

A Medicaid Moment - Not Exactly!

It just kept gnawing at me. There had to be an answer. There had to be a way. Then it hit me. Medicaid was the answer. Government mandated universal home maintenance insurance – similar to the highly successful Medicaid (and other health insurance) models currently operational within the health care sector - was the solution.

I had just come from a Rotary Club meeting where the speaker discussed how a large percentage of West Virginians live in unsafe, unsanitary, and substandard housing. He stressed how the failure to maintain an optimal shelter environment results in costlier consequences down the road, e.g., serious injuries and illness, structural collapse, fire, etc. He implored that as a society we, or our government, assure that no West Virginian lives in unsafe, unsanitary, or substandard housing. We must assure every West Virginian access to high quality, suitable, well-maintained, equitable, and affordable housing he emphasized.

I could not wait to bounce my idea off my golfing friend, Jake, who was a local family physician and

great sounding board. At our next outing, I outlined my idea and invited his insight. I explained that it was my understanding that a similar issue existed within the health care system 25-50 years ago and that by greatly expanding health insurance coverage, including government plans for the poor and otherwise disenfranchised, we had largely solved the problem. Jake's initial response was, well, not exactly. I pressed on item by item.

I began by noting that by insuring every home for maintenance we could enhance home status and safety, avoiding huge costs subsequently. I intoned, did not the expansion of health insurance coverage result in folks today much better maintaining and elevating their health status, savings millions in costly body repairs down the road? Jake responded, not exactly.

He continued. Longevity and health status have improved but this is largely due to advances in public health and medical science. In many respect, these gains have resulted despite, not because of, what people are doing to maintain their health. Various life style and personal behavioral characteristics, e.g., substance abuse, stress,

obesity, sedentary habits, violence, etc. that reduce health status have increased. Some folks possibly believe since they are insured that - coupled with continued advances in medical science – they will always be able to restore their health status regardless of the amount of personal abuse they inflict upon themselves.

He added that although, many individuals (over 50% in certain situations) have insurance that covers many proven effective preventive services, they fail to receive them. The reasons or barriers are many, e.g., educational, geographic, cultural, social, motivational, poor care continuity, system fragmentation. We direct only pennies (about 3%) of health expenditures to address these barriers, with the majority of funds providing insurance coverage for clinical care directed at containing (or repairing) personal health maintenance and health system failures. It is obvious the current insurance approach is very expensive measured by health status gains per dollar expended. It is unclear that absent addressing these other barriers – and providing positive and negative personal life style behavioral and compliance incentives - it saves money in the end. Jake said he was not sure what

personal and system factors affect how well folks maintain their homes. He said he would be cautious about assuming home maintenance insurance is the most cost-effective route to explore to assure optimal housing status and safety.

I conceded that he raised some challenging consideration but continued on a different tangent. I agreed not everyone acts responsibly but many individuals do. I noted that they usually maintain their home's status but at times just do not have the resources to do so. Home maintenance insurance could provide them the most affordable and efficient means to do so. I asked whether he agreed that the expansion of private and government health financing programs had accomplished this end within the health care sector for such responsible folks. Jake's response again was, not exactly.

He averred that there would always be poor and otherwise compromised individuals who a compassionate society should help obtain necessary health services. He noted that there are many public and private ways to do this directly, e.g., "sliding scale" or free clinics, charity hospitals, in-kind contributions, and indirectly, e.g., insurance coverage, capitation coverage, charitable subsidies. There are

advantages and disadvantages of each approach. For example, insurance coverage per se does not guarantee the provision of care. If reimbursement rates are too low, practitioners and institutions will vanish or use implicit measures to limit care. Alone, such an insurance approach does not assure practitioners and institutions are accessible – either directly or through referral – or the other barriers previously mentioned are adequately addressed.

On a somewhat different tangent, he also raised a question of whether an insurance approach is always the most affordable and efficient mechanism to follow. He conceded that without sharing risk there is little way most individuals could afford to protect themselves against costly, catastrophic health events, e.g., analogous to flood, fire, etc. in the housing scenario. However, for the much more usual, low "per unit cost" maintenance services he contended it is not clear it is cheaper to purchase such care through an insurance mechanism rather than directly. Insurance companies hire many people and make huge profits processing low dollar value claims. We all pay for this.

