Health care reform in the U.S.

REVIEW

A review of health care reform in the United States and in Alaska

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ABSTRACT

Objectives. To review the status of health care reform in the U.S. in general and in Alaska in particular.

Study design. This paper reviews the literature concerning health care reform in the U.S. and in Alaska.

Methods. N/A.

Results. N/A.

Conclusions. The United States spends more per capita on health care than any other OECD country, yet its health outcomes such as life expectancy and infant mortality lag behind other countries. Health care reform has been a major activity of the federal government and of some states for the past several years. The 3 goals of optimizing cost, access and quality, at both the national level and at the Alaska state level, are discussed. Some of the major policy changes at the national level, including payment system reform, enhanced insurance regulation and increased attention to prevention, are discussed. The unique health care reform challenges in circumpolar Alaska are highlighted and the status of current state level reform initiatives is reviewed.

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INTRODUCTION

It is widely held that the United States is in, or at least on the brink of, a national health care crisis. The U.S. health care system is a complicated amalgam of public (i.e., government) and private payers that pay both public and private providers, such as doctors, hospitals, and clinics, for health care services. Reform is difficult, not just because of this complexity but also because of the strong influence that private interests can exert on any government attempt at change.

The numerical elements of the crisis most discussed are the increasing numbers of uninsured and underinsured people and the rapidly growing cost of health care. The moral and ethical elements are the health and financial consequences to those with little or no access to health care.

In the third quarter of 2009, health care was reported by numerous non-partisan polls (1) to be the second or third most important issue in the country after the economy and, in some cases, after the wars in Iraq and Afghanistan.

Health care reform in the U.S. is commonly discussed in terms of a “triumvirate” of goals: cost, access and quality. Cost refers to a sustainable financial system of payment, with sources matched to uses. Access refers to the degree to which people can avail themselves of health care services – it may be limited by supply or location of service or by affordability. Quality refers to the performance of the system versus either what is theoretically possible or what is the current best practice. The overarching goal of health care reform is to optimize these 3 dimensions, and it is generally acknowledged that compromises are required to achieve a workable balance.

This paper discusses the 3 goals at the national level and at the Alaska state level. It also outlines some of the major policy changes that have been considered in addressing them.

BACKGROUND

Health care spending and outcomes

In 2007, U.S. health care expenditures comprised about 16% of the gross domestic product (GDP) annually, the highest among the 30 OECD countries when compared to 8–11% for other industrialized nations (2). In the absence of major reform, it is expected to rise to 20% of the GDP by 2016 (3), and this level of spending is considered by many to be unsustainable (4,5).

Even in light of this spending, some key U.S. health outcomes such as life expectancy at birth and infant mortality are in the bottom quartile of OECD countries (2), leading to the concern that the U.S. health care system is not producing as much value as its peer countries.

How health care is paid

According to the U.S. Census Bureau (6), in 2008, 66.7% of individuals had private health insurance, which either pays the provider directly or reimburses the individual for all or part of the provider’s bill. Of the privately insured, 88.7% have employer-sponsored insurance (ESI) and 13.3% purchase health insurance directly from insurers (6). It is difficult to count the number of distinct health insurance companies, but a lower bound is about 1,300, the number of members of the largest trade association (7). The largest 7 insurers cover over 90% of privately insured Americans (7).

The average worker with family ESI cove-
rage pays about one-quarter of the total annual premium of $13,375. Most private insurers require the insured to pay for a certain percentage of their health care, typically the first $600 to $1,800 of annual charges plus a 5–20% portion of each provider charge beyond the deductible (8).

There is no standard way to count the number of uninsured in the United States, although there are multiple initiatives to do so. Collection efforts include reporting by insurance providers, the Census Bureau (6) and the National Health Interview Survey (9). Methodological controversies include whether to count people who could afford insurance but choose not to purchase it, how to account for those who are temporarily uninsured and whether to include illegal aliens (10).

A commonly cited source (6) approximates 46 million uninsured people in 2007, an increase of 17.8% since 2000. Young people aged 19–29, the poor and ethnic minorities are over-represented in the uninsured population (9,11). Fourteen percent of adults are underinsured (12), meaning their insurance coverage is insufficient to protect them from extreme financial hardship in the event of major medical expenses. Concentrations of uninsured persons in 2008 varied from a low of 3% in Massachusetts, a leader in health care reform, to more than 20% in the large states of Florida and Texas (7). Nationwide, the trend in the last decade is erosion of coverage for adults and no change or a slight gain in coverage for children (13).

