Averting Future Shock
Some Business Community Perspectives
on
Vermont's Health Care System

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The Vermont Business Roundtable is a non-profit, non-partisan organization of 115 chief executive officers representing geographic diversity and all major sectors of the Vermont economy. The Roundtable is committed to sustaining a sound economy and preserving Vermont's unique quality of life by studying and making recommendations on statewide public policy issues.

Averting Future Shock:

Some Business Community Perspectives on
Vermont's Health Care System
A Vermont Business Roundtable Policy Paper

Introduction: Successes and Problems

By almost any measure, Vermont's health care system is doing a good job for its people. But there is a widespread and growing perception that the system is increasingly fragile. And, if it is not already in trouble, some significant underlying problems need to be addressed now to avoid more serious difficulties in the near future.

Consider the following positive indicators:

- Vermonters are healthier than residents of most other states, according to measures published by the Vermont Department of Health, and most key indices are improving.

- Access to care is above average. The state's well-developed health care delivery system is built around strong community hospitals, the University of Vermont medical school and teaching hospital, and a generally adequate (although unevenly distributed) supply of primary and specialized providers of care.

- Almost all Vermonters have some form of health insurance. A currently vigorous economy, widespread private health insurance coverage, and liberal and aggressively promoted State and Federal programs leave only 6.8% of residents with no coverage, the second lowest rate in the nation.[1]

  Since 1993 the number of Vermonters with no health insurance has *fallen* 36%, while the number of uninsured nationally is climbing at an alarming rate. Vermont's improved numbers largely result from new or expanded State government programs. Private health insurance, generally obtained through employer groups, has remained relatively constant since 1993 with the number insured at about 395,000.

- The cost of health care in Vermont remains below New England and national averages. Latest available comprehensive figures place Vermont per capita health care expenditures at $3,043 — compared to a national average of $3,925. Hospital in-patient use in Vermont, as well as per admission costs of care, remains lower than elsewhere in New England.[2]

- Private health insurance premiums in Vermont reflect lower-than-average health care costs. For example, managed care premiums for Vermont's largest insurer

[1] For numerous comparative statistics on Vermonters' health, health insurance coverage, and goals for the future, see "Vermont Health Plan 1999," Vermont Department of Health, Agency of Human Services.

[2] "1997 Vermont Health Care Expenditure Analysis," Department of Banking, Insurance, Securities and Health Care Administration, July 1999. p. 25.

average $3,737 annually compared to $4,146 for similar coverage across the nation. The saving is even larger for traditional indemnity coverage (still held by 55% of privately insured Vermonters) with annual premiums of $3,748 in Vermont — more than $1,000 annually or 23% below national averages.[3]

- The State's health care planning process is good, with strong leadership at the State government level, cooperation and support from providers of care, and broad public and professional input. The 1999 health plan contains specific, realistic, and measurable public health improvement goals supported by historical and projected outcome data.[4]

- Health care is a very significant factor in Vermont's economy. For example, hospitals employ 7,600 people, generating nearly $800 million dollars in annual payrolls and non-salary expenditures. Physicians, dentists, and other health care professionals add an estimated $220 million annually, and nursing homes, drugs, and supplies, etc., brought total annual health care spending in Vermont to nearly $1.9 billion in fiscal 1998.

  Scientific and medical research at the University of Vermont and Fletcher Allen Health Care brings more than $50 million a year into the state. Furthermore, our physician Governor Howard Dean has pointed out that the UVM medical school "sustains the entire research capacity of our state, enabling research-oriented high-paying jobs to be transferred out of the University into the surrounding communities."[5]

- Finally, periodic measures taken by insurers in Vermont and required by State regulators show that Vermonters feel good about their health care providers, most do not report serious problems with access to care, and the customer satisfaction ratings of Vermont's larger health insurance carriers are relatively favorable.

Behind our health care system's seemingly healthy façade, however, lie serious and growing problems. Consider the following:

- The demand for and cost of health care, which for several years have been constrained in Vermont and nationally, are resuming the double-digit increases common in the early 1990s, raising serious affordability questions among consumers, insurers, businesses, and governments which pay the bills. Furthermore, while health care spending in Vermont historically has been below regional and national averages, the gap is rapidly closing.[6] We are in danger,

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[3] Premium estimates provided as of July 1999, by Blue Cross and Blue Shield of Vermont.