He contended it probably is necessary to use such insurance mechanisms for

high dollar, or catastrophic, events, but that we might be better off considering more cost efficient mechanisms (for those who can afford insurance) to pay directly for routine services that have not exceeded a catastrophic level. He opined that perhaps the same is true in the case of home maintenance, noting that if folks are paying directly for small repairs (or making them themselves) they might have an incentive to perform better and cheaper than a third party. Moreover, they might better maintain their homes to reduce the cost of out of pocket expense and the size of their catastrophic event coverage premium payments.

To save in-pocket resources, he conceded that it is possible that a few folks would fail to make any repairs, letting their homes deteriorate to "catastrophic" coverage conditions. However, Jake was unconvinced that the percentage would be any greater than those who currently can afford routine maintenance/repairs but fail to do so. He expressed that rather than cover everyone for routine maintenance services by a "first dollar" insurance approach, it might be more cost-efficient to concentrate upon only covering in this manner those who truly cannot

afford such routine maintenance/repair.

Interesting points, I conceded, but what about fraud artists, who perform low quality, incomplete repair services and/or greatly overcharge for their services? How do we avoid them from ripping folks off? I inquired, have not the growth of government and private health insurance programs been the best means to greatly reduce the cost of health services and guarantee their quality? Again his response was, not exactly. He continued.

Society has used many mechanisms to detect and control unscrupulous service providers. For years, the health care sector has employed mechanisms to monitor/assure quality and prevent excessive charges.

Any mechanism that captures information on health service encounters can assist to provide data to ascertain the quality, appropriateness, completeness, and value of any service encounter. The more such information is automated - and available as well as compatible across institutions and practitioners - the easier it is to assess the quality, value, etc. of overall care. Insurance derived data is usually more automated than other sources of data so it is helpful in that

respect. However, it represents a limited and incomplete data source to assess the quality of care provided by the health care system as a whole or the value of its provision

The key to quality monitoring and improvement is information automation, availability, and compatibility. Currently this is at least 20 years behind other sectors. Moreover, most insurance derived data focuses upon "services" rather than "patients". The result is serious limitations as regards assessing the entire process of care for each patient (or health system performance) as opposed to determining the quality, value etc. of a specific service rendered. It is often directed more towards cost-containment than quality per se critics have also claimed. It is a source of quality assurance data but not necessarily an adequate (or the best) one. In your situation, such data would probably help monitor the quality and value of a specific paint job but not the level of improvement in overall home status of all the housing units in your community.

It is true that large insurance purchasers (government and private) can negotiate a discounted payment rate for services provided to their covered members. However, it is not clear this reduces the

cost of care services or simply shifts the payment source. Thus, although the payment for one individual may decrease, it may increase for others – or receive supplementation through general tax revenues, philanthropy, etc. - such that the overall cost and aggregate charges are not contained. There are also potential quality and access tradeoffs. Drive payments too low and it can result in a shortage of skilled professionals willing to provide the services or quality lapses, e.g., dropped referrals, missed follow-up, inadequate patient education, duplication of procedures, that are undetected by the quality monitoring screens in use. There is also a consequence to society as a whole if practitioners and institutions curtail their research and development (R&D) activities because of reduced reimbursements that often help support such efforts. The results of many of these R&D efforts often provide quality of care gains and cost savings down the road. Unless a community monitors the process and cost of care for all its citizens over an extended period, there is little one can conclude about the impact of the expansion of insurance programs upon overall cost and quality. Thus, in your situation, based upon the health system experience, it is questionable whether

house maintenance insurance per se would significantly contain costs and improve home maintenance quality overall, although it could probably assist specific individuals obtain higher quality/better value services in specific instances.

Okay, I said, let me try a different approach. Most of us are not experts on home maintenance. We are not sure exactly what services we need, when we need them, how much they should cost and whom to trust to provide them. It just seems a lot easier and more efficient to have a public or private insurance plan employee handle all the arrangements for us. Are not most patients much happier not having to bother with all the hassle of arranging for services from practitioners and institutions, making payment, etc., leaving all that hassle to the insurance company? Once again Jake's response was, not exactly.

He continued by noting that some insurance plans include extensive networks of providers, or "closed", delivery systems such that the continuity, comprehensiveness, and integration of health care is enhanced. These plans can free the patient from a lot of hassle. They also can limit the patient's choices (insisting on sources of care that some

patients find inconvenient or unacceptable for a variety of considerations.) Each patient has to weigh these tradeoffs.

