retain employees, strong union contract negotiations, and legislatively mandated benefits. As a result, most consumers are shielded from the real costs of healthcare. In this situation, consumers lack incentives to manage their demand for healthcare services. Furthermore, they lack strong economic incentives to shop for efficient healthcare providers.

A few key facts demonstrate this point:

- In the U.S., only 14% of total health expenditures are paid out-of-pocket by consumers. The remainder is paid by private insurance and public programs.[9]
- The percentage of premium paid by employees for single coverage in the U.S. has declined from 20% in 1993 to 16% in 2004. The percentage of premium paid by employees for family coverage in the U.S. has declined from 32% in 1993 to 28% in 2004 [See Figure 6]

Compounding this problem for consumers is the lack of useful comparative data regarding the costs and quality of healthcare services. In addition, consumers are often not in a position to make informed decisions about the diagnosis and treatment of diseases, and they usually rely on providers to tell them what medication or treatment is needed. (An extreme case of this is when an unconscious accident victim is rushed to a hospital emergency room and is given whatever treatment the attending physician feels is needed.)

Furthermore, the consumer and employer segment is somewhat fragmented. It is true that employers, unions, private insurers and the government serve as "payors", i.e., collective purchasers of healthcare on behalf of consumers. Most payors have not, however, effectively exercised their influence on providers to deliver value.

Finally, several other important factors are driving consumer demand. In particular:

- The aging of the population, both in the workforce and those 65+.
- The increase in the number of people with chronic conditions. (It is estimated that five conditions (heart disease, mental disorders, pulmonary disorders, cancer and trauma) have driven 31% of cost increases over the past 15 years.)[10]
- Unhealthy lifestyles, exacerbated by limitations on public health initiatives. For example, it is estimated that 21% of Americans are obese; the same proportion applies in Oregon. Over 50% are considered obese or overweight in the U.S. and Oregon. Severe obesity nationally has grown 200% since 1990.[11] The estimated U.S. medical costs due to obesity & overweight conditions were $93 billion in 2002.[12]
- Direct-to-consumer advertising, especially for new technology and drugs

Supply-side Factors

The providers – physicians, hospitals and other care-givers – have a major role in driving healthcare costs and quality. While a certain level of consumer demand is given, providers are very influential in deciding how most diseases should be treated. This is due to:

- Consumers' trust and reliance on providers to tell them what medication or treatment is needed.
- Consumers' lack of economic incentives to shop for efficient healthcare providers

In general, most payors – employers, insurers, etc. -- also defer to provider decision-making. Combined with the fact that consumers are largely shielded from costs, this deference results in limited economic incentives for providers to compete or deliver value based on efficiency and quality.

Most providers – especially physicians – are paid on a fee-for-service basis. This compounds the effects of rising consumer demand. For a physician to be successful financially, he or she is driven to provide a greater number of services. While this may result in improved health outcomes in many cases, it also can provide an incentive to provide more services than are necessary. In some cases, over-treatment can also cause poor medical outcomes.

Few people outside of the healthcare system realize that there is tremendous inconsistency and variation in the delivery of health care. A team of clinical researchers concluded that "studies over the past decade show that some people are receiving more care than they need, and some are receiving less.

Simple averages from a number of studies indicate that 50 percent of people received recommended preventive care; 70 percent, recommended acute care; 30 percent, contraindicated acute care; 60 percent, recommended chronic care; and 20 percent, contraindicated chronic care." [13] Another expert observed that "per enrollee Medicare spending in various regions of the country to vary by a factor of about three, even after statistical adjustments for interregional variations in the age-sex composition of the Medicare population, practice costs, and case-mix." [14]

The medical care delivery system is very fragmented. In 2001, 53% of nonfederal physicians nationally were self-employed in solo practices, and only 25% were in practices of 8 or more.[15] This is an obstacle to creating more efficient care delivery processes, investing in electronic health information systems, and coordinating care more effectively for patients. It also has contributed to the slow and inconsistent adoption of "evidence-based guidelines" for medical practice, leading to both under- and over-treatment of common conditions. It has also delayed the implementation of initiatives to reduce serious medical errors.

The medical/legal system is also a factor in healthcare cost increases. Medical malpractice insurance premiums have been rising rapidly in recent years. The rising insurance costs are due to increasing litigation and large jury awards, as well as continuing quality problems in healthcare delivery. There is debate about the potential savings from limiting awards for non-economic damages. A Department of Heath and Human Services (HHS) study quotes estimates that could save 5-9% in total health care costs,[16] but others are skeptical that the impact is this large. Furthermore, the threat of malpractice lawsuits increases the use of "defensive medicine", i.e., additional tests or treatments that may have little effect on medical outcomes. The impact of defensive medicine is difficult to quantify, but it is probably much greater than the cost of malpractice premiums.

