Expanding Health Coverage in the District of Colombia

Washington, DC's shift from providing to purchasing services, 1999 - 2009

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Study documents the shut-down of public delivery system and creation coverage for private providers

- Report prepared for Brookings Institution
- Funded by the Rockefeller Foundation
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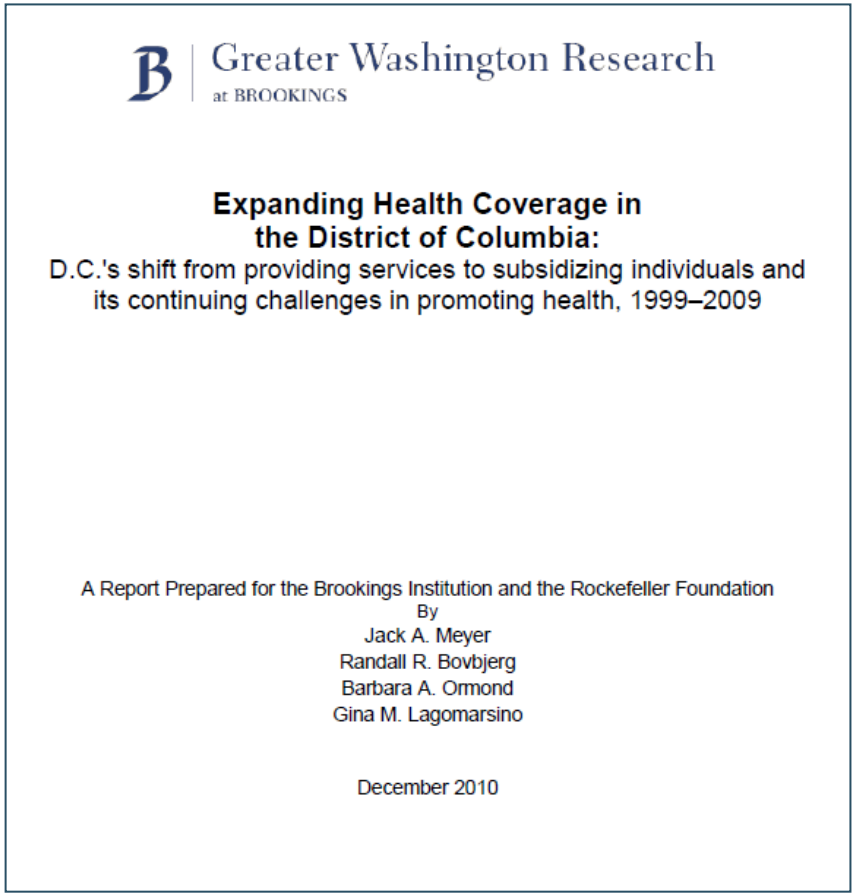
- Methodology:
  - Review of published and unpublished materials
  - Key informant interviews
  - Author's own experience as participants and observers



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Expanding Health Coverage in the District of Columbia:
D.C.'s shift from providing services to subsidizing individuals and its continuing challenges in promoting health, 1999–2009

A Report Prepared for the Brookings Institution and the Rockefeller Foundation
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US capital city is plagued by poverty and poor health outcomes

- US Federal District:
  - Locally elected Mayor and city council
  - City and state functions
  - Budgets subject to Congressional approval
  - District residents have no vote in Congress
- 2010 Population: 601,723
- 61 square miles
- Population below poverty level: 17.6%
- Black population: 51%
- Poor health statistics with massive health disparities:
  - HIV/Aids diagnoses/1000: 119.8 (vs. 11.2 US)
  - 6.5% of black males living with HIV
  - Low birth-rate babies: 14% (vs. 7% US)
  - 27% of population has hypertension (36% in poor areas)
  - 54.6% obesity rate (nearly 70% in poor areas)

Source: US Census Bureau; US Centers for Disease Control; Lurie 1999

Pre-reform (1990s), the poor relied on public hospital, with many uninsured residents

Financing System

- 19% of non-elderly uninsured in 1999 (vs. 15% US)
- Another 19% of non-elderly covered by state-federal Medicaid (vs. 12% US)
- Private, employer-sponsored coverage for the well-employed
- Federal Medicare coverage for people over age 65

Delivery System

- Most care for poor provided by public hospital and clinics
- Several non-profit, charitable “safety-net” clinics
- Poor generally received free care from government and non-profit facilities, but of variable quality and access
- Six private hospitals and private physicians for privately insured
- Private facilities retrospectively billed uninsured patients at high prices – high rates of medical debt

Public delivery system faced significant challenges

Financial challenges

- Significant budget deficit (cumulative $74M between 1996-2000)
- Inadequate billing of federal and state coverage programs
- Magnet for non-resident care

Operational challenges

- Overstaffing, poor staff attendance, and self-referral to private hospitals (dual-practice)
- Low occupancy: Typically 165 out of 300 beds occupied
- Long lengths of stay due to high-severity and "boarder patients"
- Aging physical plant

Quality challenges

- Significant lapses in quality – No Board Certified trauma surgeons or ER MDs
- Poor care coordination between clinics and hospital
- Reliance on hospital emergency department for primary care