However, such insurance driven plans are relatively rare. Moreover, such plans represent organizational delivery options more than they do insurance plans per se. Favorable insurance coverage can help such plans develop and flourish but do not per se usually establish them.

Most insurance programs add, rather than reduce, the hassle experienced by patients. They are confused over which practitioners and institutions they can access, which services are covered and how much of any services is reimbursed through the insurance plan. They are often uncertain what services must be approved in advance or what to do in an emergency. Benefit and billing statements from institutions, practitioners, and insurance companies are undecipherable to most patients. They spend hours hassling with insurance company employees attempting to obtain payment authorization for care they desire or trying to get the company to pay for rendered care.

Deductibles, co-payments, primary and secondary payment sources, balanced billing,

participating provider status for ancillary service providers, patient's payment responsibility, non-formulary item, etc. are examples of terms and concepts that frustrate and confuse most patients. Most patients tolerate such hassle because they are afraid of financial ruin and they believe there is no other mechanism available to them. The cost of health care under such an insurance system increases because it must support many patient assistants and advocates helping patients traverse the quagmire.

Jake, added that he was not sure that if they thought it through homeowners would embrace the concept of home maintenance insurance coverage for most non-catastrophic, routine home maintenance and repairs. He explained that he did not believe they would want to hassle with the maintenance insurance company over whether a minor repair was necessary or an emergency, which repair service to use (or they should have used), the allowable reimbursement for the maintenance, part or repair performed, what replacement product brands were covered, etc.

I can see your point, I said. However, as a community or society we do not have unlimited resources to spend to improve home status and safety. We

also have to worry about paying for health care, education, transportation nutrition, recreation, etc. Folks could spend infinite amounts of money fixing up their homes. Those expenditures could just make their homes “prettier” or really improve home status, structure, sanitation, and safety. Because our resources are limited, we primarily need to use them only for the provision of services that make a real difference in home status. We need a mechanism to assure expenditures are truly cost-effective and cost-efficient, so as a society we can reap the greatest gain in home status improvement per dollar expended. Do not Medicaid and other insurance programs promote such cost-effectiveness and cost-efficiency within the health care sector? Not exactly, Jake responded. He continued.

Decision making regarding health care expenditures have migrated in the last several decades from individuals and local communities to higher governmental and private insurance company levels. Criteria and priorities for the expenditure of finite health resources have shifted from patient/practitioner or collective community determinations of relative need and potential benefit to a construct whereby a higher level predetermines

the need and priority for all individuals and communities. This can both assist and detract from promoting cost-effectiveness and cost-efficiency.

Using evidenced based research to guide expenditure determinations can increase the use of the most effective and efficient “health status improvement” interventions. Since practitioners and institutions like reimbursement for the care provided - and patients like their insurance program to pay for such care -, an insurance approach can be very helpful in this regard. The same principle applies regarding centralized categorical funding to prompt communities to institute “state of the art” public health initiatives.

However, there is a downside. Each individual and community is different. Insurance “benefit packages”, and centrally funded, categorical community health programs, tend to be rigidly defined. This reduces flexibility in the case of each individual and community. This can lead to inefficiency, e.g., duplication, waste, and the provision of ineffective, e.g., futile, incomplete care. If the services is covered and rendered, it is reimbursed. This

centralized approach reduces the incentives for individuals and communities actively and aggressively to do all they can do locally to maintain and enhance their personal or community health status and assure the optimal effectiveness and efficiency of all services delivered. As long as the perception is that “someone else” is paying for ineffective and inefficient services, the attitude often is “who cares” since its provision results in dollars and jobs for the local community.

In reality, we all pay for such ineffective and inefficient services through increased taxes, insurance premiums and out of pocket expenditures. It is a major reason overall health care expenditures continue to escalate. Jake went on to provide several examples.

As one small example, he said to consider the effectiveness and efficiency of preventive services. The U.S. Preventive Services Task Force’s *Guide to Clinical Preventive Services* found that only 32% of 172 available preventive screening procedures had evidence to support their use. Only 22% of behavioral interventions currently in use were shown to be effective in reducing risk-taking behavior, although that percentage could be raised to 70% by

employing strict criteria for participation. A minority of the public at risk (even with insurance coverage) receives certain preventive services, e.g., colorectal cancer screening, proven to reduce risk.