There are several major public payers at the federal level: the federal government as an employer, various forms of military and military dependent coverage, the Indian Health Service for American Indians and Alaska Natives, Medicare for the elderly, Medicaid for the lowest income families and the Children’s Health Insurance Program (CHIP) for lower income families who can afford to pay for some but not all of their coverage. State governments are expected to supplement federal Medicaid and CHIP funding from their state budgets.

**National and state level initiatives**

Health care reform has been on and off the national agenda since 1912, when Theodore Roosevelt campaigned for national health insurance. The major government payers, Medicare and Medicaid, were created in 1964 under Lyndon Johnson. Bill Clinton’s administration initiated major health care reform in 1993 but was unable to get any legislation passed in Congress. In the early 2000s, several states passed state-level reform packages. In 2009, after a presidential election that featured intense debate over health care reform, Barack Obama’s administration outlined its goals for health care reform and both houses of Congress began crafting legislation that was ultimately passed into law in March 2010. As happened in the Clinton years, reform has elicited strong reactions from lobbying groups and the public in general.

The New England states of Massachusetts, Maine and Vermont initiated the most comprehensive state-level health care reform, and several other states, including Pennsylvania, Oregon, Utah, and California, instituted less sweeping initiatives (14).

The comprehensive state reforms aim to provide near-universal coverage and they use a multi-pronged strategy that may include cost, quality and disease-management initiatives. Massachusetts began with a relatively high level of coverage from ESI in its demo-
graphic, so its plan builds on this strength. In keeping with its goal of providing universal coverage, Massachusetts mandates individual coverage and levies fees to medium and large employers that do not provide “fair and reasonable” insurance coverage. This reform package also addresses private insurance companies by merging the small-group and individual markets and by outlining the terms of policies that will be made available through a state clearinghouse agency. The Massachusetts initiatives are funded through federal matching, general state funds and the company assessments.

Vermont, unlike Massachusetts, did not aspire to universal coverage, but rather to 95% coverage by 2010. It emphasized chronic care management as a way to lower demand in the future. Tobacco tax increases as well as federal matching and non-participating employer assessments were used for funding. Maine enacted the earliest comprehensive reform package, passing legislation in 2003 and beginning implementation in 2005. Maine has no individual mandate and no non-participating employer assessments, relying instead on voluntary compliance. Maine has also emphasized direct cost-containment measures such as voluntary caps on cost and operating margins, and it created a Quality Forum to provide information for residents to make choices regarding service. Originally, Maine’s funding was to come from providers and insurers that would contribute part of the savings from the overall reduced burden of uncompensated care, but this did not provide sufficient funding. Instead, Maine is relying on employer contributions, general funds and federal matching dollars (14).

Many elements of the national reform bill that were passed in March 2010 reflect these earlier state initiatives, including the individual and corporate mandates and the clearinghouse concept for the purchase of individual health insurance. In addition, it expands eligibility for Medicaid and restructures payments to certain forms of Medicare. Medicare payment plans also now incent higher quality hospital care and efficient coordination of care across multiple providers. Strategic planning and research for quality measurement and improvement is funded, as are grants for privately funded prevention and wellness programs. Implementation of the provisions of this bill will be phased in over 4 years (15).

Since its enactment, the national reform bill has generated controversy, and as of May 2010, 20 states have filed lawsuits challenging the individual mandate on constitutional grounds (16).

NATIONAL GOALS: Cost, access and quality

Health care reform in the U.S. is difficult, in large part due to the delicacy of making the trade-offs necessary to balance cost, quality and access. Clearly, unlimited access raises the overall cost of health care, and reducing costs might impact quality. Early reform states like Oregon struggled with budgetary constraints as their publicly funded programs enjoyed wider enrollment (17).

Cost

The U.S. spent more than $2.2 trillion dollars on health care in 2007, a more than three-fold increase over 1990, but with the lowest growth rate since 1998 (18). Without major reform, total spending is projected to reach $4.3 billion by 2018, which would be 20.3% of the GDP (19). The 3 largest components in 2007 were hospital care (31% of total spending), physician/clinical services (21%) and prescription drugs (10%)
The largest drivers of the increase in the past several decades are believed by most to be advancing technology, prescription drug spending, chronic disease and administrative costs (19). The general aging of the population is often suspected to be a major driver, but research does not bear this out (18).

