

QUARTERLY HEALTH CARE REPORT

Cost, Quality and Access-to-Care Issues: Internationally/ U.S. / State / Northeast Ohio

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Baldwin-Wallace College is pleased to offer its Quarterly Health Care Report by Professor Tom Campanella, director of the Health Care MBA program, as a courtesy to those in the healthcare sector. In it, Professor Campanella summarizes and comments on what's new on the critical issues of healthcare costs, quality and access to care at the national and international levels, as well as healthcare news of interest in Ohio and the Northeast Ohio region.

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SOURCES

Sources cited in this Quarterly Health Care Report are listed at the end of each article. The articles detailed in this Quarterly represent a summary or excerpts from the original articles that can be accessed in total through the associated source link at the end of each article.

Tom Campanella joined Baldwin-Wallace College as associate professor & director of the Health Care MBA Program in 2003. He is also an attorney (of counsel) with the law firm Baker Hostetler, Cleveland, in health care law since 2000 and has over 25 years' experience in the health care industry. He was vice president of healthcare finance and care management at Blue Cross & Blue Shield of Ohio and Medical Mutual of Ohio from 1989 to 1997 and was associate dean of the Ohio University College of Osteopathic Medicine and manager of its physician clinics in Athens, Ohio, from 1997 to 2000.

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INTRODUCTION

Tom's Take on Health News of Note

I believe that the debate in Washington should focus on what we can do to address our healthcare costs. Health care reform to be sustainable must address health care costs directly and indirectly (through better quality and access to care). My challenge to the Republicans and the Democrats is to take on the difficult political decisions relating to addressing the “real cost drivers” which are noted in my [Quarterly Rant](#). Finally, as Congress plays their “blame game” we cannot expect the uninsured to be satisfied sitting on the side lines as both their health and finances reach the critical stage.

This issue's [Cover Story](#) focuses on Health Insurance Exchanges. Specifically, we will focus on the overall merits of health insurance exchanges, the debate relating to standardized benefit designs as well as minimum benefit packages, and the role of broker in the health insurance exchanges. We will also explore the merits of the exchange playing an active purchasing role.

Our commentary in the [International](#) section of this Quarterly explores the trend of international health care systems experimenting with different approaches to address their health care cost, quality and access to care issues. We will also explore the role of provider competition in addressing issues of cost, access and quality in a variety of healthcare systems around the world.

In the [National](#) arena, we will further explore Accountable Care Organizations (ACOs), which are a core element of the new healthcare reform law. We initially reviewed ACOs in the last issue of the [Quarterly](#). As part of our review of ACOs, we will evaluate the potential impact of ACOs on provider competition.

The best example of the “good,” “bad” and “ugly” side of the self-interest is the debate over pension and retiree health benefits reform which is discussed in detail in the **State** section of this [Quarterly](#). The debate on all sides of this issue

has become very “ugly.” Unless we address these issues now, the problems will only get worse.

We will also review recommendations relating to mental health services in Ohio based on a study conducted by the Mental Health Advocacy Coalition and The Center for Community Solutions.

Finally, on the local front in **Northeast Ohio**, we have an opportunity to develop real partnerships among our tax-exempt hospitals in both identifying and addressing the healthcare needs of our community. The result of this cooperation would represent “real” community benefit, and would also demonstrate the “good” side of self-interest.

Quarterly Rave

Cleveland Clinic and Lowes hammer out a win-win relationship. Six months after it [struck a deal](#) to have Cleveland Clinic doctors perform heart surgeries on its employees and their families, home improvement retailer Lowe’s calls early returns on the alliance a “home run.” That’s because more Lowes’ employees have chosen the Clinic for cardiac surgery than the North Carolina-based retailer initially projected, according to spokeswoman Karen Cobb.

Since the agreement took effect in April, 17 Lowe’s employees or family members have had cardiac procedures done at the Clinic, with six more scheduled for surgery this year, and another six under review for possible surgeries, Cobb said. Lowe’s officials initially said if 10 employees or family members had heart procedures done at the Clinic in first year of the agreement, the company would consider the deal a “home run,” she said. So far, one out of three Lowe’s employees or family members in need of “serious cardiac surgery” have chosen Cleveland Clinic, according to Cobb.

