MISSISSIPPI AND HEALTH CARE REFORM

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The national crisis in health care is affecting Mississippi as much as any state. Nationally and locally, costs are rising and insurance coverage among working age adults is shrinking. In addition, health outcomes are below what they should be in many categories. For example, the U.S. ranks about 30th among high-income countries in life expectancy at birth, and infant and maternal mortality rates are high as well.[1] The health care legislation working its way through Congress represents a major effort to address three basic problem areas: cost, coverage, and quality.

Controlling the soaring cost of health care may be the most critical issue. Falling coverage is directly related to rising costs, and cost constrains the quality of care that can be provided. Moderating the rise of health care costs while enhancing quality will remain a major, long-term challenge even if any legislation passed this year fully covers the cost of reforms enacted. See the National Economic Outlook article for more detail on health care reform proposals.

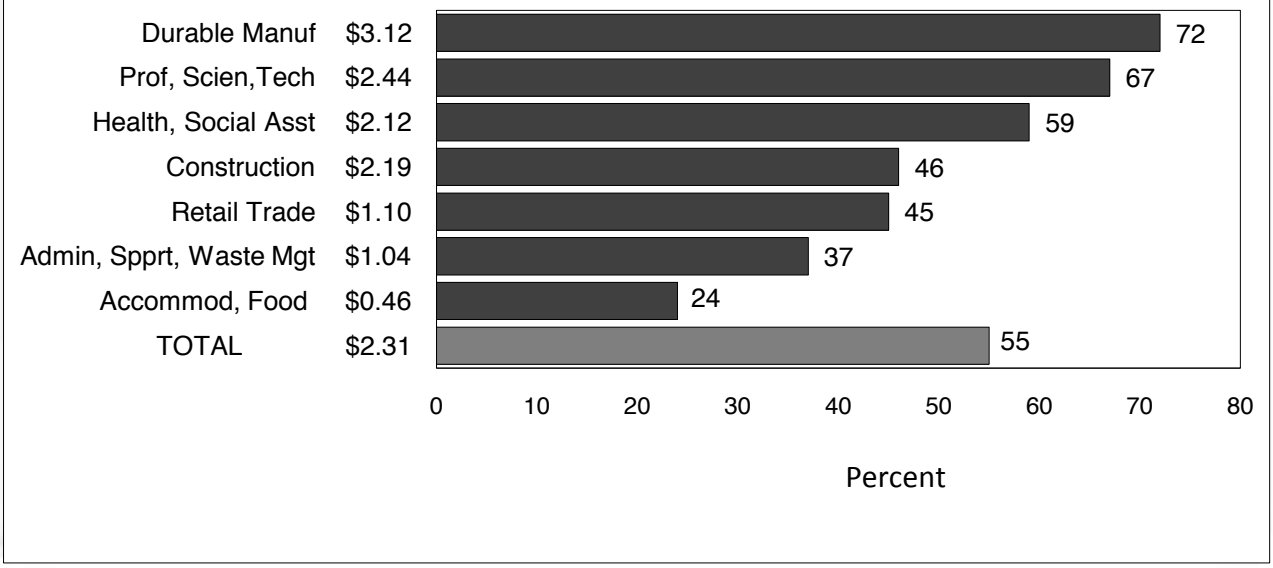
The falling percentage of persons with health insurance coverage has been a major catalyst of current reform efforts. Nationally, roughly 46.3 million people in the U.S. lacked health insurance coverage in 2008, according to the U.S. Census Bureau, or about 15% of the population. Most of the uninsured are of working age. Figure 1 shows the percentage of workers covered in selected industries, along with the average hourly cost to employers. Note that in some industries less than half of workers have employer-sponsored health insurance. Overall, 20% of the U.S. population aged 19 to 64 lacked insurance coverage and this percentage has been increasing. In Mississippi, the figure for this group was over 24% (six states had higher rates than Mississippi).[2]

Health insurance coverage profoundly impacts health outcomes. A 2009 study by Harvard Medical School researchers found that adults age 64 and younger who lack health insurance have a 40% higher risk of death than those who have coverage. This translates into nearly 45,000 deaths annually linked to a lack of insurance.[3] In Mississippi, the number of persons dying from causes considered treatable or preventable with appropriate medical care is the highest in the nation, at 142 persons per 100,000, according to the State Scorecard of the Commonwealth Fund.[4] The U.S., by the way, also ranks high in this statistic in comparison to other countries.[5]

Rising costs have been the key problem for employers. It is also a key concern of individuals: 62% of personal bankruptcies filed in 2007 were linked to medical expenses and of those who filed for bankruptcy, nearly 80% had health insurance according to a 2009 Harvard study by Himmelstein.[6]

The potential benefits from health care reform, then, are great, but the challenge is also formidable. Consider the rate at which expenditures per person have been rising. Between 1991 and 2004, health care expenditures per person in the U.S. increased at an average annual rate of 5.5% and, in Mississippi, at 6.7%.[7] (The average health care expenditure per person in Mississippi was $5,059 in 2004 and in the U.S. $5,283.) More recent data available from the State Employees Health Plan show that benefits paid per person under this plan rose an average of 9.8% annually from fiscal year 2001 to fiscal year 2008.[8] Rising expenditures mean rising premiums. In 2008 the cost of a family health insurance premium was $11,363 in Mississippi, up 41% from 2003, but still about $1,000 less than the U.S. average.[9]

Figure 1. EMPLOYER-SPONSORED HEALTH INSURANCE COVERAGE: COST PER HOUR OF WORK, AND % COVERED 2008



SOURCE: Bureau of Labor Statistics ECEC December 2008 survey and March Census Current Population.

