

# The Best Medicine

## How Can Montanans Take Charge of Changes in Health Care?

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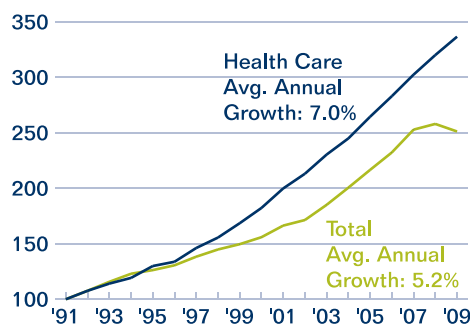
In case you haven't noticed, things have been changing lately at your doctor's office and your hospital. Perhaps your doctor is getting ready to retire – a large fraction of Montana primary care physicians are at or near retirement age. Maybe your doctor now works for the hospital – individual medical practices are vanishing across the state as the reimbursement, regulatory, and record-keeping requirements cut into private practitioners' time and money. And nothing short of a revolution is sweeping across hospitals as they prepare to cope with the largest changes in health care regulation and finance since Medicare.

But real change in health care is just getting started. In the next few years, we're going to see things like:

- online kiosks where we can shop for health insurance;
- a government-financed insurance coop to compete with Blue Cross;
- the Frontier Hospital, a new concept where higher Medicare reimbursement rates can help support the survival of our smallest rural facilities;
- retail medicine, where prudent buyers can shop for treatments and surgery like we shop for cars or clothing.

The Patient Protection and Affordable Care Act (the ACA, or Obamacare) is certainly the driver of many of these changes – but not all

**Figure 1**  
**Montana Health Care Spending and Total Spending, 1991-2009, Index 1991 = 100**



Sources: Centers for Medicare and Medicaid Services and Bureau of Economic Analysis.

of them. Changes are coming about because the costs of our current system are on an unsustainable trajectory. Historically, the rate of growth in health care expenditures in the U.S. has exceeded the rest of the economy by about 2 percent for the past 40 years. This same pattern has been seen in Montana where health care spending has grown by 7 percent since 1991 (Figure 1). The prospects for continued spending growth are strong due to the aging of Montana's population and the potential for coverage of formerly uninsured by Medicaid and commercial insurance. The system has become unaffordable on a national, state, and personal level.

For Montana consumers, businesses, providers, and governments, this is both a challenge and an opportunity. The

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issue for all is the same: What are the new decisions that the changing health care system will confront us with, and how do we prepare ourselves to make good ones? Let's take a look at each group in turn.

### Consumers

For most people, several questions arise when it comes to health care: Can I get care? Can I afford care? Is it the right care? Access, cost, and quality are the outputs of the health care system (Figure 2). Access to medical care when it is needed is directly related to insurance coverage. People without health insurance delay obtaining care until a condition becomes emergent and when the cost of care is greatest. Today about 195,000 Montanans are without health insurance. And rewarding quality

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of care is increasingly recognized as vital for both patient outcomes as well as controlling costs.

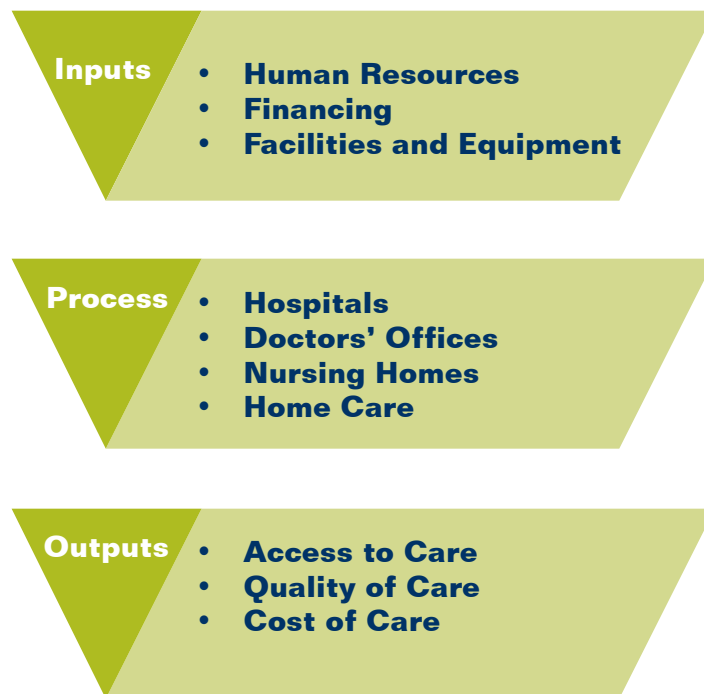
A direct result of providing insurance to more Montanans is a reduction of cost shifting to private payors due to charity and bad debts costs. The savings could be substantial. In 2011, uncompensated care costs for Montana hospitals, doctors, and other providers was about \$286 million, or 10 percent of total costs.

