Asked to Respond to 3 Questions

- What data or research do we use to develop policy?
- How can researchers reach out to state policymakers to inform them of research and collaborate on state level research?
- What lessons learned have there been from the PA S-CHIP implementation that we can take to future reform efforts?
Data & Research We Use to Develop Policy

- Biggest policy development was our comprehensive health care reform plan.
- Started in 2004 with a comprehensive health insurance survey conducted by Market Decisions.
- Did focus groups with small employers and uninsured individuals.
- Relied heavily on data from the Pennsylvania Health Care Cost Containment Council.

Use Medical Expenditure Panel Survey (MEPS) data a lot, although it is not very timely.
- Kaiser State Health Facts
- Commonwealth Fund Reports
- Economic Policy Institute on loss of employer-based coverage
- Go to rxforpa.com to see the 163 footnotes for sources of information and to see the plan
The State of Insurance Coverage in Pennsylvania

- The survey found over 1,000,000 Pennsylvanians are uninsured – 1 of 8 are adults.
- Our uninsured totals more than the population of Alaska, Delaware, North Dakota, South Dakota, Vermont, Wyoming or D.C.
- Most of uninsured adults are employed.
- 562,000 Pennsylvanians have lost their employer-sponsored health insurance since 2000, making Pennsylvania the second highest state for such loss, slightly behind Michigan.

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2008 Survey Results

- The number of uninsured increased despite state-sponsored enrollment increasing by more than 500,000. (from 1.7 to 2.2 million)
  - Greatest increase was for children
  - Most of the increase were below 100% FPL
  - Increased among African-Americans reducing their uninsured rates from 13.7% to 9.2%.
  - Uninsured rates doubled for Latinos (8.6% to 16.2%), but Latino population grew by 200,000 in 4 years.
  - Two-thirds of uninsured work and are concentrated in firms with 4 or less or over 1,000 employees.

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In 2006, the U.S. spent $2.1 trillion on health care, more than twice what the nation spent on food. It was also more than China’s citizens spent on all goods and services. McKinsey Global Institute compared U.S. spending to 13 peer countries and adjusted spending for the wealth of the country. For 2003, $477 billion of the $1.7 trillion is above expected and resulted in no better health care. Hospital and physician care accounted for 85%.

Pennsylvania’s Employees and Pennsylvania’s Businesses Cannot Keep Up with Health Care Inflation

% Increase in Family Health Insurance Premiums vs. Inflation and Increase in Median Wages in PA Between 2000 and 2007
Every Day that Passes Without Meaningful Change Increases the Cost to Our Health Care System

Inefficiencies Drive Cost in Pennsylvania's Health Care System

- Cost of the Uninsured
- Health Acquired Infections
- Chronic Care Hospitalizations
- Readmissions and Errors

Costs:
- $3.5 Billion
- $1.4 Billion
- $1.7 Billion
- $965 Million

Prescription for Pennsylvania

Prescription for Pennsylvania is a set of integrated practical strategies for improving the health care of all Pennsylvanians, making the health care system more efficient and containing its cost.

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Right State | Right Plan | Right Now

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### Rx for Affordability
- Cover All Pennsylvanians
- Coverage for College Students and Young Adults
- Community Benefit Requirements
- Uniform Admission Criteria
- Fair Billing and Collection Practices
- Capital Expenditures
- Small Group Insurance Reform
- Transparency of Cost and Quality Data

### Rx for Access
- Health Care Workforce
- Removing Practice Barriers
  - CRNPs
  - Physicians Assistants
  - Nurse Midwives
  - CRNAs
  - Pharmacists
- Cost-Effective Sites
- Co-Occurring Disorders

### Rx for Quality
- Health Care Acquired Infections
- Quality Outcomes
- Technology
- Pay for Performance
- Chronic Care
- Health Disparities
- Child and Adult Wellness
- Long Term Living
- End of Life and Palliative Care

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#### Quality: The Cost of Failure for Pennsylvania’s Families

In 2006, the first full year of reporting all HAIs, Pennsylvania hospitals reported the following to the Pennsylvania Health Care Cost Containment Council:

- 30,237 incidents of HAIs
- 3,716 deaths
- These figures represent a mortality rate of 12.3%
- Median charge without HAI is $18,538; with HAI it is $79,670
Health Care Acquired Infections

- In July 2007, Governor Rendell signed into law Act 52, which requires health care facilities to do more infection control with a goal of eliminating health facility acquired infections.
- In 2007, the average charge for a hospitalization for a patient who became infected with an HAI was $191,872 and the average charge for a patient without an HAI was $35,168.
- The new law requires that Pennsylvania health care facilities report all incidents of health care associated infections.
  - DOH Infection Control Plans
  - Increased use of electronic surveillance
  - Benchmarks to measure improvement.
- For 2007, the Pennsylvania Health Care Cost Containment Council (PHC4) reported that 27,949 patients contracted an infection during their hospitalization, a decrease of 7.8% from 2006, with 300 fewer Pennsylvanians dying of HAIs than the previous year. (Law only in place six months that year.)

#2 Reaching Out to State Policy Makers

- If research information is free and relevant, find out who is working on the area and just call for an appointment.
- Look at state department web sites for projects that are related to your research and call the main number and find out who is working on it.
- Propose research projects to the state using non confidential state data.
- Serve on advisory committees
Be Sensitive to State Realities

- States are in the worst fiscal state in decades—so your request can’t cost money.
- Most states have hiring freezes so state employees are often doing several jobs, while having wages frozen and being asked to take days without pay. Make request as labor unintensive as possible.
- Try to propose “win-win” research projects, e.g., projects that come with some foundation funding for the state or will help them with some program.
- If possible, establish a relationship with the state employees before proposing research project. If possible, help them out with something they are working on, before you propose a research project.
- No harm in trying.

#3 Lessons Learned from Cover All Kids

- Did a state plan amendment at the end of 2006 to increase CHIP limits to 300% FPL.
- Approved by CMS and has resulted in enrollment of 37,000 more kids.
- Don’t be afraid to ask. CMS and the Bush Administration was giving signals that 300% was too high.
- State law permitted parents with incomes over 300% FPL to purchase coverage at cost if unable to obtain commercial coverage due to medical underwriting or if coverage was unaffordable for the family.
- Only 1,941 “at cost” children are enrolled out of 32,000 eligible. Cost remains a barrier for parents with incomes over 300% FPL from premiums of $161/month per child.
#3 Lessons Learned from Cover All Kids

- When you cover children first--you lose the poster children and may never get the legislature to expand coverage for adults.
- Enrollment spikes are directly tied to program advertising on TV. Enrollment can be controlled by how much you do or do not publicize the program.
- With different federal matching rates we still have the problem of older kids in CHIP, younger kids in MA and parents in adultBasic--all with different MCOs and possibly different PCPs.
- We need federally funded, single payor universal health care coverage.

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