[4] See "Vermont Health Plan 1999."

[5] John N. Evans, Ph.D. From "My Turn: The Economic Value of Research, *Champlain Business Journal,* August 1997.

[6] Vermont regulators are predicting 15% per year increases in health insurance premiums (see "Increase in Vt. Health Premiums Forecast," *Burlington Free Press*, June 29, 1999), while nationally premium increase projections range from 7% to 10% (see "The Next Decade of Health Spending: A New Outlook," *Health Affairs*, Vol. 18, #4).

then, of losing an important competitive advantage, which has helped to attract good businesses and good jobs to the state.

- Driven by increased demand (particularly for outpatient care, diagnostic services, and costly new drugs), shortfalls in government reimbursement, and the limits of Federal research dollars, Vermont hospitals suffered losses of more than $19 million in 1998 on operating revenues of $787 million. As a result, they requested a 12% increase in net patient revenues in their year 2000 budgets.

  An increasingly significant contributor to hospitals' losses is the failure of State and Federal government to pay the actual cost of care used by their programs' beneficiaries. According to the Vermont Association of Hospitals and Health Care Systems, in 1998 hospitals were paid $40 million less than their cost of providing care to Medicare and Medicaid patients, in effect forcing them to try to collect the shortfall from self-paying and privately insured patients. The estimated Medicare and Medicaid shortfall in year 2000 hospital budget submissions rises to $54.6 million, on charges of $550 million. Medicaid reimbursement to physicians is even less sufficient, reportedly averaging less than 50% of charges.

- Health insurers in Vermont lost nearly $70 million over the past three years, and as a result are estimating that premiums must go up 15% per year for the forseeable future. Several health insurance companies (including Kaiser-Permanente, the state's second largest private insurer) have pulled out of the state or are planning to leave, reducing the choice of health plans for consumers and businesses, and weakening the competition among insurers that has helped keep costs down. Kaiser-Permanente's inability to find a buyer for its 92,000 Vermont customers raises serious questions about the viability of private health insurance in the state, given the present regulatory and competitive environment.

  Health insurers' problems were, in part, self-generated. Aggressive competition from new entrants in the market caused the incumbents to under-price their products to retain market share.

  However, in 1998 the Vermont Legislature passed several laws requiring coverage of new benefits (e.g., for mental health services, diabetic supplies, and chiropractic care) in all licensed insurers' standard contracts. These mandates alone added about 7.5% to the cost of coverage — roughly $500 per year per family.

  Increasing losses that result from higher utilization, mandated benefits, and underpriced products have left the insurers remaining in the state extremely vulnerable.

- Seeking to avoid increases in health insurance benefit costs, more and more Vermont businesses — particularly those with younger and healthier employees — are turning to self-insurance, and\or reducing their benefit packages, or dropping health insurance altogether.

  Self-insurance is perceived as having two advantages: First, it permits businesses to avoid mandated coverages, thus helping control costs for benefits that their

employees may not necessarily need or want. Second, by removing themselves from larger insurance pools, which may include older and less healthy workers, companies can reap direct benefits from behavioral changes among their own employees. Unfortunately, the migration of better risk customers to self-coverage leaves the insurance companies with sicker and costlier participants, driving up their costs even further and eventually forcing marginal-income customers out of the market.

Further, the declining percentage of privately insured (and better paying) patients leaves providers of care more dependent on poorly funded government programs, with consequent negative impacts on their ability to maintain a high quality delivery system. Over time as more people fall back on government programs, taxes will inevitably go up, making it more difficult for Vermont to compete for businesses willing to locate in the state.

Three other unfortunate factors exacerbate the impacts of these problems on consumers in Vermont.

First, as earlier Vermont Business Roundtable surveys have shown, most employers do not absorb health insurance cost increases. Rather they raise employee out-of pocket contributions, raise deductibles or co-pays, reduce benefits, or otherwise pass along the higher cost to employees. In the worst case, they drop health insurance altogether; this is particularly likely in small firms. The latest available State data show that only 27% of workers in Vermont firms employing fewer than 10 people are offered health insurance

Second, because average wage levels in Vermont are lower than elsewhere in the region, rising health costs hurt Vermonters more than they would people in other states, who are more able to pay. In effect, then, even if our costs are equal to or slightly below national averages, the burden on the average family is no less — and probably is greater — than elsewhere in the nation.