Other Factors Driving Costs

The U.S. healthcare system has very complicated administrative processes. As a result, administrative costs are high -- 7% of total healthcare expenditures according to government statistics.[17] Some researchers estimate that total system administrative costs – including costs hidden in hospital and physician costs – are much higher (31%).[18] Part of this is due to the market fragmentation among providers, insurers and payors. As a result, the system has a high level of duplication and a lack of standardization. In addition, there has been an increase in regulatory requirements, e.g., HIPAA privacy regulations.

The lack of a well-developed infrastructure for healthcare information systems has also been a major obstacle. Healthcare information exists in a multitude of

places in varying formats, some paper, some electronic. This has created inefficiency because information flow between consumers, providers, employers and insurers is not timely. This adds expense due to redundancy and re-work. Furthermore, the delays in the availability of health information often lead to compromised safety and quality.

How Escalating Costs Limit Access to Care (and further increase costs)

It seems obvious that higher costs make healthcare less affordable, thereby limiting access to care for many people. The dynamics are complex, however, and depend on which segment of the population is affected.

For the majority of people, escalating healthcare costs drive higher commercial rates. Competition among commercial insurers, regulations regarding benefits and pricing, employer actions and workforce composition can lead to segmentation of the risk pool and higher rates for certain employer groups. As a result, many employers are reducing coverage, especially for dependents, or are dropping employee health benefits altogether. The percentage of small firms (1-99 employees) offering coverage in the U.S. declined from 68% in 2000/2001 to only 63% in 2004.[19] Similarly, increasing healthcare costs have forced the State to reduce the number of people in the Oregon Health Plan by over 10% in the last two years.[20] These actions by employers and state government have increased the number of uninsured, for whom it is much more difficult to get access to care.

The increase in the number of uninsured and the resulting access problems results in delayed treatment and inappropriate use of hospital Emergency Departments for non-emergency care. This further increases costs, creating a vicious cycle by putting additional pressure on the State to reduce OHP coverage. The increasing number of non-paying patients in hospital Emergency Departments also creates a cost shift to commercial payors. This cost shift results in higher commercial rates, creating another vicious cycle by forcing employers to reduce coverage, thereby increasing the number of uninsured.

Higher costs have also forced the State and Federal governments to under-pay for care provided to Medicare and Medicaid (OHP) patients. This has led many providers to set caps on the number of Medicare/Medicaid patients they will see, thereby exacerbating the access problem. This also contributes to the cost shift, as commercial rates are increased to subsidize the low payments for Medicare and Medicaid. Furthermore, the uneven distribution of charity and OHP patients among insurance plans and the providers in their respective networks skews the cost shift impact.

Rising malpractice insurance costs have caused physicians in some specialties, e.g., Ob-Gyn, Neurosurgery, to stop practicing. This has become a serious

problem in some rural communities with a small number of providers. As a result, access to Ob-Gyn care and some specialty services has been reduced. In addition, a shortage of healthcare professionals is a factor limiting access in some communities and increasing labor costs.

What Can Be Done

Many people, when faced with the depth and complexity of the problems with our healthcare system, feel that the situation is hopeless. We believe, however, that the stakes are too high to take a passive approach. We can and must slow the rate of healthcare cost increases, find ways to improve healthcare outcomes, and improve access to care. In order to do this, it will be fruitless to attack the symptoms; we must deal with the root causes. And in doing this, all stakeholders must step up – employers, consumers, providers, insurers and the government. We should focus on what we can influence and look to innovators who are already achieving success.

Although many of the changes in the healthcare system will require nation-wide initiatives, we believe that we can make a difference here in Oregon. There are actions that local stakeholders can take that will affect healthcare cost trends and improve quality. As we develop innovative solutions in Oregon, they can become a model for other states or national initiatives

Moving Toward a Solution

In developing solutions, we must make a key strategic choice: a Government-directed or a Market-based approach? We strongly believe that a system that uses market forces must be in place to achieve the goals of cost control, quality and access to care. A government-run system without effective market forces will not be successful in controlling costs. There is an appropriate role for government as a facilitator, regulator and purchaser/sponsor for low income and elderly persons.

Vision of the Future Healthcare System

> *We support actions to give all Oregonians access to quality healthcare by creating a fair market where everybody is motivated to improve health, ensure quality and control costs. In such a system, providers of healthcare goods and services will compete -- and consumers will make informed choices about treatment options – based on transparent prices and quality.*

This is a key point: we support access to care for all Oregonians, but only after we get the costs under control. Providing universal access in the existing healthcare system is not affordable. Solving the cost problem will enable us to offer access to everyone.

"Treatment" – short-term recommendations

The Task Force has developed a list of priority action items, based on (1) our ability to bring about change, and (2) the importance of these items in addressing the problems.

Our recommended actions are driven by our understanding of the root causes, especially:

- Most consumers are shielded from the real costs of healthcare
- Most physicians have limited economic incentives to compete or deliver value based on efficiency and quality.
- Unhealthy lifestyles
- Chronic conditions
- Lack of comparative data on cost and quality
- Lack of a well-developed infrastructure for healthcare information systems to support quality care, coordination and simplified administration

It is clear that everyone is contributing to the problems with the existing healthcare system, so all stakeholders need to be part of the solution: employers, consumers, insurers, providers, and government.