Rising health care costs have an increasingly negative impact on families. According to the non-partisan Thomson Reuters service, more than 20% of those polled in 2009 said they were concerned about their ability to pay for health insurance or health care services in the next 3 months (20). In 2007, 62% of all bankruptcy filings were a result of medical expenses, an increase of almost 50% over 2001, and about 75% of bankruptcy filers were actually insured at the time of filing (21).

There is considerable research documenting a large geographic variation in health care costs when they are measured at the state or lower levels, without commensurate difference in the quality of outcomes (22–24). Dartmouth Institute estimates a 30–40% reduction in overall spending on acute and chronic illnesses if all providers were to adopt the practices of best-in-class organizations (25).

Cost reform elements
Potential elements of health care reform aimed at cost containment include redesigning payment systems so that consumers are responsible for a larger portion of their health care bill, altering federal tax treatment of ESI, electronic health records and prevention. These elements are controversial because neither politicians nor scholars agree that their enactment would lower costs. Regulating costs and revamping provider compensation to reward outcomes instead of volume of service have been under consideration as well, and they are controversial because they would negatively impact at least some providers’ incomes.

Prevention is often considered a cost reform element. While prevention programs have clearly been shown to improve health outcomes, their effectiveness in saving cost is unproven. A meta-analysis of almost 600 articles published between 2000 and 2005 concluded that the “vast majority” of peer-reviewed preventive measures do not save money (26).

Access
Limited access to health care is typically a result of insurance issues, such as lack of coverage, being underinsured or having a low income that prohibits making the required co-payment; geographic challenges; or lack of health care workers. People with poor access suffer worse health outcomes than those with good access, likely because they receive less preventive and therapeutic care, and they are typically diagnosed at a more advanced stage of disease (27). Lack of access has both direct impact on the uninsured, in the form of pressure on the family budget when medical expenses are incurred, and indirect impact, in that people in poorer health have reduced earning power.

Access reform elements
Elements included in various health care reform proposals to improve access include health insurance reform, attention to the health care workforce and addressing geographic challenges. Insurance reform initiatives that are typically considered include establishing a co-operative health insurance market through
which individuals can purchase affordable insurance; requiring that private insurers guarantee affordable coverage and renewability to those with pre-existing health conditions; reducing the tax advantage to an employer offering health insurance to its employees; and offering a publicly funded insurance product, either an extension of Medicare or a new program (16).

The public option was one of the most controversial of all potential reform elements and was defeated in both houses of Congress during the reform debate. Under this option, the government would have provided health insurance to those who either chose not to be covered by private insurers or, in other versions, were unable to obtain affordable private insurance. In Congress, liberal backers of the public option believed that its creation would have driven competition, provided a much-needed safety net and encouraged innovative reimbursement designed to encourage greater efficiency. Conservatives were concerned that a public option would have driven private insurers out of business, limited choice, increased the federal debt and inevitably lead to nationalized health care.

Outside of Congress, some constituents advocated more drastic change regarding access, including the U.S. adopting a single payer system like Canada (28), incorporating intensely consumer-driven components (29) and decoupling health insurance from employment (30). None of these positions were able to gain majority support.

Quality

In a system as complex as health care, quality is difficult to define. Two commonly cited measurement systems in the U.S. are the annual National Healthcare Quality Report (NHQR) (31), funded by Congress, and the annual Commonwealth Fund State Scorecard (CFSS) (32), compiled by a private non-partisan foundation.

NHQR reports on 220 measures across 4 dimensions of quality: effectiveness, patient safety, timeliness and patient centeredness; and across 3 categories of activities: prevention, acute treatment and chronic management. The 2008 report (33) focused on a core set of 45 process and outcome measures across these dimensions and categories. It concluded that slow progress was being made on the majority of measures and that the acute treatment measures showed the most improvement. This suggests that the U.S. health care system remains overly focused on acute medical care and is less successful in chronic disease prevention and management.