More people work for very small businesses in Vermont than virtually any other state in the nation. Despite the State's efforts to implement community rating, small businesses pay higher premiums for health insurance coverage than larger firms pay. Furthermore, workers in smaller businesses typically earn lower salaries *and* usually have to pay a greater portion of health insurance premiums out of their own pockets. As costs continue to rise, more and more low-wage workers in small firms drop out of the insurance market simply because they can't afford coverage.

Vermont, then, needs to be extraordinarily sensitive to the need to control the spiraling costs of health care. Affordability is a serious and growing problem, even among those who have good health insurance available. At average family premiums of $6,000 per year, and median family income of $47,300, we may already have reached the point where health insurance affordability becomes a very serious problem.

A third, unique Vermont problem has recently been coming into focus: the growing imbalance between the scope and quality of health insurance paid for by the State for Medicaid recipients, and that generally held by workers in hundreds of small companies across the state.

Vermont's Medicaid program includes comprehensive, no-deductible coverage of a very broad benefit package, including preventive care, dental care and prescription drugs. Co-pay amounts are small (e.g., $2 for a physician office visit), except for the prescription drug plan which has 50% co-insurance. Premium payments are scaled to income up to a maximum of $20 per month. The Dr. Dynasaur program for pregnant women and children provides similarly comprehensive coverage at family incomes up to $50,000 per year at virtually no cost.

By comparison, the average indemnity package held by working people in Vermont is far less comprehensive and requires significant out-of-pocket deductibles (typically $500 per family) before any benefits are available, plus 20% of charges for most covered services. Late 1999 small group premiums for this benefit set ranged from $400 to $575 per month for family coverage.

Non-group coverage (for persons unable to get group insurance) imposes even higher front-end deductibles (currently averaging $3,000 per year per family) and co-pays averaging 20% of charges. Non-group rates vary by insurer, but generally exceed group premiums by at least 20%.

In summary then, Medicaid and Dr. Dynasaur families of four with incomes *up to $50,000* a year can acquire broadly comprehensive health coverage at very low out of-pocket expense. But another family of four earning only a little more must pay several thousand dollars a year for health insurance premiums, plus substantial out-of-pocket deductibles and co-pays, plus an income tax contribution to the State's general fund to subsidize the free care for the family down the street.

The working family also pays substantial Federal Medicare taxes to subsidize health care for the elderly. Finally, Federal and State tax policy makes it very difficult for employees of smaller companies to deduct health insurance and co-pay expenses, unless the total amount exceeds 7.5% of income.

Commendably, the State of Vermont is achieving one laudable social objective, i.e., providing health insurance for children — and no one would want to reverse recent gains in this regard. But, legitimate questions can and should be raised as to whether this progress is coming at increasingly onerous — and some think unfair — costs to the working individual or family.

As private health insurance costs go up, and as employers pass more of the cost along to employees or drop insurance altogether, the apparent inequities worsen between those covered by State-sponsored and private insurance programs.

Further, if present sources of funding to the state dry up (e.g., tobacco money), understandably there will be great reluctance to cut government program benefits or reduce eligibility, bringing more pressure to pay providers less adequately and force them to shift even more cost to private insurers.

In addition to the escalating burden placed on working people who pay most of their own premiums, the cost shift also hurts businesses that are trying to provide good jobs in an often difficult Vermont business environment.

As noted at the beginning of this paper, on balance Vermont's health care system serves us well. It has been an asset in Vermont's on-going struggle to attract and retain good companies with high paying, desirable employment opportunities to the

state. But the system is showing strain, the trends are not positive, and action is needed now to assure that a competitive asset does not become a disadvantage.

Inventing The Unaffordable — Spending The Unsustainable

Two previous Roundtable reports discussed several of the most significant factors that drive health care costs upward.[7] These include new medical technology; new drugs; the growth and widespread availability of public and private health insurance (which insulates consumers against the cost of care); and legislative mandates of broader private insurance benefits — all fueling a seemingly insatiable demand for more and more health care services.

The American public appears to believe that more health care is always better health care, and that unlimited access to unlimited amounts of health care is a "right," regardless of whether the individual has personal resources to pay for it.