In 2000, shift to purchasing care from private providers, eliminating public hospital and clinics

- Public DC General Hospital closed
- Control of public clinics transferred to private non-profit provider
- New health coverage program created – DC Healthcare Alliance
  - Provides comprehensive health coverage to previously uninsured residents
  - Contracts with 5 of 6 local private hospitals
  - Contracts with non-profit health clinics and some private physicians for primary and specialty
  - Funded through local general revenues
    - Roughly $100M transferred from public delivery budget to new coverage program to fund private providers

Politics of reform were intense and dramatic

- Reform made under duress of poor financial situation – imposed by Congress
- Extreme opposition from unions and pro-poor community activists -- "People will die in streets"
- Powerful private hospitals worried about increase in uncompensated care for uninsured residents
- District Council opposed Mayor and voted 13-0 AGAINST closure of hospital
- But…Congress mandated closure through the DC Financial Control Board (arm of US Congress in place from 1995-2001 due to District's financial insolvency)
- Federal lawsuit seeking to block the closure of public hospital denied by federal judge

DC's lack of full "democracy" facilitated this dramatic and abrupt policy shift

Reforms were iterative, over a decade

2001 – 2002: Contract with single private hospital, managing consortium of providers

- Initial attempt to "contract-out" whole delivery system to one organization at fixed price
- Vision: A primary care led system where each patient would have a "medical home"
- But just one "viable" bidder - weak hospital owned by for-profit, out-of-town corporation
- Partial risk contract signed, but failed within 18 months due to quality and financial issues

2003 – 2006: Multiple direct contracts with different private provider organizations

- Most providers reimbursed using simple fee-for-service case rates from one pool of funds
- Some providers received line-item budgets (based on "historical" costs)
- Third-party administrator for claims-management
- Administratively unsustainable, constant political pressure from contracting providers

2006 – present: Capitation contracts with two insurance companies

- Funds now follow patients – end of historical budget line-items
- New auto-enrollment system integrated with other anti-poverty programs
- Attempts to create quality metrics

New publicly-funded, privately delivered system for the poor has some accomplishments

- **Increased coverage levels**
  - Rate of uninsured dropped from 19% (1999) to 12% (2007) while US rate increased from 15% to 17% over same period
  - District now offers health coverage to any resident with income under 200% of Federal Poverty Level
- **Comprehensive free benefits**
  - Primary, specialty, hospital, dental, and drugs
  - Fully subsidized -- no premiums or copayments
- **Poor now use previously inaccessible hospitals – less segregation of poor**
  - 5 of 6 private hospitals – more choice and better geographic access
  - No evidence of people left stranded without access to care as a result of changes
  - Providers reimbursed relatively well and quickly – new source of revenues
- **Some evidence of improved utilization and quality**
  - Shift toward primary care away from hospital care – primary care clinics strengthened
  - Some evidence of reductions in avoidable hospitalizations
- **Stable funding even as enrollment grew**
  - From 1999 until 2007, annual Alliance spending no more than what had been spent on public delivery system, despite large increases in enrollment

However, still a number of shortcomings and remaining challenges

- Health outcomes still poor
  - Only small steps toward addressing the underlying drivers of poor health
  - Not enough attention to social and behavioral determinants
  - Do managed care organizations really manage care?
- Delivery system still not ideal -- missed opportunity to significantly restructure
  - Still too hospital focused -- primary care “medical homes” model not fully implemented
  - Not enough initial attention to health information systems (now changing)
- Inadequate supply of participating specialists and dentists
  - Lack of systematic referral system
  - Some long wait times
  - Inadequate compensation for providers
- Ongoing cost issues
  - Ongoing problem of non-resident enrollment drives up cost
  - Capitation payment model makes budgets predictable, but hard to track real costs of insurers and contracted providers
  - Federal money “left on the table” – could have been a federally-funded program

Some lessons learned may be relevant in other jurisdictions

- Coverage reforms require a viable delivery system
- Management capacity is key – different skill sets for delivery, contracting, public insurance
- Political influence of providers makes direct contracts a challenge
- Supply-side budgets with private providers -- similar challenges as with public providers
- Entrenched interests make significant change difficult
  - *Sad truth* -- easier when democracy is limited
- Reform is an iterative process
  - Initial administrative challenges make it hard to focus on quality – but can create platform for future progress

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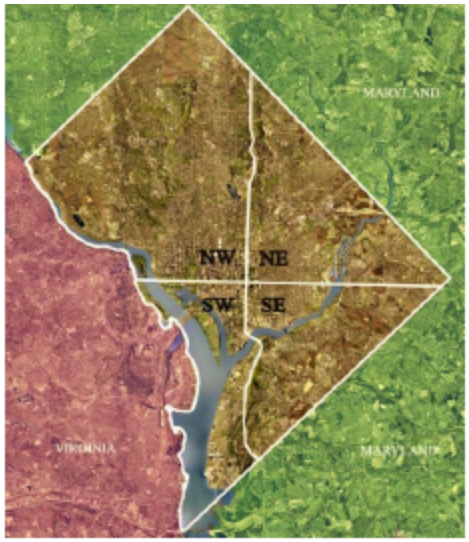
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