

SAVING LIVES, SAVING MONEY

Fixing what Ails Health Care in America

SLIDE 1 – Title slide

Opening story – Why are you – a busy doctor - here talking to the audience? How do these issues touch you and your community personally in few sentences?

An example:

Thank you for coming out today to talk about this important issue - I know how busy everyone's lives are and I appreciate your time.

My name is Evan Saulino.

I am a family physician, and I have seen the state of health care worsen during my career, but I wasn't motivated to action until I lost 2 of my patients in 2006. Despite working full time, neither had health insurance and they died because they lacked affordable access to care.

After their deaths, I began to investigate and fully understand the flawed and harmful direction of health care in America. I began to realize that even as a doctor, I cannot ensure that my two children will have access to medical care in the future.

As the national health care discussion unfolded over the last couple of years, we heard an earful from a lot of directions. But we didn't hear a lot from doctors and nurses – people who actually work in the system everyday, who understand many of the problems and recognize solutions. That is why I'm here talking to you today.

I believe as a health care professional, I have a duty to try and help shape a health care system that works better for my patients and for all Americans.

SLIDE 2 – TAKE HOME POINTS

I hope that you to take these three things home with you today.

First, I want to break through some of the confusion Americans have about the new federal health care law, tell you how Medicare is affected, and also tell you about the exciting things going on in our state - where we are at the leading edge of innovation.

Second, it's important to understand our journey has just begun. The federal and state health care reform laws I'll discuss are not the end of the story but are just a beginning. In particular the federal law fails to tackle some of the core problems in our health care system. Further transformation is the key to our success and financial sustainability.

Finally, I hope you come away wanting to learn more, and knowing you can have a voice in shaping the changes coming our way, especially in Oregon.

SLIDE 3: THE CURVE

If you've paid attention to the federal health care debate over the last couple of years, you realize that health care in America is really quite complicated. But today, I'm going to try to boil it down into just a single slide.

This is it.

What is this? What does this graph represent? Any ideas?

Solicit answers from the audience. Likely answers: health care costs, uninsured, deficit, taxes, bankruptcies, drug/insurance company profits, CEO salaries, obesity. Try and incorporate some of these suggestions in your discussion over the next 3 slides (if not already included below).

It turns out you're ALL right!

SLIDE 4 - Skyrocketing Costs

The United States already spends 2-to-3 times what any other nation does on health care, and costs continue to skyrocket 200-300% faster than wages or general inflation. In 2009, American families were already spending nearly \$17,000 per year for health care and coverage – or \$1,400 per month – for many of us rent, or a house payment! So this curve represents the costs of your insurance premium, copays, and deductibles.

SLIDE 5 - Uninsured/Underinsured

This curve represents the number of uninsured Americans as well. Over 47 million Americans didn't have health insurance coverage in 2009, and it's estimated another 14,000 lose their health insurance every day in the current recession. The most recent estimate is 50 million uninsured Americans.

The curve also could represent the number of Americans who are under-insured. A 2007 Consumer Reports study showed 72 million Americans have bare-bones coverage too flimsy to protect them from major medical expenses – and we all see that although we pay more every year, our benefits keep shrinking.

SLIDE 6 – Economic Drag

If you turn this curve on its side (90 degrees), it could represent the enormous drag our dysfunctional health care system is on the economy.

Businesses who try to “do the right thing” and provide health benefits for employees find themselves at a competitive disadvantage. Many have to choose between hiring more employees or paying for the latest insurance premium increase. 5 businesses

drop health insurance every hour in the United States, and if costs continue to rise unabated, this trend is sure to continue.

So this curve could represent the number of small business owners offering health benefits to employees.

The curve could represent the money you have available after health care costs, taxes, and other necessities of life. Research shows already 50% of all bankruptcies are due to medical bills in the US – a phenomenon unheard of in other industrialized nations.

The curve could represent the public dollars available to spend on other important things like roads, schools, and parks, or the dollars left in the Medicare Trust Fund - which is projected to run dry in 2019.

This curve shows us the true cost of doing nothing.

SLIDE 7 – Real Stories, Real People – John

PRESENTER: You should substitute your own patient story here if you have one that's appropriate and makes the same basic points about delayed care/increased costs/bad outcomes.

I just threw lot of numbers at you.

To translate those into something more tangible, I'd like to tell you the story of a fellow Oregonian named John.