That public mindset drives the growth of government sponsored programs like Medicare and Medicaid, encourages legislators to "mandate" new private insurance benefits, and hampers cost containment efforts, such as HMOs' limitations on choice of physicians or use of generic drugs.

Further, it encourages or requires providers to keep inventing newer, costlier, and presumably better ways to provide more health care services. This entrenched public attitude may be the single most significant reason why the United States spends almost twice as much of its GDP on health care as any other developed nation.[8]

Now, however, more and more health care experts are beginning to argue that too much health care may actually be harmful, and certainly that we cannot keep allocating unlimited resources to the system. One proponent of these views is Richard D. Lamm, a former Governor of Colorado, now Director of the Center for Public Policy and Contemporary Issues at the University of Denver.

Former Governor Lamm notes that over the last three decades the U.S. has practiced "spare no cost" medicine, involving "the most massive transfer of wealth into one sector (health care) that history has ever seen," and driving the cost of health care from 4% of GNP to 14%. "Seemingly endless pools of money," he says, "allowed us to do everything 'beneficial' for everyone lucky enough to be in the system." But, drawing on his experience as Governor, Lamm says that "beneficial" is an unsustainable standard.

"We can no more afford to do everything beneficial for every patient than the education system can do everything beneficial for every student or the police department for every citizen. No society, no matter how rich, can fund such a yardstick or sustain such an open-ended system. We are delivering," he says, "and

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[7] See "Laws and Consequences: An Examination of certain Impacts of Mandated Health Care Benefits" (January 1998) and "Can We Have It All? Balancing Access, Quality and Cost in Health Care" (January 1999). Both are available in print from the Roundtable or on the Web at <*www.vtroundtable.org*>.

[8] J. Iglehart. "The American Health System: Expenditures," *New England Journal of Medicine,* January 7, 1999.

the public is expecting, more medicine than we can afford to sustain, and using a standard — beneficial — which will bankrupt us. Modern medicine," Lamm concludes, "must recognize that resources are limited, choices are inevitable, and that today's status quo is unsustainable."[9]

Lamm sees a "coming clash" between patient advocates, who believe that everything possible must be done for every patient, regardless of cost, and public policymakers, who must recognize that while certain treatments are beneficial, they may not be worth the cost. "Much of the recent controversy about health care has to do with our refusal to admit that we will have to set limits and make priorities."

When spending public funds," Lamm says, "we shall have to forego some medical care so that we can maximize the health of the group. We must decide what marginal medicine we can morally leave undone. This is a dilemma so new that neither our social, legal, and religious institutions, nor our health care providers or consumers have developed a satisfactory way of coping."

Lamm suggests that part of the reason for runaway health care costs is that state and Federal governments have failed to understand and carry out an essential balancing function against patient advocates.

> "Government's role is qualitatively and quantitatively different from the role of providers of care. Government can never fund all the beneficial health services a caring, imaginative, and technologically advanced society can develop.
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> No one has conclusively articulated, either to the public or to health care providers, that what we are now doing cannot long continue … Government refuses to set limits, yet pretends that there are no limits ... Government is not about what we need, rather, it is about what we can afford."

Lamm's views may be particularly noteworthy in Vermont, where beneficiaries of government programs account for more than 44% of all health care expenditures, making government the largest single payer in the state.

Further, government health care spending is rising at a rate well in excess of private patient spending. For example, Medicare spending in Vermont rose 44.6% from 1993 through 1997; Medicaid spending rose 40.8%. The percent of spending on Medicaid in Vermont considerably exceeds national averages, at 21.5% compared to 14.6 percent elsewhere.

There is an urgent need for a new kind of policy dialogue in Vermont, one not about how much health care we *would like* to make available to our citizens, but how much we *can afford* to make available. The focus must be not only on every citizens "right" to unlimited health care, but also on how to balance the resource demands of health care against the needs of other — equally desirable — social goals such as education, transportation, nutrition, and housing.

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[9] Richard D. Lamm. "Marginal Medicine," Policy Perspectives, *Journal of the American Medical Association,* September 9, 1998.

More Medicine Is Not Always Better Medicine

Former Governor Lamm's writings on U.S. medical spending address socio-economic rather than medical concerns. But over the past decade a growing number of medical experts have been arguing that too much medical care may actually be harmful to the patient.

