When Tea and Sympathy are not Enough:
The Catastrophic Gap in Prescription Drug Coverage in Atlantic Canada

Special Guest Speaker - Grace-Marie Turner

Insuring the Uninsured: Lessons from the field

This is the transcript of remarks made by Grace Marie Turner as special guest speaker following the luncheon at AIMS "When Tea and Sympathy are not Enough" conference.

Grace-Marie Turner is the founder and President of the Galen Institute, a think tank in Washington that specializes in the policy problems around insuring the medically uninsured. She played a major role in the design of last year's Medicare Bill in Washington. In July of 2005, she was appointed to the Medicaid Commission, charged by Congress with making recommendations to modernize and improve this program that serves the poor, the disabled, and the elderly. Turner is also a member of the National Advisory Council of Healthcare Research and Quality. She reflected on what she has learned from a long career striving to extend health care coverage to the uninsured.

Grace-Marie Turner:

Is there anything possible that we, here in Canada, might be able to learn from the United States? There are novel ideas on not only both sides of this border, but around the country, and around the world. I think we can share information and try to network and see what we can all learn from each other.

It probably does surprise people to realize the United States has 46-million uninsured, and that this is an important issue to us. It is actually a dip in coverage between low income citizens who are covered by government programmes and high income citizens who are covered by private plans. We actually have named that dip. We call that dip the Galen gap. People making $25-30,000 a year, in the United States, are those most likely to be uninsured. They make too much to qualify for public programs like Medicaid, and they don't often have the higher paying salaries or the resources to have good employment base coverage.

The great majority of those, 90% of those with private coverage in the United States, get it through the employer, but there are a lot of people who are falling through the cracks. We are, in the United States, looking at a lot of different solutions, both at the state level and trying to pick up different categories of people who are uninsured. The uninsured are of great concern.

So while there are significant differences between the United States and Canadian health system, and many other systems around the world, all of our nations face similar problems, such as the rising cost of health care, aging populations that are

going to be demanding more services, and consumers who are demanding more control over health care decisions. As costs increase and more and more people need health care services, the problems we are facing now are only going to grow more acute over time. And so putting some anchor points in place now to begin addressing those issues is tremendously important.

The United States, with its 46-million uninsured, is seldom held up as a model for Canadian or European nations, but yet I think you all know that no one in the United States who needs medical care goes without it. We have a federal law that requires any hospital in the United States to provide care to anyone showing up needing treatment. We also have a number of private community health centres, private clinics, and physicians are often giving their services free to the uninsured. It is a very bad system.

In fact, one of the explanations for at least some part of the uninsured is that they feel they don't need insurance since they know that they are going to get medical care. Pharmaceutical companies have programs in which they give away their drugs free to the uninsured, in many cases. So there is a sense we have set up an incentive structure here which discourages people from getting health insurance. That is one of the challenges that we are having.

On the issue of prescription drugs, we have very recently had a major national debate over adding a prescription drug benefit to our Medicare program for seniors. The United States has 35-million seniors, 6-million of whom are disabled. Some of them are eligible to have coverage through individual state programs, but this was a major, major national issue. I will talk in a few moments about some things from this debate that we had about prescription drug coverage that might elucidate your conversations on the topic.

So bottom line is – what is the problem that we are dealing with, not only in the United States, but also in Canada and around the world? If you identified the single biggest problem in the health care system, what would it be? Cost. The cost of health care is the problem everybody is dealing with. It is really the reason we have so many uninsured in the United States. As costs go up and up and up, not only can people not afford to buy private coverage, but employers find it more and more difficult to pay people a living wage, and continue to provide ever more expensive health coverage.

The Kaiser Foundation did a study in 2004 which showed that if you were an individual with job-based coverage, that policy was worth about $4,000 a year. If you had a family policy, the value rises to almost $11,000 a year. That is an add-on to someone's salary, and a lot of small businesses just can't afford those costs, and that is a huge contributor to the lack of people not having health insurance. Plus, there is the sheer size of our population.

Medicaid is the program for lower income Americans who don't have private insurance. It served 53-million people last year, and cost the federal and state governments, together, $330-billion. That is just for one program. Medicare for

senior citizens over 65, was another $300-million. Then with the private insurance companies you add $300-400-million on top of that. All told the federal state governments and private sector will spend $2-trillion on health care services this year in the United States, a figure equaling one-sixth of our economy.