Empirical evidence suggests some people participate in multiple identical screening activities, duplicated by many community institutions, whereas participating a single time would suffice. The Prostate Specific Antigen (PSA) screening rate for elderly men with multiple system disease is high even though it is unlikely any intervention will – or should – occur regardless of the results. An insurance approach, by controlling reimbursements, could help to cut down on unproven interventions and encourage expanded use of effective ones. However, in other situations only each community can control the nature and intensity of preventive activities. Although the percentage of health care resources currently expended on preventive services is small (about 3%), the percentage of these resources wasted on ineffective, unnecessary, duplicative and unproven preventive interventions is enormous.

Each day – at huge costs to themselves and society - thousands of

disoriented, minimally responsive, incontinent, elderly folks - with far-advanced multiple system disease and no chance of regaining any functional improvement in the quality of their lives, are physiologically maintained by dialysis and other “end of life” artificial means. Such costs are not primarily the result of ineffective care provided by medical professionals and institutions per se but are the consequence of communities’ inability or unwillingness to address complex, often controversial, moral, ethical, cultural, economic, and political issues.

Huge savings could result from limiting or denying payment coverage for such futile “end of life” care, including dialysis for barely responsive, terminally ill individuals. According to Moss et al., the patient and family demands for all possible care is the largest (73%) perceived barrier to providing quality end of life care within West Virginia. Denying ineffective kidney transplants for poorly controlled diabetics, hip and knee replacements for the obese, dental extractions, inhalers, and erectile dysfunction drugs for smokers (who appear able to afford cigarettes but not drugs) are a few other examples. If it is covered, a centralized insurance model pays for such care even if these finite resources could be

used much more effectively and efficiently elsewhere to improve the health status of a community. How could they be used?

A community could consider redeploying such resources to promote improvement in the health status of patients with certain chronic conditions and the care they would receive. Even though considerable resources are wasted on futile care, many individuals fail to receive the care they need to maintain or enhance their health status. For example, there is strong evidence, as most physicians know, that individuals with histories of serious thrombotic cardiac events (or the proclivity to develop them) can significantly reduce the probability, and associated costs, of future such events, including stroke, by employing certain preventive therapies, e.g., ACE inhibitors, aspirin, thrombolytic agents, and life style changes. The same is true, i.e., avoiding future morbidity and associated costs, in the case of diabetes, hypertension, and certain other chronic conditions. (Some patients possibly suffer preventable morbidity, death, and unnecessary care expense, solely because they have no health insurance and cannot afford a clinic visit or thrombolytic, diabetic, or

other disease control agents. However, it is doubtful that this factor alone accounts for preventable morbidity and avoidable cost in very many instances.)

Many insurance programs inadequately cover the cost of educational, patient management and related life-style promotional activities proven effective in reducing the sequelae and avoidable costs of many chronic diseases. For example, recently, I was discussing this subject in the context of a semi-rural practice of five internists. The practice administrator reported that if the practice discontinued its highly effective diabetes nurse educator and post thrombotic episode management programs (which were operating at a loss) each physician in the practice could take home \$12,000 more each year. A community could insist upon adequately reimbursing for such effective preventive services (directly or through community/public health initiatives). In addition, it could consider imposing positive and negative sanctions upon patients to increase treatment compliance and prompt life-style changes.

A community could also insist resource priority be given to address community efforts directed at serious socio-cultural community health concerns, e.g.,

methamphetamine and other drug abuse, violence, obesity, etc. Many contend that just expanding insurance coverage, so more individuals can obtain certain drugs or limited clinical care - without adequately funding effective ancillary services and community health initiatives- is just likely to increase costs with little net savings down stream

Unlike end of life and futile care, there are other examples of ineffective and inefficient care that should not be controversial. For instance, rapid treatment of victims of stroke with clot busting drugs in emergency rooms can prevent a large portion of the morbidity and disability, e.g., paralysis, weakness, speech loss, associated with stroke. Not only would this allow folks to maintain the functional quality of their lives but also would result in overall system- wide cost savings. The cost of rehabilitation and support services for those who survive a stroke are enormous. Yet few folks who suffer a stroke receive such care in a timely manner. The costs to fix these effectiveness and efficiency problems involve patient, public, and health care personnel education, certain liability reforms, and the institution of electronic health record systems. They have little to do with health financing

coverage. These fixes are cheap as compared to the rehabilitation and associated costs of caring for stroke victims.