1. Employers must take a leadership role

A market-based strategy implies that we must strengthen the employer-based system of providing coverage. Unless the U.S. decides to switch to a government-directed health system, employers have the primary responsibility to offer health benefits to their employees and dependents. Employers must take a leadership role in pursuing a value-based purchasing strategy. This will create greater incentives for employees to make choices based on cost and quality, and it will encourage providers to offer better value to consumers. In order to address the problems described above, employers should pursue the following strategies:

- **Consider health benefits that encourage cost-conscious choices**. Since one of the root causes is the lack of cost-consciousness by most consumers, employers should consider redesigning health benefits so that employees are sensitive to the costs of the choices they make. This would promote a sense of "ownership" and accountability for employees and their families. Employers may also want to design their benefit plans to protect low-income employees from undue economic burdens and potential barriers to care. For example, some employers have introduced a "sliding scale" of contributions to health plan premiums.

Specifically, employers should consider the following **options**:

- **A "defined contribution" approach for the cost of monthly premiums**. In the current situation, many expensive and cost-inefficient health plans are subsidized by employers who pay the full cost or a high percentage of premiums for employees. This discourages cost competition among health plans. Contributing a fixed amount toward premiums – adjusted for the health plans' risk profiles – would encourage employees to shop for the best value.
- **An increase in consumer cost sharing at the point of service.** In addition to cost sharing for monthly premiums, it is desirable for employees to be sensitive to the costs at the time they need or want services. Co-payments and deductibles can accomplish this, but current benefit designs are often simplistic and provide insufficient incentives to shop wisely. Cost sharing also needs to be designed to encourage appropriate preventive care and to protect consumers from catastrophic costs.
- **An introduction of Health Spending Accounts.** HSAs and similar plans provide another mechanism to increase consumer cost sensitivity. By offering a cash amount to employees to purchase health care services (combined with coverage for catastrophic costs), these plans encourage consumers to shop for the best value. This may be an attractive option for those employers who have not been able to afford to offer coverage.

- **Ensure that employees' are well-informed consumers and have information on quality and prices from providers.** Increasing cost sensitivity is only one part of the solution. In order for consumers to be smart buyers, they need to be well-informed about the quality of care and the prices offered by physicians and other providers. Employers can play a critical role by requiring that this information is collected and disseminated to employees.
- **Implement programs to keep employees healthy and productive.** Since unhealthy lifestyles are another important root cause of increasing costs, targeted efforts to promote health are a wise investment by employers. In addition to reducing health benefit costs, health promotion programs can also reduce absenteeism, increase productivity and improve employee morale.
- **Insist that providers deliver value: quality/cost.** Employers have an important role to play as payors for healthcare services. It is difficult for individual consumers to drive changes in the market, but employers can act as "agents" of large groups of consumers in demanding better value. A collaborative effort by several large national employers has had success with the "Leapfrog" initiative, which sets minimum quality standards for any health plan offered to their employees. Employers should establish formal specifications for health benefit purchasing, in much the same way that

they do for all other purchasing. For example, they could insist on the use of electronic health records and set minimum standards for quality outcomes.

2. Consumers must take responsibility.

For a market-based system to work, consumer must play an active role. In particular, consumers should:

- **Become well-informed purchasers of health insurance and health care.** In the current system, too many consumers are not active purchasers, and many are frustrated at the lack of information to make choices. Although some consumers are using the Internet and other tools to become better informed, most are not using information to be smart buyers. More informed consumers will get better healthcare and will drive improvements in the healthcare system.
- **Become aware of the cost implications of healthcare choices.** Most consumers are in a system that does not reward cost-conscious choices. As a result, most consumers are not aware of the cost implications of the choices they make. Consumers can have an important effect on cost trends if they make cost-conscious decisions.
- **Demand value: high quality care at an affordable cost.** Consumers should demand better value from the healthcare system. Providers, insurers and government will respond if consumers begin to speak up for improved quality, lower cost trends and better access.
- **Partner with providers to manage your care.** Traditionally, most people relied on physicians and other providers to tell them what treatment was best for a given condition. Many people did not take an active role in managing their care; their attitude was "I'm sick; fix me." As people become more informed and cost-conscious, they have the tools and incentives to be more proactive. Working in partnership with providers can result in better care and higher patient satisfaction.
- **Stay healthy.** As noted above, unhealthy lifestyles are a major cost driver. Consumers have a responsibility to keep themselves and their families healthy by eating right, exercising, avoiding risky behavior, and getting preventive care.

3. Insurers Have an Important Role

Although insurers do not directly provide or consume healthcare services, they play an important role in ensuring that market forces work effectively. Specifically, insurers should:

- **Offer plan designs that encourage cost-conscious choices when service is provided.** This will encourage the use of more cost effective

providers by consumers. As noted above, these benefit designs should also encourage the use of appropriate preventive care and protect consumers from catastrophic costs.