These include two physician researchers at the Dartmouth Medical Center, whose recent articles cite a number of examples where more care isn't necessarily better care:[10]

- A 1995 study of Medicare patients with heart disease in Texas and New York showed that even though Texans were more likely than New Yorkers to receive intensive treatment, New Yorkers fared better overall.

- Another classic case studied the efficacy of extending medical treatment to patients with mild cardiac arrhythmia, and found that medicines used with good result for patients with more severe arrhythmia provided no benefit at all in milder cases. In fact quite the opposite was true: the mortality rate for these patients increased 2.5 fold from all causes, and deaths due to arrhythmia were 3.6 times higher than in the group taking a placebo.

Welch and Fisher cite other research suggesting that our increasing capability to diagnose diseases — and the availability of new drugs to treat them — may lead to a tendency to redefine patients as diseased who may have no symptoms. For example, there used to be 11 million diabetics, now there are 13 million. There used to be 38 million hypertensives, now there are 52 million. "When you get to the bottom line," says Welch, "you find that given these definitions three out of four adult Americans are 'abnormal' or 'diseased.' That's kind of ludicrous, isn't it?"

Drs. Welch and Fisher suggest that the runaway growth in medical care interventions and related spending stems from at least two factors. The number of physicians per capita has increased by 50% over the past 20 years. There are twice as many cardiologists and five times as many radiologists in the U.S. now than in 1979. "Physicians believe fundamentally that they do good," Welch says. "And if they can do more, such as finding disease at earlier stages, they believe people will be better off. This is a problem of the best of intentions."

But, he adds, "I would be remiss if I didn't say that money's part of the story too. There is a strong incentive on the part of the device manufacturers and pharmaceutical companies to expand the indications for the use of their machine or their drugs. If you're just going to stick with people who are sick, you've got a relatively small population."

These comments are particularly noteworthy when considered in the context of data collected by Blue Cross of Vermont indicating that prescription drug costs for its members nearly doubled in just three years, rising from $31 million in 1995 to $56 million in 1998. Prescription volumes rose over the same period from 494,000 to 855,000.

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[10] Elliott Fisher and Gilbert Welch. "Avoiding the Unintended Consequences of Growth in Medical Care," *JAMA*, February 3, 1999 and "The Making of a Medical Skeptic," *Dartmouth Medicine*, Summer 1999.

Dr. Fisher suggests that Federal Government policy has been in part responsible for these trends "by investing a disproportionate share of research funds into the development of new treatments and technologies, many of which receive little ongoing evaluation. We invest a huge amount at NIH into idea generation; we invest very little into evaluation of technology in practice."

The editors of *Dartmouth Medicine* comment that the aim of Drs. Welch and Fisher's research is to "distribute the country's health care resources more equitably and to concentrate those resources where they are more likely to produce positive outcomes."

Certainly such an objective would be appropriate for health care policymakers everywhere, especially given the premise that resources are limited, and that priorities must be set. It is particularly important that small states like Vermont focus less attention on giving some of the people everything they want, while trying to give more of the people what they truly need.

Policies and Recommendations

The Vermont Business Roundtable recognizes that Vermont's health care system is operated by a diverse, multi-functional, and dedicated group of independent entities, that it is constrained by complex legal issues, and impacted by thousands of individual and group decisions made daily under often urgent circumstances. Certainly controlled, significant change is difficult to achieve.

However, the Roundtable notes that Vermont's businesses ultimately pay much of the cost of health care, either through taxes, fringe benefit costs, or charitable contributions. Business therefore deserves a strong voice in health care policy dialogues and can offer responsible points of view.

In that context the Roundtable sets forth the following principles, or policy points, and several very specific recommendations that we think will help heal some of the health care system's current ailments.