John was in his mid-50s and had worked the same job for the last 15 years. He was healthy until he developed high blood pressure and diabetes in his 40s. His employer provided his insurance, he went to the doctor when he needed to, and his problems were controlled with the help of medication.

John never thought that he was at risk until his employer dropped health benefits because the costs were unaffordable. Suddenly, despite working full time, John was one of America's 47 million uninsured.

Because he had pre-existing conditions, John could not afford health insurance on the individual market, and would be denied coverage even if he were a millionaire.

Without insurance, he started skipping medication and doctors appointments. His illnesses were soon wildly out of control.

Then, one morning he suffered a heart attack. John didn't go into the Emergency Room until a week after because he was afraid he wouldn't be able to pay the hospital bills. When he finally went in, **literally drowning in fluid filling his lungs**, he was sent directly to the Intensive Care Unit.

After the heart attack, John was in and out of the hospital repeatedly. Each time he was sent home with no doctor he could afford to see, and prescriptions he could scarcely pay for. After a month or two John would start to skimp on medication again, worsen, and end up back in the ER.

John ended up owing nearly \$200,000 in medical bills he couldn't pay because he was too sick to work. He was embarrassed and upset because he also understood someone else would have to pay for his care.

John's bills, and those of everyone who can't pay, are shifted to employers and consumers who pay for insurance. This "cost-shift" results in a hidden "Tax" of over \$1,100 per family insurance policy in Oregon every year (*"Paying a Premium: The Added Cost of care for the Uninsured"*, Families USA - 2005).

If John had access to basic primary care and medication to prevent problems, we wouldn't all end up paying for his expensive crisis care. Worst of all, despite being a productive member of society, John ended up paying the highest price of all.

In September 2006, he died of heart failure.

As a physician and an American, I find this story unacceptable. There is a clear moral imperative to ensure everyone can go to the doctor when they need to. But John's story demonstrates there is an economic imperative as well. Healthy people build healthy communities, and we must find a way to ensure every American has access to quality, affordable health care when they need it.

SLIDE 8 - WE HAVE UNIVERSAL HEALTH CARE NOW

The fact is, the United States has universal health care right now. It's called the hospital Emergency Department (**Room**), which is mandated by law to treat sick patients regardless of their ability to pay. We don't check for cash in the wallet of a car accident victim before we care for them – we just try and save their lives.

John's experience shows us that if Americans don't get the right care when they need it, they too often end up in the Emergency Department. It's just a slower process than getting hit by a car.

Emergency Room care is the most expensive care in the world and it is well worth it when needed. But now ERs are filled with people who don't have a regular doctor and this delays access for those who need help quickly.

John shows us a real life example of fragmented care leading to unpayable medical bills and bankruptcy.

Meanwhile, businesses and health care consumers pay those "cost-shifted" bills that the underinsured and uninsured can't pay, leading to higher premiums, deductibles, and co-pays, for everyone. Ultimately fewer employers can afford to offer benefits and more people are without insurance – the cycle continues.

Slide 9 - RUNNING FASTER WILL GET US NOWHERE

As our dysfunctional universal health care system spirals out of control, it's clear that running faster on this wheel will not get us where we want to be.

SLIDE 10 – WHY DO WE PAY SO MUCH AND GET SO LITTLE?

The main question we need to ask ourselves is why we pay so much and get so little. We are a rich nation – and if we were getting the best health outcomes for the

money we spend, that might be just fine. But instead, despite spending 2-3 times more than *any other nation* on health care, we are 42nd/43rd best in male/female mortality, and 39th best in infant mortality. Our health care system overall is 37th best in the world. So we are clearly not getting the best value for the money we spend.

SLIDE 11 – WHY IS AMERICAN HEALTH CARE IN TROUBLE?

So, why is American health care in trouble?

Some of my colleagues blame it on lawsuits. Although this is a very personal issue for us, actual payouts for lawsuits amount to less than 1% of total health care costs (*Medical Malpractice Law in the United States, 2005; kff.org*). So, this is not the whole story.

Some people argue it the drug companies, insurance companies, or hospitals making huge profits. Moving from non-profit models of care that we had when I was born, to for-profit Wall Street stars offering “health services” certainly contributes to rising medical costs. But that’s not the whole story either.

Some blame the problems on the government. Rules and regulation inhibit the free market.

Others say the problem is bad doctors. They’re too greedy and they make too many mistakes.