In March, Lowe’s and Cleveland Clinic [announced the unusual deal](#) in which Clinic doctors perform heart surgeries for a bundled payment. Lowe’s waives employees’ usual \$500 deductible and other out-of-pocket costs and pays for their airfare, hotel and living expenses while in Cleveland, [Hospital Review reported](#). “Lowe’s: Early Returns on Cleveland Clinic Heart Deal a ‘Home Run,’” Brandon Glenn, MedCity News (<http://www.medcitynews.com/2010/10/lowes>)

Tom's Take:

The ripple effect of relationships such as the Cleveland Clinic – Lowe's heart contract is not only positive for the Cleveland Clinic; it is a positive for Northeast Ohio (NEO). Successful programs such as this could translate to similar referral programs for other services at the Cleveland Clinic, as well as some of our other great hospitals in the region, (e.g. University Hospitals, MetroHealth, SummaHealth Care Systems, etc.).

Large self-insured employers like Lowe's are facing escalating healthcare costs that negatively impact their overall profitability. Much of the costs relating to healthcare are the big tickets items such as heart procedures. It is a prudent business decision for these mega organizations to seriously evaluate "centers of excellence" that result in not only lower costs, but more importantly better quality outcomes.

NEO is experiencing both economic challenges and loss of population, which is a challenge for Ohio as well as many states in the Midwest. Our hospitals cannot continue to prosper by relying solely on our own NEO population. Remember, hospital revenue sources are mainly the federal government (Medicare), the state of Ohio (Medicaid) and local employers, and we all know the financial challenges these stakeholders are facing. Initiatives, such as the Cleveland Clinic – Lowe's deal will also enhance our national reputation in NEO as a healthcare mecca, which hopefully will carry over to other healthcare initiatives, such as the Medical Mart, etc.

Quarterly Rant

Tom's Take:

Will we address the "real" issues impacting our healthcare system? Less political rhetoric, and more responsible leadership, please!

I would like to repeat some of my comments from the [April/May 2010](#) issue of the Quarterly. The healthcare reform legislation is far from perfect, but it is a start. In the ideal world, we should have first addressed the cost and quality issues that are embedded in our health system. Using an analogy from the private sector, if you owned a manufacturing firm that produced costly "widgets" with inconsistent quality, would you address this issue by producing more widgets or would you first fix your operations? The answer is obvious, but there are also millions of Americans who would be satisfied with just receiving access (both from a cost and timeliness perspective) to our current healthcare system (warts and all).

In the April/May issue of the [Quarterly](#), I gave the new healthcare law B/A grades for addressing the access to care issues, as well as for laying the foundation for addressing some of the quality of care issues in our healthcare system. I also gave the healthcare law C/D grades in regards to addressing the key cost drivers (and I may have been too generous with the “cost” grades). Any reform strategy must target cost directly to create an affordable and sustainable model. Ideally, over the long-term, improved quality and access will also have a positive impact on healthcare costs.

A major part of addressing the cost drivers is real reform of Medicare which has played the major role in shaping our high cost, fragmented healthcare system. While the legislation does address Medicare payment reform and clinical effectiveness research, given past history, I am not optimistic that “real reform” of Medicare will occur. Even though “the law extracts about \$500 billion over 10 years from the future growth rate of Medicare, bringing it down from 6.6% to about 6%” (USA Today, 3/23/2010), past history has shown that actual savings are much less (as a result of Congressional rollback of cuts, cost trends being higher than expected, etc.)

As discussed in the last issue of the [Quarterly](#), the new healthcare law established an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. IPAB's recommendations for controlling these growth rates must be implemented unless Congress adopts equally effective alternatives. Congress can only overrule IPAB with a two-thirds vote of both chambers. As also discussed in the last issue of the [Quarterly](#), interest groups have already started lobbying Congress to mitigate or effectively neutralize/eliminate the role of the Payment Advisory Board.