Access to Care

The Roundtable believes that all Vermonters should have access to *necessary*, high quality health care. But universal access cannot mean unlimited or unrestrained access. *To assure an equitable and affordable system of health care delivery, we must be prepared to control costs by accepting reasonable, non-discriminatory constraints on access.*

Prioritizing Health Benefits

Since an affordable system cannot provide all health benefits that might be deemed *beneficial*, public policy must prioritize the health benefits subsidized or paid for by the public. *Fundamentally, we must rationally define the essential benefits to be covered — those benefits most necessary to restore and/or maintain health. Since any system of priorities will have exclusions, this process undoubtedly will raise difficult political and ethical issues, but these cannot be avoided.* As former Governor Lamm has said: "It is unethical for a state *not* to have a system of priorities … those

in health plans who distribute pooled resources have an ethical duty to prioritize and budget the funds to maximize the total health of the group."[11]

Maintaining a Competitive, Multi-Payer Market

The Roundtable believes that the most effective, socially acceptable, and politically realistic method of funding health care and access to care is a combination of self-payment, private health insurance, and government programs, each of which pays its fairly allocated share of reasonable and necessary costs.

The Roundtable notes that single-payer systems, while attractive in some respects, typically are operated by governments, chronically under-funded, and characterized by diminished access to lower quality care. The Canadian and English systems are prime examples. *Government policy should promote, not impede, the development of a healthy, competitive marketplace for private insurance in Vermont, since this is essential to maintaining quality and affordability of care.*

Fair Government Funding

Government under-funding of health care benefits is increasingly recognized as a major contributor to the rising cost of private insurance. A recent report by the Vermont Public Oversight Commission stated: "In the end, employers and ultimately employees are paying far more for health insurance than is necessary. [And,] this cost shift almost always trickles down to the average worker, either with [lesser] pay increases, greater insurance premium sharing, reduced hours, and in some cases, layoffs."

Government should pay the full, reasonable cost of the care it provides. This means that government must either increase payments to providers of benefits for Medicare and Medicaid recipients, or — if that is deemed unaffordable — then it must reduce benefits. Government, like other health care consumers, must live within its means.

Promoting Reasonable Cost Controls

The "backlash" against managed care (see earlier Roundtable papers) has generated broad public antagonism against any constraints at all on health care access. But an affordable health care delivery system *requires* sensible limits on health care utilization.

Government regulation must not impede the development and implementation of reasonable devices that limit access to control cost without negatively affecting quality of care. Government programs themselves should be required to include such devices. In developing new regulations, policy makers must more carefully balance the need for sensible controls against the goal of protecting health care consumers.

Maintaining An Important Asset

Vermont's existing health care system has many valuable assets, including a first-rate medical school and academic medical center, and a strong system of community-based, non-profit health care providers. These assets provide a strong

[11] Richard D. Lamm. "A New Moral Vision for Health Care."

foundation for an excellent health care delivery system, and also serve as a powerful economic engine in the state.

Moreover, good health care is an essential component of the quality of life that attracts desirable industries with better-paying jobs into Vermont. *Public policy must*, *therefore*, *take into account the need to maintain and preserve these valuable assets, since a viable, well-funded health care system is a lynchpin of the State's continued economic well being.*

Vermont Not An Island

The Roundtable emphasizes that its members, while trying to provide good jobs in Vermont, compete not only with our New England neighbors but increasingly across the U.S. and internationally. *The costs of all desirable social programs, (e.g., access for everyone to high quality health care) should be more clearly identified, funding sources better defined, and the long-term impacts of health care decisions on Vermont's ability to compete must be taken seriously into consideration when decisions are made.*

Further, policymakers should think of wages and fringe benefit expense as a single component of the overall cost of doing business. If health care costs escalate, and a competitive market does not permit businesses to raise prices, there is less money available for wages. Therefore any actions that increase the cost of health care in the final analysis are borne by employees, not employers.

Mandates Cost Impact Analysis

Legislative requirements and mandates, even if deemed necessary or socially beneficial, can substantially increase the cost of health care (see "Unexpected Consequences: Some Impacts of Mandated Benefits," January, 1998.)

Policymakers should be required to identify and justify these added costs, before enacting new health care benefits or regulations, by conducting independent cost-benefit analyses measuring the likely cost impacts of new laws or regulations against their perceived benefits.

Improved Information Flow

The Roundtable believes that better public and individual understanding of and involvement in health care decisionmaking can positively affect health care outcomes and help control costs. Some positive steps are being taken in that direction, including member education and self-help efforts by health insurers, (e.g., Blue Cross and Blue Shield's "Your Health" program) and state regulations which require insurers to make publicly available selected health care quality and outcome measures from HEIDIS and similar data sources.