Some blame immigrants who they believe are packing Emergency Rooms. Clearly, immigration intimately affects our economy and our communities, and it must be dealt with in a more rational manner. But uninsured immigrants are not the primary driving force behind skyrocketing health care costs. *In reality their care represents a fraction of the problem (RAND study - Health Affairs, Nov. 2006).*

Finally, we could blame individuals for our financial woes – everyone should take care of themselves better - exercise, not drink or smoke.

Research does show as much as 40% of health is related to personal behavior (McGinnis J.M., Williams-Russo, P., Knickman, J.R. (2002). *Health Affairs, 21(2), 83*).

SLIDE 12 – DETERMINANTS OF HEALTH

Of course, this means that 60% is NOT related to personal behavior. Genetics, the environment we live in, the level of education we have – these also affect our health greatly. In fact, only an estimated 10% of our overall health is related to actual medical care. So we spend \$2.3 TRILLION dollars every year for an effect of 10% of our overall health – and how much do we focus on these other issues?

And if we look too close at “personal responsibility”, blame may lay with all of us who does anything unhealthy. If I work long hours to be more productive and “successful”, this increases my stress – one of the top (6) risk factors for a heart attack (*The Lancet. Vol 364 (September 11) Pgs 937-952. 2004*). Could I be blamed for working hard if I had had a heart attack and raised everyone else’s health care costs as a result? Where do you draw the line?

You see, in health care things go from black and white to gray pretty quickly.

In fact, there is plenty of blame to go around – we all share a little. Every one of us belongs to one of these groups and there must be more responsibility and accountability from us all.

Yet blaming drives us apart instead of bringing us together to work on solutions.

And the arrows I showed you demonstrate the symptoms, not the *causes* of core problems in American health care. You don't cure a disease by treating the symptoms – you understand and attack the underlying cause.

SLIDE 13 – LEGISLATIVE ACTION 2009/10

So, with more than 8 out of 10 Americans agreeing our health care system needs major change, state and federal legislative leaders made health care reform a top priority in 2009.

Before I explain what's in the new federal law, I want to say as a physician I'm upset at the tone the debate took on. I don't think health care is a Republican issue or a Democratic issue – it's an American issue. The use of divisive messaging and misrepresentation of facts led us away from important conversations about solutions, and instead baited us into arguments with our fellow Americans.

Still, following a year-long battle, a bill was signed into law in 2010, and has just started to be implemented.

Meanwhile, here in Oregon, we followed a different route. Starting in 2005, we had a lot of community meetings around the state to get public input, built consensus among “stakeholders”, and quietly passed our own health reform law in 2009 with bipartisan support in both legislative chambers.

Oregon used this process to begin to take a comprehensive look at our health care system, and we decided we could not follow a Band-Aid approach. We set a goal to simultaneously:

- Improve the health of Oregonians
- Increase the quality, reliability, and affordability of care and
- Contain or lower health care costs

a strategy called the Triple Aim. This ongoing work has put us well ahead of the federal law.

SLIDE 14 – WHAT'S REALLY IN THE NEW HEALTH CARE LAW?

Much of the meat of new federal law called the Affordable Care Act – or ACA - passed in March 2010 focuses on reforming health insurance by providing expanded coverage, offering more affordable insurance, increasing insurance company regulation, and trying to foster more responsibility across the health care marketplace.

The Affordable Care Act – or ACA - also has elements that target some of the fundamental problems to try and control costs and improve care in the long-term. The law recognizes that primary care and prevention play a critical role in keeping Americans healthy. There are efforts to start improving the value we get for our money, and to begin training more of the medical professionals we need.

Now, it's notoriously difficult to project costs on ideas and programs that have yet to be implemented. But theoretically, according to the non-partisan Congressional Budget Office, this law will not increase the federal budget deficit.

Funding is provided by taxing health plans that cost over \$27,000 per year starting in 2018, and in additional taxes on Americans earning over \$250,000 per year.

Savings in Medicare are projected to cover the rest.

It's this last part – the effects of the new law on Medicare – that is clearly important, and possibly concerning to you.

SLIDE 15 – THE DONUT HOLE

Let's start by considering the situation in Medicare prior to the new Affordable Care Act/ACA. Who can explain to us about the "Donut Hole"?

(Engage audience here – then summarize what audience member said...)

Right, Medicare Part D drug coverage has a limit, after which you pay 100% until a certain dollar amount – and then drug coverage picks up again. Some who have supplemental drug coverage don't worry about this, but for most Medicare beneficiaries this is a concern.

In 2009 the amount a person receiving Medicare could be responsible for was \$3,600.