I am on the Medicaid Commission; we are examining this program which is bankrupting state governments. State governments are looking at this program, which is actually more in structure like the Canadian system in that the federal government shares with the states some of the costs. The federal government pays 57 percent on average of the cost of the Medicaid program. The costs are actually allocated according to the number of people in the state above the poverty level. The poorer states get a higher “match rate.” The federal government may pay $3 for every $1 they spend. A rich state like New York, the government will pay $1 and they pay $1. So there is an income-based match rate but it is based upon the state's wealth level. So Medicaid is truly a safety net for low income Americans, but it is experiencing many of the problems that public programmes experience around the world.

Medicaid has a very generous benefit package on paper, but many physicians refuse to see patients, because they are paid so little that they actually lose money on every patient. They often will see Medicaid patients and go through all the hassles in the paperwork, because they want to offer charity care. But if they ran their whole practices just on Medicaid reimbursement they would not be able to stay in business. So as a result Medicaid patients often wind up going to hospital emergency rooms for their care because the hospitals are required to see everybody. In a crowded hospital emergency room they may wait six hours if their child has an earache or a cold because they can't get a private physician to see them.

We are trying to figure out how can we solve these problems and make this a better programme. At the same time we don't want to bankrupt the states, because the states have to pay for roads, have to pay for schools, have to pay for public safety, and if all of their discretionary dollars are being eaten up by the Medicaid program, they are not going to be able to run other important programs in the state.

Another problem with our Medicaid program is that it pays for acute care but not for keeping people well. It spends money without looking at the outcomes. Are we getting value for these dollars? Do patients have choices in making sure that their care is coordinated? You find in the Medicaid and Medicare programs that someone may be seeing several different physicians. None of them are communicating with each other; they have all prescribed different versions of the same drug and the person is feeling worse and worse. Well, they're taking the same drug with four different names and different dosages from their four different physicians. So the concept of coordinating care in order to maximize the efficiency of the programmes is really a major challenge that all of us are dealing with.

I thought it might be useful to talk about some of the ideas that we are experimenting with for reform in the United States that could be instructive here. Jeb Bush, in Florida, has been a very innovative governor, and has looked at

different things they can do to try to empower competition in patients and still get better value for the dollar. They have a program called Cash and Counseling.

Imagine you are somebody on his Cash and Counseling program. You are in the Medicaid Program, low income, one of these 55-million people, and you have severe disabilities. As a part of your typical benefit you are able to have somebody come in and help you bathe, help you get dressed, do your grocery shopping, etc. It is a long list of categorical eligibility. People kept coming to the governor saying, “You know, we also need this service, and this and this.”

The Governor acknowledged that the government couldn’t add everything that everybody needed, so he asked why don't we just, essentially, set up an account. This is how much we were going to spend on you for this particular part of your service. It is just a pocket; it is only one part of the overall Medicaid benefit, like personal care services, and you tell us what you need.

That is where the counseling part comes in. The Medicaid recipient might say, “I don't have to have anybody come do my grocery shopping, if I just had a ramp so I could get out of my house. I can't afford to have that built, but could I save up the money that you would have ordinarily spent for a couple months on grocery shopping to build a wheelchair ramp.” Yes, we can do that. Somebody else said, “You know, I wouldn’t need to have somebody come every day to cook my meals, if I could had a microwave.” Okay. We will buy you a microwave. Someone else says, “You know, I really don't like that woman who has been coming in to give me a bath; she's a stranger; she doesn't treat me right. My daughter could come over, if she could just pay a sitter and have taxi fare.” Okay. We'll do that. There is a 98% satisfaction rate with this program. Not surprising. People are in charge, and when these providers get the cheque, it says, State of Florida, but it also says, "For services provided to," and that's the name of the Medicaid beneficiary. So people are able to get the services they need. The program is saving money, because people aren't using all this long list of services they didn't need anyway; they're using what they need. One of the things that that required was really trusting people to use that benefit wisely and beginning that experiment. This program has now been adopted in something like 25-30 states.

Medicare part D, I know, we've all heard the news reports, “It is confusing; this is a terrible disaster; they should have never passed it; $400-billion is going to bankrupt the government.” It is a new way of delivering a benefit through a public programme, and it has really unsettled the boat, because it utilizes private competing companies to offer a benefit to seniors, who now have choices.

Congress designed a benefit only a politician and a bureaucrat would create. It looks nothing like an insurance policy. It has a $250 deductible, everything is covered up to 2,250, and there's a big gap, between $2000, $3000, and over $5,000 you pay five percent, the government pays 95% of your bills. Insurance agents were telling me they would never try to sell a policy like that, but you can have actuarial equivalence. So as long as the numbers come out the same, they can offer a different structure of the benefit. So a lot of the “4,000 plans” are just state versions

of the same plan. There are not really 4,000 different plans. You can offer actuarial equivalence so that if you want to eliminate the $250 deductible, you can do that. Maybe the insurers will even want to provide generic coverage in that big gap.

