Next Steps for Health Reform in Rural Oregon
October 19, 2017
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Goals

- To explain a context for the choices now facing our nation and state
- To define eight ways in which local health care leaders can make a difference in this process
- To define six important questions to be answered in a debate about reforming our health care system
- To outline a way to explain health reform to patients and community leaders
Political Realities in 2017

- Health care has become a divisive partisan issue and it is 18% of the nation’s economy.
- The nation cannot agree about basic questions regarding health care.
- The health care system is complicated and hard to explain.
- People do not have trusted sources of information.
Eight things we can do now

1. **Stop blaming others** - This is not someone else’s problem to solve. Health care professionals are leaders in their local communities and need to lead.
Eight things we can do now

2. **Stop waiting on the government-** Americans cannot agree on basic questions about health reform. The government represents the people perfectly in this regard.
Eight things we can do now

3. Be skeptical about large health systems-
   Evidence suggests that creating large systems does not lower costs or improve outcomes. In fact, costs rise in such systems.
Eight things we can do now

4. Health care is becoming unaffordable to too many people- we must reduce its cost.
Eight things we can do now

5. Cost-effective care will require a fundamental change in our clinical method- we must partner with patients to create this new clinical method.
Eight things we can do now

6. Decreasing total health care costs will require increased spending on primary care and mental health - we need to insist on this.
Eight things we can do now

7. A lot of money is being taken out of the health care system for things that add little value— we must speak out and inform patients about this.
Eight things we can do now

8. The financial crisis in health care is a symptom of underlying moral uncertainty about the mission of our health care system and the values of our society- we must incite public debate at the local level.
Steps to creating public debate

1. Understand vocabulary and history
2. Find reliable sources of information
3. Debate basic principles
4. Foster empowerment and agency
Essential stories from history

- Medicare and Medicaid - 1965
- Medicaid in Oregon: The Oregon Health Plan - 1994
- The Affordable Care Act - 2010
Medicare and Medicaid in 1965
Impact of Medicare

- 19 million enrolled when first passed
- 56 million now enrolled (17% of population)
- Cost $588 billion per year (1/7 of federal budget)
- Accounts for 20% of US health expenditures
- ¾ Americans think Medicare is very important

Impact of Medicaid

- 77 million enrolled in 2017 (24% of population)
  - 34 million children, 6 million in CHIP
  - 9 million blind and disabled
  - 6 million elderly (11 million dual eligibles)
- Funds 40% of US births (2 million annually)
- Eligibility determined by states
- 57% funded by federal gov, 43% by states
- Costs $545 billion in 2015 (9% of federal budget)

Medicaid in America: 2013

Medicaid Enrollment and Expenditures, by Eligibility Group, Fiscal Year 2013.
Oregon Health Plan
Accomplishments: 1995

- Immediately covered 130,000 uninsured people by expanding eligibility to 100% FPL
- Reduced uninsured from 18% to 8% of adults (<3% in metro Portland)
- Reduced emergency department use by nearly 20%
- Rapidly introduced managed care to the state
- Achieved national and international recognition

Health Insurance in America 2009

- Insured by government ~40%
  - Medicare for disabled and people over age 65
  - Medicaid for the poor
  - VA, Indian Health Service
- Insured by Employers ~40%
- Private personal insurance ~5%
- Uninsured ~15%
The Affordable Care Act: 2010

1. Require basic benefits
2. Reform employer based insurance
3. Mandate Coverage
   - Employers
   - Individuals
4. Expand Medicaid to 130% FPL
Many adults obtain health insurance coverage through their spouse. In 2015, married adults aged 19 to 64 years had the highest coverage rate, at 91.0 percent (Table 3). The coverage rate was lowest for individuals who were separated, at 79.4 percent. The coverage rate was 83.2 percent for people who were never married. The coverage rates for people who were widowed or divorced were 85.8 percent and 85.1 percent, respectively.

In 2015, the health insurance coverage rate for widowed individuals was not statistically different from the coverage rate for divorced individuals.

Between 2014 and 2015, most marital status groups experienced an increase in their coverage rate, except for people who were widowed. The coverage rate for the married population increased by 1.3 percentage points. People who were divorced and people who were never married experienced an increase of 2.2 percentage points and 2.3 percentage points, respectively, in their coverage rates.