#### Employers

One of the key decisions for Montana employers will be to decide whether to continue offering a health plan or to shift employees to purchase directly from the new insurance exchange. Cost growth has caused smaller businesses in particular to struggle with offering health insurance to their workers and families. In a state where most businesses have fewer than 100 employees (Figure 3, page 4), the ACA will present some attractive opportunities. Its provisions include:

- Employers under 25 employees with average wages under \$50,000 are eligible for small business tax credit up to 35 percent (increases to 50 percent in 2014).
- Employers under 50 employees are exempt from the employer “mandate.”
- Employers under 100 employees are eligible to shop in the

**Figure 2**  
**The Health Care System**



insurance exchange, thereby gaining purchasing advantages of larger employers.

- Insurance exchanges offer choice of plans that meet cost and benefits standards set by state.
- Individuals earning less than \$44,680 and families of four earning less than \$92,200 are eligible for a federal tax credit.

Collectively, these provisions could enable up to 97 percent of

Montana employers to give employees the opportunity to buy their health insurance at the exchange, thus introducing the concept of the “prudent buyer” to the health care marketplace for the first time. Until now, the private consumer has never been a major factor in controlling health care costs because insurance furnished by the employer or government has largely insulated the patient from the cost of the service.

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### Providers

For health care providers, more regulation increases compliance and operating costs. Hospitals and practitioners have already reacted in Montana and elsewhere by consolidating into larger organizations that can spread these costs across higher volumes of business. Already, more than 90 percent of all primary care doctors are employees of hospitals. The size and breadth of a new concept of care networks known as Accountable Care Organizations (ACO), which are designed to better manage medical care, could produce as few as one or two such entities in a less populous state such as ours.

Today, Montana has 2,264 practicing physicians, but 78 percent are located in just six counties. Because primary care is the life blood of our Critical Access Hospitals – those designated by Medicare as sufficiently remote and rural to merit higher reimbursement rates for their services – their capability to recruit new doctors is essential for access to care for rural Montanans.

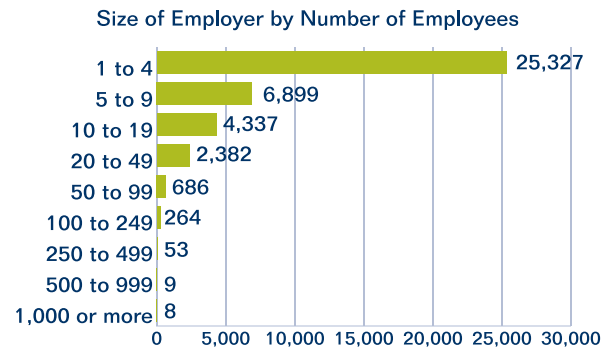
Rural communities already have proportionately fewer primary care doctors than urban areas, and aggressive programs to promote residency training in primary care may be needed to head off a shortage-induced decline in rural health care access.

### State and Local Governments

The Montana Legislature and the executive branch have a pivotal role in this historic opportunity for Montana to make major inroads on this chronic social and economic problem called affordable health care. Decisions that lie ahead for these policy-makers include:

- whether to increase insurance coverage by authorizing the expansion of Medicaid;
- whether to assist cost control by authorizing the Commissioner of Insurance to approve insurance rate increases;
- whether to assist cost control by improving price transparency the way states like New Hampshire have ([nhhealthcost.org](http://nhhealthcost.org)); and

**Figure 3  
Number of Employers by  
Employee Size,  
Montana, 2012**



Source: Quarterly Census of Employment and Wages.

- whether to ramp up efforts to support graduate medical education for primary care doctors and other critical workforce shortage areas to address shortages in rural areas.

### Conclusion

For the health care system, changes in cost control, access, and quality are already upon us. Whether or not those changes produce more desirable, more affordable outcomes or not depends on the decisions made by all of us.

The Affordable Care Act should be custom-fitted to Montana for these health care changes to maximally benefit Montanans. The best medicine requires a collaborative blend of federal, state, and private health provider efforts.

There are still plenty of unsolved problems in American health care. But it's important to know that the system is not standing still. Is your household or business ready to capitalize on the opportunities they present to us? 13