Some of the plans cost more; some of the plans cost less. Humana decided it was going to compete on price. They charge $5 a month for the premium, instead of the $37 a month that the government had anticipated that the benefit was going to cost seniors. They have competed like mad for seniors' business. The government was worried nobody was going to come forward. All the major plans came forward. A lot of other plans came forward, because they wanted people's business. When does that ever happen in public programs? Usually we are trying to say, “How can we spend less on you?” And here are all these companies saying, “We are going to make our program as attractive as possible. We are going to give you choice.” Of course, it is the choice that's freaked everybody out. Oh my goodness, we can't have choice.

Well, when seniors go on the Medicare website, they can see a map of the country. What state do you live in? Click on that state. Then they get a whole list of the plans that are available on your state. Who is offering it, what their 800 number is, what the deductible is and what the premium price is. People have choices. Do you want to get your prescription drugs by mail order, or do you want to go to your corner pharmacy? So there were a lot of choices. People weren't used to that in a public program.

In a 21st century economy, I don't think this program would have succeeded, if it hadn't offered choice. I don't think they could have done this before the internet. The internet has really facilitated going through this decision tree and making choices. It is not perfect, probably a little ahead of its time, certainly not the right demographic population to have started with something that requires using the internet. But it is an interesting new dynamic, and because of all this competition among the different plans, they are negotiating with the drug companies, to try to get the best price for Lipitor so that they can have the lowest premium and attract the most members. I mean, if competition really is working and the estimated price of the program is going down, when have you ever heard of that before? So you are starting to see, just in this one pocket of one program, injecting choice and competition and having that begin to produce the kind of results that people want. They want to have something that fits them, so they are able to put the drugs they are taking in this website and see five or six plan choices that offer the six different drugs they are taking. They see the prices, the premiums and the trade offs, so they can make those decisions.

People make complicated decisions all the time. They are just not used to making them in health care, and I think that they are going to start to find, gee, we really like this. In fact, satisfaction rates, 75-80 percent of people who have signed up say, you know, that was actually pretty good. They wanted to know what I needed, and by the way, I am already saving money.

To move to the discussion about catastrophic drug coverage for prescription drugs here in Canada, of which there was some discussion today, I think David Griller was

the first one to bring up the idea of having disease management as part of the drug benefit. That is really one of the things that we, in the United States, are focusing on in an effort to lower costs, increase value, and do a better job of patient care, whether it is in the private sector, or in public programmes. The Medicaid program in this new legislation that created that drug benefit also includes a lot of demonstration projects to begin disease management.

So that means we are not just going to think of drugs as a silo. We are going to think of what do you need as a whole person. I think David used the word holistic. What do you need as a whole person in order to be able to be as functional as possible? Drugs are going to be part of it, but the management of your health, the counseling, the coaching, and the monitoring are an important part of making sure that you are not only getting the right drug, but that you are using it properly, and that you are getting the right outcomes.

Regina Herzlinger, from Harvard, talks a lot about focus factories, and how she expects that we will evolve toward a system in which we have plans or entities, whatever you want to call it, that focus on AIDS patients, that focus on diabetes, that focus on coronary artery disease. They would figure out how can we learn what works best for these populations, and begin to gather information so that we are not just spending money on health care, but we are spending it wisely, and spending it based upon information that we are gathering, so that we can get better patient outcomes.

The Pitney Bowes project that was mentioned several times this morning, actually evolved from a program that started in Asheville, North Carolina, Asheville Project. The city of Asheville, North Carolina did a survey of why its health costs are going up, and what they could do about it. And they found they had a disproportionate number of diabetic patients who are costing them a lot of money. The National Pharmacists Association partnered with them and pointed out that their pharmacists can do a lot more than just count pills. So they set up a program where city employees who had diabetes would go see the pharmacist every month to get a foot exam, check their A1C levels, and have their blood pressure taken. Just simple little tests that they basically weren't motivated to get if it required they take a half day off to drive across town and wait in a doctor's office for two hours. Yet without this simple monitoring, these diabetics were winding up in emergency rooms or in crisis situations. So the city said, if you will go see this pharmacist for this little routine, we will give you your drugs for free. And what resulted was that not only were the diabetic employees taking their drugs, but more importantly, the pharmacists were finding the problem cases earlier, and keeping people out of hospitals.