The CFSS is a comprehensive scorecard that reports on 38 measures of access, quality, cost and health outcomes by state. The 2009 report (32) concludes that while almost all states are improving in hospital, nursing home and home health quality, measures related to ambulatory care were more likely to stay steady or decline. Also, the gap between top and bottom performing states appeared to be widening, with top performing states continuing to set new high benchmarks (32).

Quality reform elements

The elements that make up the health reform legislation include incenting coordinated primary care, promoting quality improvement, promoting public reporting and reforming payment structures, including pay-for-performance and bundled payments (34). Of these, the payment reform options generate the most
controversy because they might negatively impact some providers' revenue and because some fear the administrative overhead costs of implementation or the setting of unfair benchmarks (35).

Pay-for-performance (P4P) involves financially incenting providers to meet designated quality and efficiency benchmarks. Bundled payments are a single rate of reimbursement across multiple providers for a major event, such as a kidney transplant, rather than the traditional fee-for-service payment to individual providers for a series of procedures and patient encounters. P4P was successful in raising overall quality in a 2005–2009 Medicare-sponsored demonstration project involving more than 250 hospitals (36), as compared to hospitals not participating. However, there is conflicting evidence in other studies about P4P’s effectiveness (35).

ALASKA

Background
The state of Alaska differs from the rest of the U.S. in several ways pertinent to health care. Two-thirds of the land mass is unreachable by road or ferry (37) and is referred to as “remote rural.” Rural areas, including the remote rural, hold 21% of the state population, while 54% of the population is concentrated in metropolitan Anchorage (38,39).

As shown in Fig. 1, Alaska has a relatively low concentration of people over the age of 65 and a relatively high concentration of Indigenous peoples and military personnel. Insurance coverage in Alaska differs from the U.S. overall in ways that mirror these demographic differences, as shown in Fig. 2.

Health care for Alaska Native peoples is funded primarily by the federal Indian Health Service (IHS). Tribal governments own and manage a non-profit organization known as the Alaska Native Tribal Health Consortium (ANTHC), which is funded directly by IHS and is responsible for providing a variety of Native health services to 130,000 customer-owners statewide. The Southcentral Foundation is the other major healthcare organization. It is based in Anchorage and serves over 46,000 Alaska Native peoples in the Anchorage Service Unit, which includes Anchorage, its suburbs, and 60 associated rural areas.

ANTHC providers rely on Medicare, Medicaid and private insurance payers, in addition to the federal funding, because the annual federal IHS funding is inadequate to cover the needs (44). Para-professional community and behavioural health aides are the first-line health care providers in the villages. There are 180 community primary care facilities, 25 sub-regional facilities with mid-level practitioners, and 6 regional hospitals statewide. The Alaska Native Medical Center, jointly operated by ANTHC and the Southcentral Foundation, serves as the regional hospital for Native peoples in the Anchorage Service Unit as well as the tertiary care referral centre for other tribally operated hospitals across the state (44).

There have been several planning efforts but little action at the Alaska state level on health reform, and, as of this writing, the state legislature and the State Health Care Commission are adopting a wait-and-see attitude pending the implementation and ultimate disposition of the federal legislation. A bill similar to the Massachusetts reform was discussed in the Alaska state legislature in 2007 and 2008 but did not garner enough support to pass.
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Figure 1. Major demographic difference between Alaska and the U.S. overall (40–42).

Figure 2. Alaska vs. U.S. insurance coverage (6,43).
The in-state tribal systems have initiated extensive prevention and coordination of care efforts, both of which are mirrored in national level reform. In terms of health indicators, the Commonwealth Fund 2009 report ranked Alaska 48th out of 51 on overall access, 40th on prevention and treatment, 17th on cost of care, 27th on healthy lives (e.g., smoking, infant mortality, obesity, etc.) and 23rd in equity, which is performance for vulnerable populations (32). Specific measures on which Alaska was ranked at or near the bottom include suicide deaths and the cost of ESI. Among Native Alaska peoples, unintentional injury deaths, suicide deaths, smoking rates and obesity rates are substantially higher than non-Native Alaskans (45).

Cost
More than $5.3 billion was spent in Alaska on health care in 2005 (46), approximately 13.5% of the gross state product (47). If the 1998–2004 annual growth rate of 8.4% holds, the total will reach $11.9 billion by 2015 (46). Health care expenditures in Alaska in 2004 were among the highest in the nation, at $6,450 per capita versus a national average of $5,283 (48).