- **Provide comparative information on quality and costs.** As noted above, it is critical for consumers and their "agents" (employers) to have this information in order for market forces to work effectively. Since insurers have access to much of this data, they need to take the lead in making this information available to consumers.
- **Support the development of standardized data elements and an infrastructure for healthcare information systems.** Much of the information in healthcare flows through insurers. They can and should play a role in encouraging the development of electronic health systems and connectivity. A potentially valuable element of this is consumer-based decision support.
- **Work with providers and offer economic incentives to reduce costs and improve health outcomes.** Insurers should pursue innovations in provider reimbursement to move away from the dysfunctional fee-for-service system that rewards quantity of service more than quality. Some pilots are underway, and these should be encouraged and accelerated. For example, "pay for performance" systems have the potential to reward providers who offer better quality care; "pay for condition" systems would provide incentives to provide more cost effective care for patients with chronic conditions.
- **Invest in effective disease management programs.** Since a large proportion of healthcare costs is generated by a relatively few people – many of whom have chronic conditions – focusing on disease management will provide greater leverage in reducing overall costs. In addition, effective disease management programs can improve quality outcomes and patient satisfaction.
- **Simplify administrative processes.** Although improvements have been made in recent years, there is still more to do to streamline membership information, contracting and claims processing.

4. Doctors and Hospitals Must Step Up.

The initiatives listed above focus on the "demand" side; providers must do their part on the "supply" side. Relying on consumer, employer or insurer initiatives will not be sufficient to bring about necessary reform. Providers have a special responsibility, since so much of the decision-making regarding healthcare treatment is in their hands. In particular, providers should:

- **Deliver value to consumers by constantly innovating to reduce costs and improve health outcomes.** Much of today's care delivery system is similar to what existed 50 years ago. Although medical technology has advanced rapidly, there have not been similar improvements in the design

of care delivery processes. Providers must find ways to streamline patient flow and build quality into care delivery processes. For example, providers should encourage home-based patient-managed care for chronic conditions, supported by electronic health records and modern communication tools.

- **Embrace electronic health information systems and connectivity as means to improve quality and reduce costs.** The pace of adoption of electronic health information systems has been relatively slow. Providers should invest in these systems and make the necessary changes to reap the benefits. They also need to drive the standardization of medical data to enable interchange of patient information throughout the system.
- **Use medical care guidelines based on scientific evidence.** The adoption of guidelines has also been very slow. Professional medical societies should take the lead responsibility to ensure that physicians are using the best scientific evidence and delivering care according to established guidelines.
- **Provide comparative information on price and quality.** To enable consumers and employers to be wise purchasers, providers need to make available comparable information about the prices for healthcare services. They also should develop methods to enable consumers to compare providers based on quality of care and medical outcomes.

5. Responsibilities of Government and the Community at large

Even in a market-based healthcare system, government has important roles to play -- as a facilitator, regulator and purchaser/sponsor for low income and elderly persons. The Task Force recommends that government take the following steps:

- **Strengthen public health initiatives for lifestyles and use of evidence-based guidelines.** Well-designed public health initiatives can have a dramatic effect on costs and the health of the community. An example of a successful campaign is the 30-year effort to reduce smoking. More recent examples include the campaigns to reduce teen pregnancy. Government can also work with providers to promote the use of medical guidelines based on scientific evidence.
- **Enable the publication of information on healthcare quality and technology assessment.** Government agencies have access to health information for Medicaid and Medicare. This data should be provided to consumers and employers to enable them to be well-informed purchasers. Government can also require providers to submit other healthcare information and publish it for public use. This approach has been successful in improving quality of care in several states, e.g., New York's publication of cardiac care outcomes. In addition, government can play a

role by conducting objective costs/benefit assessments of new technologies and treatments.

- **Support the development of standardized data elements and an infrastructure for healthcare information systems.** Government should work with providers and insurers to develop data standards and encourage the development and connectivity of electronic health information systems.
- **Modify regulations to allow and encourage innovation.** While many government regulations are well-intentioned, the costs sometimes appear to exceed the benefits. Furthermore, regulations sometimes have the unintended effect of stifling innovation. For example, some privacy regulations may be an obstacle to the sharing of healthcare data among providers. A rigorous re-evaluation of regulatory requirements would help to avoid unnecessary barriers and administrative costs and help to restore credibility.
- **Support reform of the medical/legal system.** Most observers agree that the medical/legal system is not working well. Government should convene the key stakeholders -- consumers, providers and insurers-- to develop innovative solutions that protect consumers' rights, minimize costs, reduce the need for defensive medicine, enhance quality outcomes and ensure access to care.
- **Stimulate and support business growth opportunities in healthcare information technology.** Targeted initiatives and financial incentives would help to stimulate an industry sector that is essential for improved healthcare efficiency and quality.
- **Correct inequitable Medicare reimbursement for Oregon.** Currently, Oregon providers receive lower reimbursement that providers in other states. This inequity can and should be corrected.
- **Revise Medicare and Medicaid policies to align with a market-based system.** The current government-sponsored programs were designed nearly 40 years ago. Since that time, the healthcare market has evolved, and many design elements have become outdated. A thorough re-thinking of these programs would enable them to be a catalyst for needed reform.
- **As an employer/sponsor, be a leader and innovator in health plan design.** As the sponsor of coverage for the poor and elderly, the government manages the health benefits for a large number of people. In addition, government employee benefit programs represent a large share of the insured market. By pursuing innovations in health plan design, government can be a major driver in reforming the healthcare system.