The key to holding down costs, which is essential to expanding coverage, is reform within the health industry, supported by the industry, according to an expert panel brought together by the Robert Wood Johnson Foundation.[10] Fee-for-service structures that reward medical personnel on the basis of services rendered, but not on outcomes, offer incentives for more, but not necessarily better, treatments. An alternative incentive structure is that followed by such providers as the Mayo Clinic, the Cleveland Clinic and the Intermountain Healthcare. These providers have a large number of doctors receiving fixed salaries, as well as incentive structures based on outcomes that encourage and obtain excellent results.[11]

The Robert Wood Johnson panel addressed payment systems, regulations and institutions in its study. Improved information systems; payments that reward lower-cost, high-quality care; incentives for better individual choices by patients; and insurance market exchanges that pool risks for small-group and non-group insurers are among the recommendations.

Prevention is an important part of their answer to the crisis in health care costs. Chronic health conditions accounted for 75% of total health care expenditures, according to one 2009 study, and many of these conditions are either preventable or amenable to treatment that would reduce the need for costly emergency care.[12]

The reform and restructuring of the health care system will be neither easy nor straightforward. The size of the health care bill wending its way through Congress is indicative of the enormity of the task.

Notes

1. Infant mortality rates here are over twice as high as in Portugal and maternal mortality rates are 10 times as high as in Ireland. A complete listing of health outcomes by country can be found at the website of the World Health Organization: www.who.int

An Urban Institute article reviews several studies of U.S. health care. The article by E. Docteur and R. Berenson, "How Does the Quality of U.S. Health Care Compare Internationally?" (8/20/09), concludes that U.S. health care outcomes are uneven across categories in comparison to other countries. For example, Canada is a country whose health care system has been extensively researched in comparison to that of the U.S. "Of ten studies that included extensive statistical adjustment and enrolled broad populations, five favored Canada, two favored the United States, and three showed equivalent or mixed results", the study notes.

2. See Kaiser State Health Facts, at www.statehealthfacts.org.

3. Reuters News Service, "Study links 45,000 U.S. deaths to lack of insurance", 9/18/09, by Susan Heavey.

4. The Commonwealth Fund (2009) estimated that the "mortality amenable to health care, deaths per 100,000" was 142.0 in Mississippi compared to the all states median of 89.9. The top five states averaged a rate of 68.2. www.commonwealthfund.org . Definition of mortality amenable to health care, deaths per 100,000 population: Number of deaths before age 75 per 100,000 population that resulted from causes considered at least partially treatable or preventable with timely and appropriate medical care, as described in Nolte and McKee (Nolte and McKee, *BMJ* 2003). Data from CDC Multiple Cause-of-Death file and U.S. Census Bureau population data.

5. The Urban Institute article cited above discusses several studies that found a high rate of deaths from conditions amenable to treatment in the U.S. relative to other countries. This is explained in part by the high prevalence of chronic illnesses here.

6. Harvard Medical School news release 2/2/05 regarding *Health Affairs* article "Illness and Injury as Contributors to Bankruptcy" by David Himmelstein et al.

7. See Kaiser State Health Facts, at www.statehealthfacts.org. This was faster than the growth rates of per capita incomes for both the U.S. and Mississippi.

8. Mississippi Department of Finance and Administration.

9. Commonwealth Fund, "Data Brief: Paying the Price", August 2009, Table 1. At www.commonwealthfund.org.

10. Robert Wood Johnson Foundation, "Health Care Policy Experts Release Steps for Containing Costs and Improving Value in Health Care", September 1, 2009. www.rwjf.org.

11. New York Times, "Making Health Care Better", 11/8/09 by David Leonhardt, examines the protocols used by the Intermountain Healthcare network in Utah and Idaho, under the leadership of Brent James, M.D.

12. Koot, A. et al. "2009 Almanac of ChronicDisease". www.fightchronicdisease.org/pdfs/2009PFCDAlmanac.pdf.

Other useful sources include: American Medical Student Association, "International Healthcare Systems Primer" by Jessica A. Hohman, 2005; European Observatory on Health Care Systems, "Health care systems in eight countries: trends and challenges" April 2002; and various fact sheets of the National Coalition on Health Care at www.nchc.org.