(Click, Click)

Without action, this "Donut Hole" would grow to \$6000 just five years from now.

SLIDE 16 – HOW THE ACA AFFECTS MEDICARE

The Affordable Care Act/ACA started gradually closing this "Donut Hole" last year, and will fill in the remainder gradually over the next 5 years.

Recognizing that preventing disease is better than trying to treat it after it pops up, the ACA will allow Medicare enrollees to get many preventive health services - such as vaccinations and cancer screenings – for free. Specifically, the law eliminates any cost-sharing - copayments/deductibles - for Medicare-covered preventive services ([that are rated A or B by the U.S. Preventive Services Task Force](#)).

Medicare beneficiaries can now get a free annual "wellness exam" from their doctors who will set up a "personalized prevention plan" for them.

The 20% co-pay on the "Welcome to Medicare" physical exam has been eliminated.

The ACA also includes funding to improve some programs for low-income beneficiaries and home based care.

The primary savings will come from eliminating automatic payments to the insurance companies that run Medicare Advantage programs. Right now, American taxpayers pay an additional 14% per beneficiary in a Medicare Advantage program, but it's not clear that seniors with Medicare Advantage benefit from that extra taxpayer money. The ACA eliminates these extra payments and replaces them with them quality-based financial incentives.

SLIDE 17- TOP 3 MYTHS

As I've mentioned, people are saying a lot of things about what they think is in the Affordable Care Act. There have been a number of myths perpetuated about how it will affect Medicare specifically. I want to dispel 3 of these myths today.

According to a recent Kaiser Family Foundation [poll](#), 36% of seniors still believe that the ACA has "Death Panels".

Let me be clear. There are no "Death Panels" in the ACA.

The term "Death Panel" was the unfortunate warping of the concept of reimbursing physicians once every 5 years for the time they spend in a patient-initiated "end-of-life" care discussion.

Oregon Representative Earl Blumenauer introduced the legislation because he, "found it perverse that Medicare would pay for almost any medical procedure, yet not reimburse doctors for having a thoughtful conversation to prepare patients and families for the delicate, complex and emotionally demanding decisions surrounding the end of life." This concept was not included in the final legislation.

The second myth is that the Affordable Care Act will cut guaranteed Medicare benefits. It will not.

It is true however, for the ¼ of Medicare recipients who are in Medicare Advantage programs, if their insurance companies can't improve their efficiency and prove their quality and yet try to maintain their income, it may put at risk some of the additional benefits people in Medicare Advantage receive beyond those that most folks in Medicare get.

Finally, the Affordable Care Act does not put the government between you and your doctor and is not a "government takeover of health care". These exact same myths were used to fight against the passage of Medicare back in 1965.

Let me be clear, although I've made the case that the Affordable Care Act will benefit most seniors with Medicare there are fundamental problems in Medicare that still need to be fixed.

SLIDE 18 – PREVENTION AND WELLNESS

A positive strategy the Affordable Care Act took to try and control long-term medical costs is to promote disease prevention, encourage healthy lifestyle choices, and to beef up our public health system.

The new law will require Medicare and insurers selling new policies to offer first-dollar coverage for preventive care – meaning NO co-pays on these services.

It will encourage premium discounts for participation in wellness programs, and now chain restaurants have to publish calorie and nutritional information, so Americans can make informed choices.

The ACA will require employers to accommodate breastfeeding mothers.

It also invests in our fragile Public Health system, which plays a critical role in disaster planning and protecting us from epidemics of infection.

SLIDE 19 – THE ROOT OF THE PROBLEM

Even with the initiatives to expand coverage, regulate the insurance market, and promote shared responsibility, it is only by controlling rising costs that these plans can be financially sustainable in the long-term.

Our health care system is broken, and I believe it will continue to be until we fix the root of the problem.

The fact of the matter is, despite spending more than any other nation by far, we do not get good value for our money. This is because we have not set up the rules of the game to reward value - our health care system pays for quantity, not quality.

To fix this, the most important thing we should focus on is how we actually deliver health care services - because the delivery of medical care is what ultimately controls the cost and generates value.

SLIDE 20 – WHAT WE KNOW WORKS

We know how to do a better job of preventing illness and providing better care for chronic and costly medical problems like diabetes and high blood pressure. Extensive research shows us the further we move along this continuum toward well-coordinated, patient-centered primary care, people are healthier and costs are lower ([numerous sources – e.g. multiple studies by Barbara Starfield MD/MPH, et al.](#)).