6. **Entrepreneurs have a tremendous opportunity,** especially in the healthcare information technology cluster. This industry has high growth

potential and a large nationwide market. Examples of products and services in this cluster include electronic health records, digital imaging, prescription and test ordering, streamlined referrals and billing, and consumer-based decision support and payment processing. There is an opportunity to make Oregon an industry leader nationwide. Furthermore, there is the potential to improve the efficiency and quality of our healthcare system.

This initiative can be a "win-win" for Oregon – a strong industry cluster that provides new jobs and economic growth, plus a healthcare system that delivers improved value to Oregon businesses and consumers. Many companies in Oregon are already working on this, but we need leadership and better coordination to strengthen this cluster. Oregon also benefits by having progressive healthcare delivery systems, e.g., Kaiser Permanente, Providence Health System and OHSU that have experience with advanced healthcare information technology. In addition, we need incentives for capital investment, standards for data exchange, and regulations that encourage data flow (while protecting consumer privacy), not inhibit it.

Next Steps

Oregon business leaders must continue their work in the healthcare arena in order to make progress toward achieving the vision. The initial work has focused on understanding the problems and their root causes, developing long-term strategies and suggesting short-term actions. We recommend pursuing next steps in four key areas: Leadership, Benefit Design, Transparency, and Information Technology.

Leadership:

- Share the findings and recommendations with the business community
- Work collectively and engage business leaders to drive change

Benefit Design

- Create a forum for employers to share best practices and develop joint initiatives, based on the principle of using market forces

Transparency

- Lead the effort to obtain and share comparative data on healthcare costs and quality. This is an important foundation of a true market-based system.

Information Technology

- Support the evolution of the healthcare digitization industry cluster as a means to enhance the value of the healthcare system and foster economic development. This will require investment and collaboration.

We recognize that the problems with the current system have evolved over many years, and it will take sustained and focused effort to reform the system and achieve the Vision. We are committed to collaborating with key stakeholders and providing leadership, support and oversight as needed to ensure the implementation of these critical initiatives.

Summary

We have a serious problem in Oregon: we are not getting maximum value from our healthcare system. We need to find ways to improve quality and access while reducing the current unsustainable cost trends.

A market-based solution is the most likely to be successful in achieving these goals. Incremental approaches, however, are not going to work. The healthcare system is broken and needs fundamental reform. We need to "change the rules of the game." In doing this, we need to attack the root causes of the problem, not just the symptoms. There is no single solution. The problem is complex, and the solutions aren't simple or easy.

All of us – consumers, employers, providers, insurers and government – are contributing to the problem, so we all must step up to be part of the solution. In the current system, employers have an important leadership role to play. In this effort, Oregon can be a leader. By stimulating innovation in healthcare, we can find ways for the system to deliver better value. This will lead to higher productivity and improved economic growth and jobs for Oregon.

APPENDIX

OBC Health Care Task Force Members

OBC Members:

- Joan Austin (A-dec, Inc.)
- Russ Danielson (Providence Health System)
- Bruce Daucsavage (Ochoco Lumber)
- Wayne Drinkward (Hoffman Construction)
- Peggy Fowler, Chair (Portland General Electric)
- Mark Ganz (The Regence Group)
- John Lee (Providence Health System)
- Eric Parsons (Standard Insurance Company)
- Curt Roberts (Nike, Inc.)
- Duncan Wyse (Oregon Business Council)