The coverage rate increased by 4.3 percentage points between 2014 and 2015 for individuals who were separated.

Disability Status

In 2015, the health insurance coverage rate for working-age adults with a disability was higher than for the population as a whole. The percentage point difference in the health insurance coverage rate for divorced individuals was not statistically different from the percentage point difference for married individuals and individuals who have never been married. The percentage point difference in the health insurance coverage rate between 2014 and 2015 for divorced people was not statistically different from the percentage point difference for people who were married, separated, or never married. The percentage point difference in the health insurance coverage rate between 2014 and 2015 for people who were separated was not statistically different from the percentage point difference for people who were never married.
Uninsured Rate by State

Figure 7. Uninsured Rate by State: 2015
(Civilian noninstitutionalized population)

Percentage without health insurance coverage
- 14.0 or more
- 12.0 to 13.9
- 10.0 to 11.9
- 8.0 to 9.9
- 0.0 to 7.9


For information on confidentiality protection, sampling error, nonsampling error, and definitions in the American Community Survey, see <www2.census.gov/programs-surveys/acs/tech_docs/accuracy/ACS_Accuracy_of_Data_2015.pdf>.

Source: U.S. Census Bureau, 2015 1-Year American Community Survey.
Coordinated Care Organizations 2010

- Transfer of cost responsibility from state to local providers
- Allow flexibility in how communities managed services
- State creates rules for standards of care
Change in Uninsured Rate in Oregon CCO’s After ACA

The table above gives the percentage of people within each CCO service area who are uninsured or who have selected types of health coverage. For example, of all the people living within the AllCare Health Plan CCO service area, 7.3 percent were uninsured in 2015, a decrease from 19.5 percent in 2013.

CCO service area data highlights

- **Uninsurance:**
  - Lowest uninsurance rate, 2015: FamilyCare and Health Share of Oregon, both at 4.2 percent, which is below the state average of 5.3 percent.
  - Highest uninsurance rate, 2015: InterCommunity Health Network at 8.8 percent.

- **OHP/Healthy Kids:**
  - Highest percentage of OHP/Healthy Kids coverage, 2015: PrimaryHealth of Josephine County at 36.7 percent.
  - Lowest percentage of OHP/Healthy Kids coverage, 2015: Health Share of Oregon at 18.8 percent.
  - Largest absolute increase in OHP/Healthy Kids coverage, 2013—2015: PrimaryHealth of Josephine County increased 19 points.

- **Group:**
  - Group insurance coverage rates decreased in most CCO service areas, but increased in six areas.
  - Highest percentage of group coverage: Health Share of Oregon at 57.9 percent.
  - Lowest percentage of group coverage: PrimaryHealth of Josephine County at 32.1 percent.
  - Largest absolute change in group coverage, 2013—2015: Cascade Health Alliance decreased 11.3 points.

* There were very few respondents in these two CCO service areas. These rates are statistically unreliable and have been suppressed.

Oregon Health Insurance Survey 2015
Health Insurance in Oregon After the ACA

In Oregon from 2011–2015, group coverage and uninsurance rates decreased and Oregon Health Plan or Healthy Kids insurance rates increased.

In 2015, 95% of Oregonians had health insurance coverage, which is the highest proportion on record. Changes in Medicaid eligibility and enrollment implemented January 2014 have influenced uninsurance and group coverage rates (see the chart on this page).

OHIS was administered in 2011, 2013, and 2015, creating three state-specific data points on health insurance coverage, access, and utilization patterns. The Oregon Health Authority (OHA) will field OHIS again in the first half of 2017.

Coverage rates by CCO service area are depicted on the next page. Survey data was categorized into CCO service areas using zip code and county. Because some CCO service areas overlap, individual responses may be counted toward more than one CCO. Hence, the statistics do not sum accurately at the state level.

Statewide rates and other OHIS data are available on OHA's website.

Every respondent is included in at least one CCO service area.

One important note is that the numbers by CCO in this fact sheet represent the entire population of each CCO service area, not only CCO members.