This type of high quality primary care provided by the doctor and medical team you choose for your family should be what everyone has access to when they need it. But this is too often not the case because financial incentives do not reward it.

Increasing access to more efficient, effective care such as this requires a reorientation of these incentives and support for innovation in care.

The new federal law begins to pay more for the value offered by primary care, and will start to foster innovation through pilot projects to modify hospital payments while also encouraging team-based care delivery that can produce better outcomes at lower overall cost.

These are steps in the right direction, but these initiatives must be expanded rapidly. Oregon is at the leading edge of this movement, and the state may begin incentivizing high value, well-coordinated, patient-centered care soon.

SLIDE 21 – WILL THERE BE A DOCTOR OR NURSE TO SEE YOU?

Of course, health insurance is no good if you can't find a doctor to see you.

Many Oregonians – particularly those with Medicare - have trouble finding a doctor today. Primary care doctors are in especially short supply. In fact, the American Association of Medical Colleges estimates a nation-wide shortage of over 125,000 doctors just 15 years from now. There is an even bigger projected shortage of nurses.

The new federal law increases funding for Community Health Centers and the National Health Service Corps - a program in which doctors work in medically underserved areas in exchange for repayment of their medical school loans.

It will begin to open up training space and consequently increase funding slightly for primary care specialties, and it works to relieve the major bottleneck in nursing training – the lack of nursing instructors.

Although these are welcome initial efforts, with such a large gap between supply and demand looming, it is clear there is much more to be done to make sure we have the 21st century health care workforce we need.

As family physicians, are working with our colleagues and legislators to do more on this in Oregon.

SLIDE 22 – OUR JOURNEY HAS JUST BEGUN

SO, it's clear there is work going on, but yet to be completed in Oregon, and that the new federal law will result in incremental, rather than comprehensive changes.

Many of the major components of the federal law should have been implemented sooner – and perhaps will be in Oregon.

Even under the new law, there will be over 20 million Americans left without health coverage. There is the problem of long-term Medicare affordability that has not been fixed.

Finally, despite the fact that many of my patients will benefit from this law, you'll notice I did not say health care costs would drop for most Americans.

We still haven't changed the shape of the curve on the first slide I showed you.

We have only taken the first steps down the road to where we need to be. Our journey has just begun.

It is critical we understand this, and that our legislators understand it as well.

We can debate how best to get to our destination, but we must overcome the divisiveness that today's politics and media feed, [and build consensus to continue on together](#) - because it is clear that we cannot stay where we are.

SLIDE 23 – WE ALL WANT THE SAME THINGS

When it comes down to it, we all want the same things. We all want to stay happy, healthy, and productive as long as possible.

SLIDE 24 – BETTER HEALTH

And we want the best health care system in the world to help us do it. But to accomplish this, we must make the primary goal of our health care system producing the best health, rather than just producing health care services as commodities.

SLIDE 25 - COMMUNITY

In order to re-orient the incentives in health care to get what we want, we must demand more responsibility from all of the players of the game – insurance companies, government, health professionals, businesses, individuals – everyone.

In community our individual threads connect and we find that what affects one of us affects us all.

Woven together we have strength to accomplish things we would never be capable of individually.

SLIDE 26– PUT OUR HEADS TOGETHER

Americans can accomplish anything if we put our heads together - but blame and infighting will get us nowhere.

SLIDE 27 – OUR LEGACY

We need to ask ourselves - what will be our legacy?

Now is the time to shape the health care future we want for ourselves and our children.

SLIDE 28 – OUR FUTURE IS IN OUR HANDS

At this critical moment, with economic and political forces molding our health care into something new, we hold our future in our hands.

If we implement solutions that work, we will lay the foundation for a more secure health care future for ourselves...

SLIDE 29 – GENERATIONS TO COME

...Our children, and for generations to come...

I appreciate this opportunity to speak with you today concerning these issues I care deeply about as a physician and an American.

SLIDE 30 – ACTION POINTS

Please continue to Listen and Learn - Educate yourself.
Advocate for affordable health care that prevents illness and delivers better health.

Please sign the Seniors Health Care Pledge we're passing around that we hope expressed the values and ideals we all share.

Second, Don't keep this information to yourself.
Talk with others in your family and community about these issues.

Finally, Your voice and vote are important, use them! Tell your legislators what you think. Become a health care voter!

SLIDE 31 – END Thank you!

Questions?