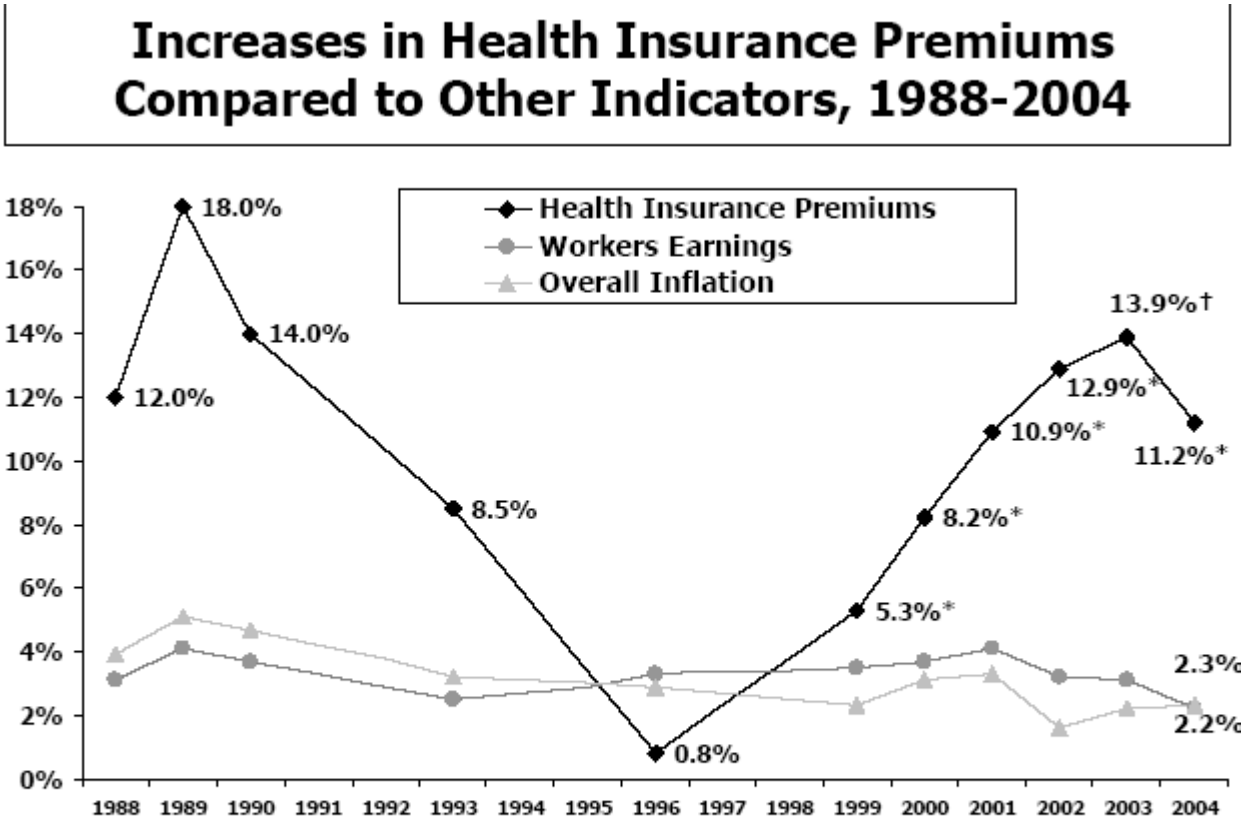
Other participants:

- Geoff Brown (Mercer Human Resource Consulting)
- Barney Speight (State of Oregon)
- Lisa Trussell (Association of Oregon Industries)

Consultants:

- Bill Kramer
- Denise Honzel

Figure 1



* Estimate is statistically different from the previous year shown at p<0.05.

† Estimate is statistically different from the previous year shown at p<0.1.

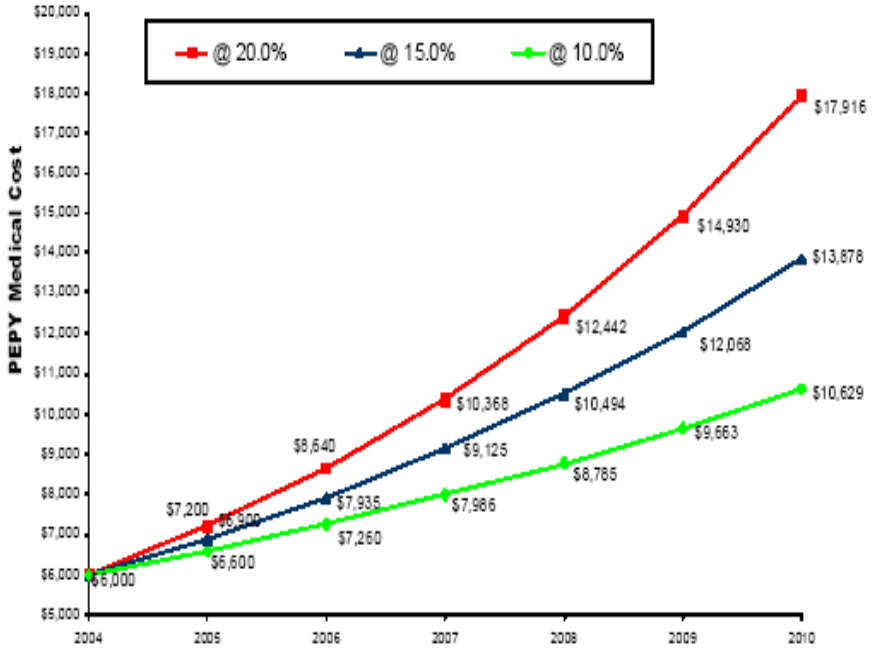
Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.

Source: KFF/HRET Survey of Employer-Sponsored Health Benefits: 1999-2004; KPMG Survey of Employer-Sponsored Health Benefits:1993, 1996; The Health Insurance Association of America (HIAA): 1988, 1989, 1990; Bureau of Labor Statistics, Consumer Price Index (U.S. City Average of Annual Inflation (April to April), 1988-2004; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April), 1988-2004.

