



# Toward Evidence-Based Health Care Reform

Vol. 2, No. 1

## What the Expert Advised the Legislature: Focus on Chronic Care and the Delivery System.

Welcome to "Toward Evidence-Based Health Care Reform," a periodic e-memo providing facts, figures, examples and analysis of current issues in health care reform in Vermont. The memo is written by Jeanne Keller, Keller & Fuller, Inc., and sponsored by BRS, Inc., a member organization providing a range of services and support to Vermont's small businesses. For more about BRS, please visit our website: [LINK](#)

To review past issues of *Toward Evidence-Based Health Care Reform*, [click here](#).

To read and download the comprehensive health care reform proposal supported by BRS and several other Vermont business associations, [click here](#).

*In two presentations January 12, 2006 to the legislative Commission on Health Care Reform and the House Health Care Committee, consultant Kenneth Thorpe, PhD, laid out a clear vision for how Vermont could address both the growing cost pressure of chronic illness, and provide financial access to basic care for the uninsured. His message is so important – and so evidence-based – that we are devoting this memo to reporting his report. Dr. Thorpe was kind enough to review this and verify that his presentation is accurately described in this memo.*

Dr. Kenneth Thorpe<sup>[\*]</sup> was hired by the Vermont Legislature Commission on Health Care Reform in 2005 to provide expert analysis and recommendations for action on health care reform in the 2006 legislative session. A frequent contributor to the respected policy journal *Health Affairs*, Thorpe's studies have produced compelling evidence that the major cost driver we face in health care is the burden of illness; that is to say, the increase in chronic illnesses and obesity is the most significant factor driving up health care expenditures and we cannot "bend the curve" of costs unless we make chronic illness our priority. In Vermont, for example, providing care to the chronically ill accounts for 75% of total health spending, public and private.

At the same time, says Thorpe, the chronically ill receive about 50% of the clinically recommended care for their diseases. Many providers are not delivering evidence-based, recommended care that could preclude more costly hospitalizations and ER use. Thorpe told the committees the Institutes of Medicine and other experts "have highlighted the need to dramatically restructure how we deliver services," making chronic care patient-focused, using a multi-disciplinary approach, and using proactive, not reactive, treatment models.

Dr. Thorpe told legislators that Vermont's Blueprint for Health Chronic Care Initiative is already positioning our state to be a national leader in reforming the health care system to meet the challenge. Providers, consumers, insurers and government have been working together for three years to plan, develop and test the infrastructure (e.g. database and IT system, evidence-based treatment models, uniform performance measurement system) that could be used by all payers to manage and support chronically ill patients more effectively and efficiently. He strongly encouraged legislative support for funding the continuation and acceleration of The Blueprint for Health initiative, especially for Medicaid enrollees.

The second major element of Dr. Thorpe's presentation was a proposal for a sensible, feasible approach to access for the uninsured. Calling the plan "**Green Mountain Health**," Thorpe proposed the following:

- Uninsured Vermonters would receive a defined benefit package of primary and preventive health care (based on the US Preventive Services Task Force recommendations of evidence-based primary and preventive services)
- Enrollees would complete a comprehensive Health Risk Assessment (HRA) to identify existing or potentially chronic health problems. Individuals with medical conditions requiring further evaluation would be referred to a physician. Based on the clinical exam, those at risk or with chronic illness would be enrolled in the Medicaid chronic care program developed through The Blueprint model.
- Non-chronic care related hospitalizations (e.g. accidents or acute illnesses) may or may not be covered by the Green Mountain Health (GMH) plan. (Dr. Thorpe is developing data on both options.) In his

presentation, Dr. Thorpe spelled out some options for funding hospitalizations if not insured by GMH, such as designating existing hospital budget authority for charity care, sliding scale fee schedules that would apply to GMH enrollees, etc. (Note: Others involved in the reform debate have suggested state-sponsored reinsurance as a possible mechanism for explicitly financing catastrophic charges.)

Dr. Thorpe reminded the legislators that the demographics of the currently uninsured population suggest that this package of primary and preventive care, combined with a route for providing more comprehensive care for those identified with chronic illness, would be the least costly method and most effective way to ensure access for this population.

**In addition to this model combining support for the Chronic Care Initiative with covering the uninsured, Thorpe provided analysis of other options or pending proposals and found them lacking in comparison:**

### **1. Impact of “No Reform” Option - Base Case**

- The number of uninsured continues to rise as costs exceed what businesses can afford, and uncompensated care and cost shift from Medicaid grow significantly. Continued spending growth outstrips public and private resources.
- Fragmentation of care for chronically ill leads to even poorer quality outcomes and higher costs.
- Slow growth in wages due to high and rising cost of health insurance, downward pressure on job creation and retention.

### **2. Impact of Individual and/or Employer Mandates (Pay or Play, etc)**

- New spending among employers current not providing coverage = \$135 million or around 13% of payroll. (Impact on payroll is higher because businesses are small and low-wage: per employee cost is high relative to larger businesses)
- Employees (currently uninsured) in these businesses would be required to pay around a 4.4% payroll tax (\$46 million).
- New state spending to provide income sensitive subsidies, etc approximately \$45-\$50 million in addition to employer-employee contributions noted above.
- Slower wage growth to low wage workers.
- Does not address rising costs in system, or dampen increases for existing employer/employee plans.
- Does not improve quality of care or delivery system.
- State programs developed for the uninsured could attract the currently insured: employers could drop their plans resulting in added cost to state for subsidies.
- “Key Economic Impact: Raises concerns about increased unemployment among low-to-minimum wage workers.”
- Vermont may be able to craft an employer mandate to survive a federal court challenge based on ERISA preemption, but he noted that it would most certainly be challenged, the fight would be lengthy and costly, and the outcome is unknown, possibly negating the entire program.

In sum, Dr. Thorpe presented an analysis based on what is actually driving health care costs, what the evidence shows is the way to slow that growth while vastly improving quality of care for all – especially the chronically ill, based on what we know about the uninsured and their needs for access, and on what is financially feasible for Vermont. After hearing the presentation, it seemed clear to many listeners that Thorpe’s hybrid Green Mountain Health/Chronic Care model is the only one of the three meriting further legislative attention this session.

---

[\*] Dr. Thorpe is Chair of the Department of Health Policy and Management, Rollins School of Public Health at Emory University.