Asheville is saving about half of what they had been spending on their diabetic patients initially. The trend lines are much lower than the projections would have been otherwise. The Public Relations Director for the Benefits Director of the city said families would come up to him with tears in their eyes saying, “You have no idea how much better our quality of life is now. We are not always worried about what is going to happen next and what new crisis we are going to have. We feel we are in control.” So giving them the drugs, and giving them an incentive, kept them

healthier and really made them, partners, in managing their care.

So to conclude, I just got back from co-chairing a conference in San Francisco on consumer-directed health care, and when you look at the things out there in the health care system that people are going to want it is overwhelming. There are 800 new drugs in the pipeline. People are going to find out about these drugs; they are going to want them. Steve Case, the guy who started AOL, is starting a new company called Revolution Health, to make information much more user-friendly for consumers. Minute Clinics, or Ready Clinics, are springing up all over. These are little clinics in department stores and pharmacies, where people can go if they have strep throat, or a child has an ear infection, or they have poison ivy, just simple things which you can usually get some sort of a prescription remedy for. Those kinds of things are all springing up, all consumer-friendly options.

So what are we doing in the United States about trying to bring more people in to the fold to have health insurance in this very dynamic world of lots of change, lots of ideas, lots of experimentation? As you've read, Massachusetts just passed the legislation that says that every citizen in the state has to have health insurance. There was some discussion today about mandating coverage.

Hawaii mandated employment-based coverage about 30 years ago. They still have an 11 percent unemployment rate, and therefore an equivalent uninsured rate, primarily because companies hire contractors so they don't have to cover them as employees. So Massachusetts said, that's not going to happen to us, we are going to mandate that individuals have health insurance. We are going to set up new systems for purchasing insurance and subsidizing insurance for individuals, offered through the workplace, but that's not your only option. Maine, Vermont, Minnesota, a lot of other states are looking at that as a model.

So because the federal government has had such a difficult time trying to get its arms around the problem of a very fluid 46-million people, who are moving in and out of the system, as they lose jobs and get jobs, and go back to school, Massachusetts says, we are going to plug the holes. Other states are saying, we are going to make employers spend at least 8% of their payroll on health care. The Wal-Mart Bill that passed in Maryland will make employers provide coverage. A lot of health savings accounts, the idea behind health savings accounts is to get people to buy real insurance.

My final thought is that when you are sick, you don't need the medical equivalent of having your windshield wipers replaced or your gas tank filled up. What you need is major catastrophic coverage. And how we get to a system that encourages competition, a system that encourages people to think in terms of getting the incentives right in the system, and ensure that that money is spent wisely and well, I think is a real challenge in the United States. In the 2008 presidential election this issue is really going to come to a head, because we are embarrassed that 46-million people don't have health insurance. But because those 46-million people keep moving around, and because we have set up incentive structures that make it difficult for them to get that coverage, and also make it awfully expensive, then we

are going to continue to have that problem unless we begin to look at some of the root causes. Thank you very much. (Applause)

MR. BRIAN CROWLEY: Well, ladies and gentlemen, to pick up a couple of the phrases that Grace-Marie used in her talk, learning to spend money wisely and well, treating the whole patient, giving people power over their own lives and their own decisions, I think that is a formula that is of universal application. I think we have time for one quick question, if there is one. Martin?

MARTIN: Do you have a prediction on Medicaid Part B?

MS. GRACE-MARIE TURNER: I think that it is going to initially start out very well, because I think it is a new way of thinking about how you bring competition in to delivering a public benefit, and the early evidence is that if you stick to the rules that they have set now, it can work. I worry that, as another 40-million baby boomers come into the Medicare program, they are just not going to be able to sustain the costs no matter how much the price negotiations bring those costs down. What is going to happen is that the government will ratchet back further and further, and I think that is really when we are going to get into trouble, in the fifth and seventh year of this program, when we have so many more people on the program and Congress's attitude has changed. I think we then risk losing a lot of the innovation that we have now.

MR. BRIAN CROWLEY: Well, ladies and gentlemen, you can see why Grace-Marie has become such an important voice in the health care reform debate in the United States, and I think we have been very lucky to have her with us today. I hope you'll join me in thanking her for a wonderful talk. (Applause)

Ladies and gentlemen, that brings our event to a conclusion. Let me just say that as always, AIMS picks up good advice wherever we find it. John Abbott, in his talk today, said that he hoped that the discussions and the recommendations that arose out of this event would be communicated to every Minister of Health, federal, provincial and territorial. I can assure you that we will undertake to make that happen. I thank you all for having attended, and participated in what I think is a wonderful discussion and reflection on the issue of bringing prescription drug coverage to everybody who needs it in Atlantic Canada. I hope that you will also carry forward to your friends and colleagues some of the very good ideas that we have heard discussed