Figure 2

Is the status-quo sustainable?

Base year with various rate of increase assumptions



Mercer's 2003 National Survey of Employer-Sponsored Health Plans

G:\WP2004\Seminar\March 10\2004 HC Survey Cut Three.ppt

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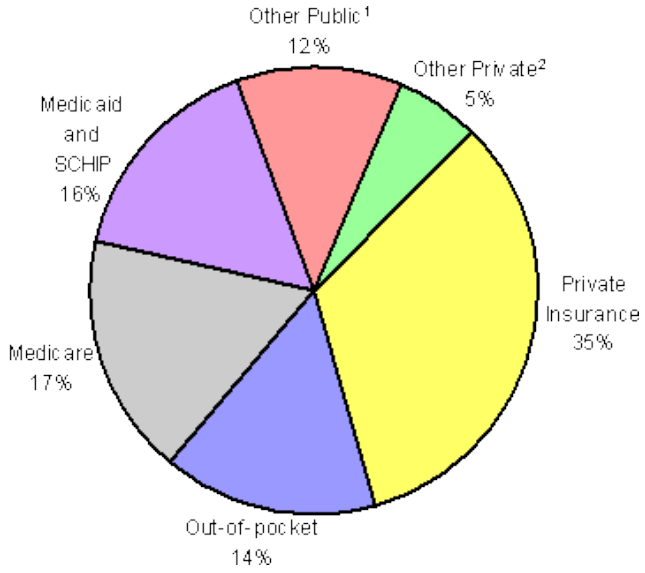
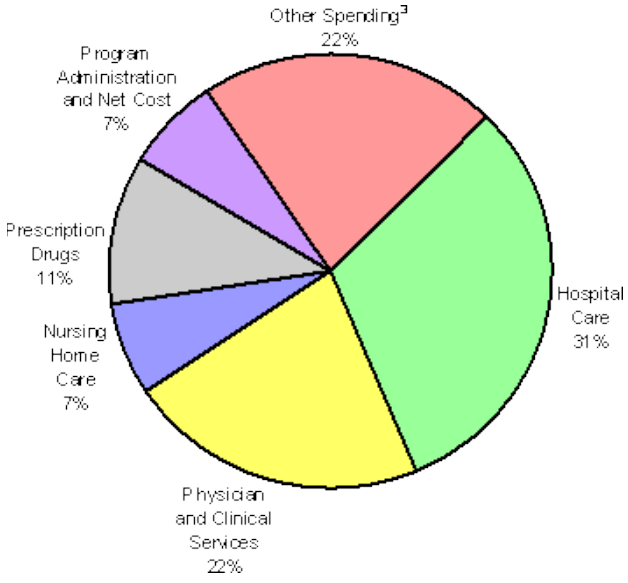
Figure 3

The Nation's Health Dollar – 2002

Where Does it Come From?



Where Does it Go?