The failure to institute broadly electronic health records and other integrative mechanisms among all health professional and institutions within a community contributes to significant waste and duplication as well suboptimal quality and continuity of care. The technology and mechanisms to promote such communication and functionality, employed within other sectors for over 20 years, are relatively cheap when compared to the consequences of the failure to employ them. Health financing reform could include incentives to encourage such development but per se cannot provide it. Furthermore, such incentives primarily provide carrots to individual practitioners to develop individual systems rather than provide inducements to communities to support development of much more powerful community systems.

The cost to communities of multiple institutions installing expensive but underutilized diagnostic and therapeutic equipment is considerable. Yet "certificate of need" programs to address this

concern have been largely unsuccessful. Citizens of local communities experience no direct, tangible negative consequences of such practices, although they, and all of us, suffer increased health care costs as a result. However, such costs are too remote to prompt responsible local action. All that local citizens experience directly from such costly inefficiency are positive gains, i.e., increased availability, access and quality of services. Health financing reform will not change this and in fact could accentuate the problem by increasing demand and expanding unnecessary use of such modalities.

Within the community public health arena, waste, duplication, inefficiency, and ineffective initiatives are rampant. A number of higher-level governmental and private advocacy and philanthropic agencies, foundations, and institutions, usually well intentioned, select and prioritize the interventions for all communities. The result is that often many communities operate multiple categorical programs to address relatively low priority concerns while failing to address – or address effectively - other higher priority concerns. Contributing to this problem is that few communities have collective decision-making

structures and process in place to assess and prioritize their public health concerns.

Most often, each community health initiative establishes its own separate administrative and programmatic structures and reporting requirements at the national/federal, state and local levels. By the time these structures are funded, and the reporting requirements fulfilled, limited staff time and resources often are left to provide actual community services. Furthermore, new such initiatives that differ little from ones already operating within the community arrive but each incurs the overhead expense of its separate operation. Currently considerable resources are wasted operating separate program and administrative accountability systems for each categorical program. Health financing reform will not fix this. Only local communities can streamline the 100s of categorical public health programs, each with its own wasteful administrative reporting/accounting system and program structure/staff. Only these communities can address the issue of nearly 55 counties each running their own small, marginally effective public health programs (each with large administrative cost percentages) rather than shared initiatives.

Jake summarized by stressing that these are but a few examples of the many integrated, interrelated, and interdependent health system components and influences that shape the cost, availability, access, quality, and continuity of health care provided to patients, as well as affect the health status of the public. Health financing is but one of these components. He continued by noting that although he was not expert on housing, he would speculate that things were not much different.

For instance, Jake said, consider the cost of maintaining safe water and sanitary conditions for all West Virginians. Given the topography, geology and population density distribution within the State, this home maintenance insurance benefit alone could bankrupt the State. Non-existent or failing septic systems and inadequate wells and water supplies, are very prevalent. Yet folks insist upon living in hollows and mountaintops in a widely dispersed pattern.

It is a futile pipedream to believe the State can afford in the near future to maintain safe water and sanitary conditions for all its residents without changing the current population distribution

patterns. Moreover, assuming resources are finite, attempting to provide such benefits while maintaining these patterns will mean that the amount of resources available to make potentially highly effective home structural and safety improvements will be significantly curtailed. Jake, opined these are tough issues that communities struggle with every day. He said he doubted that instituting a universal home maintenance insurance initiative – whereby benefits and categorical funding priorities are determined for every individual and community by some distant commission – would make things any easier. He said he was just not sure that when local conditions are different and need is infinite - but resources are finite - that a distantly controlled, standardized, insurance (or categorical financing) approach is the most prudent course of action. In such situations, flexibility in order to enhance effectiveness and efficiency based upon local need and delivery conditions is often imperative.

In frustration, I told Jake, you sure do not think much of insurance or centralized funding mechanisms. Jake responded that this assertion was not true. He said, they are good mechanisms to do what

they are designed to do, i.e., spread risk and pay bills in the case of insurance and provide cash in the case of central funding. However, they have serious limitations if used as the primary strategy to assure each unique population has in place a mechanism to assure quality, contain expenditures, promote the most effective and efficient delivery systems and services, and design/set priorities for community health initiatives. These are functions best left to others and those closer to home within the community. You need to tell your friends at the Rotary Club that the answer lies within.

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