The Roundtable encourages these efforts, but believes that the public also needs clear, easily accessible information on the comparative costs and relative effectiveness of various health care services and treatment methods, as well as understandable, regularly updated data on the training, outcome records and similar measures of the capabilities of medical professionals and institutions.

Controlling Prescription Drug Costs

The Roundtable applauds the Vermont Legislature's efforts to address public concern with the escalating cost of prescription drugs. Certainly action is needed; according to *USA Today*, U.S. consumers are paying for much of the world's drug research via prices that substantially exceed the government-controlled prices in most other developed countries.[12] Drug manufacturers argue that U.S. profits are necessary to fund their research capacity that keeps new, lifesaving drugs coming on line.

But, *Consumer Reports* says the industry spends more money on advertising (an estimated $1.8 billion this year) than it does on research.[13] *USA Today* points out that the U.S. is the only industrialized country that permits prescription drugs to be advertised directly to consumers. And, the ten most heavily advertised drugs accounted for 22% of the increase in total prescription drug spending since 1993.

Further, the U.S. prohibits the importation of drugs that are sold cheaper elsewhere, while most European countries *encourage* such comparison shopping. U.S. retailers may not import Prozac, for example, from Canada, where it costs 53% less than in the U.S. and is manufactured in the same plant.

The burden of runaway drug prices falls heavily on business, for those employees with health insurance coverage, and on taxpayers, who fund the costs of prescription drug coverage for Medicaid recipients. But millions of people across the U.S. and in Vermont have no drug coverage at all, and must pay the cost out of pocket.

Giving more people access to private or public insurance would help those with limited or no coverage, but costs would be astronomical unless the underlying problems that drive up drug prices and usage are first addressed.

And, as the *Rutland Herald* points out, state-level solutions often are complicated, if not prohibited outright, by Federal Laws, regulations and constitutional issues.[14] Clearly this is a problem that cries for concerted and coordinated action among State and Federal policymakers, focusing on solutions rather than merely expansions of eligibility and more spending.

Negotiation rather than regulation might be an immediately fruitful approach. Large insurance companies in the U.S. already purchase drugs on behalf of insureds at very substantial discounts via rebates directly from the manufacturers. Similar discounts might be negotiated for all insureds (including those without prescription drug coverage) and vouchers issued allowing purchase of drugs at the lower price.

The State of New Hampshire recently announced an experimental program that involves State purchase of drugs at discounted prices for certain residents not falling within eligiblity limits for Medicaid.

U.S. law already requires pharmaceutical companies to sell drugs to the government at the best wholesale prices given to the largest private customers. And, certain Federal agencies (e.g., the Veterans Administration) get an additional 25% discount,

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[12] "High Prices Force Tough Decisions," *USA Today*, November 10, 1999.

[13] "Prescription Drug Prices, An Update," *Consumer Reports*, September 1999.

[14] "Lawmakers Mull Drug Price Issue," *Rutland Herald*, September 11, 1999.

essentially bringing prices down to international levels. And, drug companies pay some state governments up to 15% of average wholesale price for drugs sold to Medicaid recipients.

Governments should seriously explore, as a useful and legal first step, negotiating rather than legislating reduced prices on behalf of the public. Leading insurance companies with relevant expertise should step forward to help structure legally acceptable approaches.

Continuing Dialogue Needed

Nothing in this or previous papers has meant to impugn the integrity of the thousands of health professionals, regulators, legislators, and others who operate and oversee our health care system. Rather, the intent has been to highlight growing concerns about whether U.S. citizens and particularly Vermonters really need all the health care we are demanding; whether more health care services necessarily equate to better health; and especially whether we can continue to sustain current rates of increase in health care spending.

If indeed, as former Governor Lamm and others have suggested, we have become accustomed to “blank check medicine,” what may be needed is a significant attitudinal change among providers, administrators, policymakers, and the consuming public.

The Roundtable hopes that these papers — and its sponsorship of related public forums — will spark and help guide continued discussion of these important issues among health care professionals, government, and other policymakers, with business adding a respected and needed voice. The hoped for result is a healthier Vermont health care system, a healthier Vermont economy, and a healthier citizenry.

VERMONT BUSINESS ROUNDTABLE

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