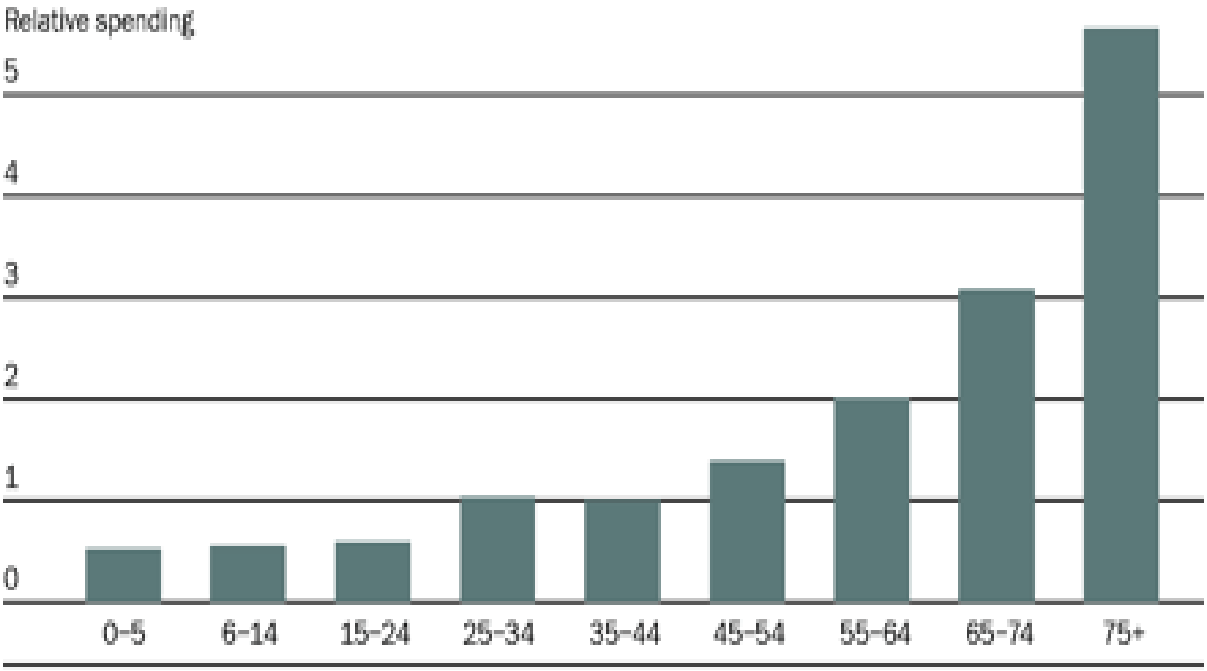


[1] "Other Public" includes programs such as workers' compensation, public health activity, Department of Defense, Department of Veterans Affairs, Indian Health Service, and State and local hospital subsidies and school health.
[2] "Other Private" includes industrial in-plant, privately funded construction, and non-patient revenues, including philanthropy.
[3] "Other Spending" includes dentist services, other professional services, home health care, durable medical products, over-the-counter medicines and sundries, public health, research and construction.
SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

Figure 4

EXHIBIT 1

Relative Per Capita Health Spending, By Age Cohort (Age 35–44 Equals 1), 1999



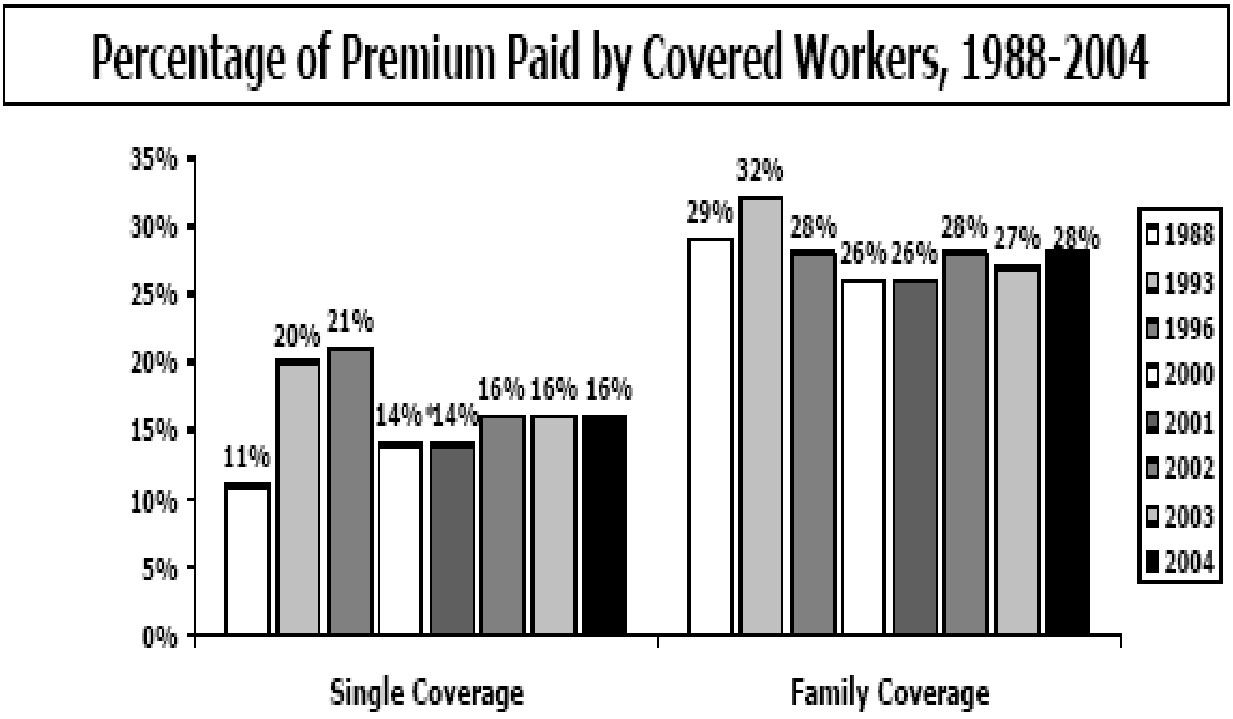
SOURCE: E. Meara, C. White, and D.M. Cutler, "Trends in Medical Spending by Age: 1963–1999" (Unpublished paper, Harvard University, 27 March 2003).

Figure 5

% of Population	% of Health Expenditures (1996)
Top 1%	27%
Top 2%	38%
Top 5%	55%
Top 10%	69%
Top 30%	90%
Top 50%	97%

Source: Marc L. Berk and Alan C. Monheit, “The Concentration of Healthcare Expenditures, Revisited,” *Health Affairs* 20:2 (March/April 2001): 9-18.

Figure 6



* Estimate is statistically different from the previous year show at p<.05.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2000-2004; KPMG Survey of Employer-Sponsored Health Benefits: 1993, 1996; Health Insurance Association of America (HIAA): 1988.

NOTES

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[12] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Survey Data, 2002, unpublished data.

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http://content.healthaffairs.org/cgi/content/abstract/22/6/27

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