Oregon Health Insurance Survey. Oregon Health Authority, 2015.
Complaints about the ACA

- The government should not force me to buy insurance.
- The required benefit package has things I do not want.
- The cost is going up too much in the individual market.
- I don’t want to pay for other people’s health care.
2016 Presidential Election in Oregon

- Clinton
- Trump
Six Important Questions In Any Health Care Reform Debate

1. What are the primary goals of our health care system? What outcomes matter to us?
2. What basic level of benefits should we provide to everyone?
3. How much do we want to spend and how will the system manage cost?
4. What mechanisms will we use to insure quality and value?
5. What is the proper balance between social insurance and free-market consumerism?
6. What portion of cost should be born by government, business, and individuals?
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The Triple Aim
- Excellent population health
- Affordable cost
- Excellent experience of care for individuals
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Benefit Categories
Oregon Health Plan 2006

1. Maternity and newborn care
2. Primary and secondary prevention
3. Chronic disease management
4. Reproductive services (excludes maternity and infertility)
5. Comfort care
6. Fatal conditions
7. Nonfatal conditions
8. Self-limited conditions
9. Inconsequential care

Prioritized list of health services methodology. Oregon Health Services Commission. Updated 10/25/13
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Inconvenient Facts

- 56% of health costs for people with private insurance are incurred by 5% of the people.
- 69% of costs are incurred by 10% of the people.
- 67% of insured people are very healthy, 20% have an acute condition, and 15% have a chronic condition. Only 1% have catastrophic costs.

Half of the US Population Accounts for 97.1% of Health Care Spending

HALF THE POPULATION

THE OTHER HALF

THE TOP 1% OF HEALTH SPENDERS

97.1%

2.9%

$51,951 or More per Person Annually

Individual Health Care
(functionally limitless resources)

Outcome

Y4
Y3
Y2
Y1

Health care spending

X1
X2
X3
X4

Current point

Optimum point
Population Health Care
(limited resources)

Current point

Optimum point

Y1, Y2, Y3, Y4

X1, X2, X3, X4

Health care spending
2011 Data from World Bank

**Life expectancy at birth and health spending per capita, 2011 (or nearest year)**

Source: OECD Health Statistics 2013, [http://dx.doi.org/10.1787/health-data-en](http://dx.doi.org/10.1787/health-data-en); World Bank for non-OECD countries.

StatLink: [http://dx.doi.org/10.1787/888932916040](http://dx.doi.org/10.1787/888932916040)
Health Depends More on Education Than on Health Care

Figure 4. Even with universal access to the National Health Service, illness rates in Britain are higher for those with less education.

* 3rd level: equivalent to receipt of a bachelor’s degree or higher.


Source: adapted from Figure 7 in *Fair Society, Healthy Lives: The Marmot Review.*
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Quality Improvement Opportunities

- The patient-centered medical home
- Integrated primary care and mental health services
- Electronic data to understand trends and patterns
- Better coordination of care across sectors
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4. What mechanisms will we use to insure quality and value?
5. What is the proper balance between social insurance and free-market consumerism?
6. What portion of cost should be born by government, business, and individuals?
“Evidently, the dominant decision makers in this nation have now concluded that our health system can properly offer the (corporate) executive’s child a higher probability of avoiding illness, or of surviving and fully recovering from a given illness, than it offers the child of a gas station attendant or waitress- that our health system can properly be tiered by income class. That is purely a moral judgment. As such, it is not wrong. But it would have been appropriate, in a democracy, to debate this important question more explicitly than it was. Instead, the proponents of this distributional ethic cloaked their case in the jargon and normative theories willingly supplied, without proper warnings, by the economics profession.”

Uwe Reinhardt, 1996
Strategies for public debate

- Be positive and encouraging
- Do not depress people, inspire them
- Empower people to take control
- Make “I” statements and ask questions
- Encourage collaboration
- Suggest resources
Eight things we can do now

1. Stop blaming others; take responsibility.
2. Stop waiting on the government.
3. Be skeptical about large health systems.
4. Reduce health care cost.
5. Partner with patients to create a new clinical method.
6. Insist on stable funding for primary care and mental health.
7. Speak out and inform patients about fraud and greed.
8. Incite public debate at the local level.
“The new departments should be teaching a **disciplined anger**, not against people, but against attitudes and situations that impede the effective delivery of medical science to sick people. Without such anger, the new young doctors will be brought up by the areas of gracious medicine; and anger without discipline is mere cursing.”