Costs for some procedures in Anchorage are 50% to 150% higher than they are in Seattle, the closest major metropolitan area in the Lower 48 states (49). According to a study conducted by the Institute for Social and Economic Research at the University of Alaska Anchorage (46), there is no research-backed explanation for why costs are higher in Alaska, but beliefs include the higher cost of attracting providers to the circumpolar north, lack of “managed care” private insurance that is more prevalent in other states, higher than average rates of smoking, rapidly growing rates of diabetes and the general aging of the population. The need to transport sick or injured patients by air from remote areas to facilities with higher levels of care also adds to the cost of service.

Access
Remote rural areas present the largest challenges to health care access. About 9% of Alaskans live in these areas, and 80% of these are Alaska Native peoples (37). The tribal system partially addresses access with its network of community, regional and tertiary care providers, but preventive care and early treatment of disease, as well as timely treatment of acute disease, continue to be compromised.

Most health care in remote rural areas is provided by tribal organizations. Non-Native peoples living in remote rural areas have historically accessed tribal clinics for emergency care but not for preventive or maintenance care. However, with new federal funding arrangements under the Community Health Clinic umbrella, many remote clinics may now treat non-Native peoples for routine care.

Physicians are not obligated to accept Medicare patients. Medicare reimbursements for primary care are about two-thirds of what private insurers pay, so non-Native Medicare patients in urban areas, especially Anchorage, have difficulty finding primary care providers that will accept them (50).

A 2007 study found vacancy rates among primary care providers of 20% or higher and nursing vacancy rates above 15% in rural areas (51,52). This shortage exacerbates the

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1 That is, 50 states plus Washington, D.C.
geographical challenges. Tribal organizations and the state have begun several co-operative initiatives to address these shortages, including expanding the medical school along with nursing and allied health programs at the University of Alaska.

**Quality**

Alaska was rated at or near the 50th percentile in about half of the 80 measures in its 2008 NHQR survey results, with the rest of the measures evenly split between above and below average (31). The measures on which Alaska scored more favourably than average include cancer deaths and low and very-low birth weight rates, and measures that were scored below average include colorectal cancer screening rates and hospital in-patient tobacco cessation counselling (31).

**Integrated care**

Southcentral Foundation (SCF), the tribal health care organization for Alaska Natives living in the Anchorage area and some associated villages, spent 10 years developing a customer-centred care model called Nuka (53). It is a precursor to the similar patient-centred care and payment reform initiatives found in national health care reform packages. By reorganizing the model of care to be truly driven by their customer-owners, SCF was able to increase customer satisfaction by 91%, decrease emergency services by 40% per person and decrease specialist utilization by 50% (53). The success of the Nuka model has important implications for cost, access and quality of health care for its constituents, and it has sparked interest in other states, in Canada, and at the federal level (54).

**Conclusions**

What is it that makes health care reform in the U.S. so difficult? Researcher Jonathan Oberlander calls it a “politically treacherous task” and says that there is “nothing inevitable about [it]” (55).

Part of the answer is the sheer complexity of the system, with its multiple public and private providers, multiple public and private payers, rapidly changing technology and disparate information technology. With so many “moving parts,” it is difficult to predict what a reform initiative might do to the landscape. The delicacy of making trade-offs between cost, quality and access cannot be overstated.

Another difficulty of health care reform is the wild-card nature of individual choice and of free market developments, both of which play a major role in the U.S. system. Individuals have the choice to live a healthy lifestyle or not, and their decision ultimately impacts their health and therefore the overall costs of the health care system, regardless of who pays.

Perhaps the most challenging aspect of U.S. health care reform is how entrenched the current system is and how many people and organizations profit from it. Making major systemic changes requires creating winners and losers among today’s players, and those targeted as losers will apply political pressure to prevent being harmed.

Alaska’s circumpolar geography leads to higher costs and more challenging access. Health care quality overall in Alaska is average among the 50 states, but disparities between health outcomes for Native and non-Native peoples must be addressed. With national
Health care reform years away from implementation, and with the uniqueness of Alaskan circumstances, continued efforts of tribal and state organizations are required to achieve a locally optimal balance between health care cost, access and quality.

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The author has no financial or personal relationships to disclose.

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