The problems relating to Medicare payment policies have been known for decades (covering 24 years of Republican presidencies and 13 years of Democrat presidencies), but during those presidential terms Congress has never been able to address these politically sensitive issues. (Remember Medicare related expenses represent revenue to the healthcare stakeholders). It will be no easy task for the government to “reform” Medicare, which makes it all the more important to focus its attention in this direction.

Republicans have lambasted the new law as too costly and fiscally irresponsible. **My challenge to the Republicans and the Democrats is to take on the difficult political decisions relating to addressing the “real cost drivers” (inappropriate use of costly technology, end-of-life heroic efforts vs. appropriate use of hospice services, clinical practice pattern variation, lack of a primary care system, fragmented healthcare system, unhealthy life-styles, lack of**

consumer engagement in the healthcare purchasing decisions, real malpractice reform, etc.).

Medicare's payment policies, in fact, have been the major cause of many of the above noted cost drivers. Taking on these tough political decisions relating to real payment reform as well as clinical effectiveness would indeed be fiscally responsible and truly address cost. The added benefit of taking on Medicare reform is that Managed Care Organizations will attempt to clone these initiatives, especially as they relate to payment methodologies changes.

Would this not be a better step for Republicans and Democrats (jointly taking on the tough political health cost drivers), than having the Republicans merely focusing their attention on rolling back this law, which would negatively impact millions of Americans' access to health insurance.

Finally, all of this does not mean that the "healthcare reform law" is perfect. There indeed needs to be a number of key fixes (e.g. it is too complex, there are many inconsistencies in the language, it relies too much on bureaucratic interpretation, it does not address some key issues such as malpractice reform in a meaningful way, it does not incent innovation on the part of MCOs, it does not engage the consumers sufficiently to make them more of a prudent purchaser of healthcare services, etc.). There should be a bi-partisan focus on these "fixes", not just political posturing. There is nothing wrong with intense political debate around legitimate issues. I have used a somewhat "corny" term over the years, which I call "benevolent confrontation," that is, confrontation for the right reason, to make "things" better.

If we fail to address Medicare reform in a substantial and real manner, the legislation that is now law will further erode U.S. financial stability now and in the future, as a result of overlaying millions of additional insured over a costly healthcare system. Medicare reform is not a Democratic or Republican issue, it is America's issue. Rather than pointing fingers at each other, our "leaders" need to truly act as leaders and take on this challenging task.

Cover Story

Health Insurance Exchanges

"Will they live up to their promise?"

What is an Exchange?

The following explanation of Health Insurance Exchanges is courtesy of the U.S. Department of Health & Human Services (I inserted the “**hopefully**”):

- “An Exchange is a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality. By pooling people together, reducing transaction costs, and increasing transparency, Exchanges (**will hopefully**) create more efficient and competitive markets for individuals and small employers.

Beginning with an open enrollment period in 2013, Exchanges will help individuals and small employers shop for, select, and enroll in high-quality, affordable private health plans that fit their needs at competitive prices.

Exchanges will assist eligible individuals to receive premium tax credits or coverage through other Federal or State health care programs. By providing one-stop shopping, Exchanges will (**hopefully**) make purchasing health insurance easier and more understandable.”

“Initial Guidance to States on Exchanges,” U.S. Department of Health & Human Services, November 2010

([http://www.hhs.gov/ociio/regulations/guidance to states on exchange s.html](http://www.hhs.gov/ociio/regulations/guidance%20to%20states%20on%20exchange%20s.html))

Tom’s Take:

The theory behind Health Insurance Exchanges is to provide a mechanism to foster aggressive competition between the Managed Care Organizations (MCOs), which would then in turn lead to lower costs (or at least trends) and better quality in our healthcare system. For this to occur, a number of factors need to take place, including the following:

- The Exchanges should be administratively simple, ideally run by a private sector firm vs. a governmental agency - less chance of politics, more efficient, etc.
- The data provided to the consumers (individuals and small businesses) should be user-friendly
- While there is a need to have data provided that allows for apples to apples comparisons, it should not prevent health plans from including innovative benefit designs (e.g. value benefit designs, tiered networks, etc., creative partnerships with providers of care, etc).
- MCOs should be allowed to offer high deductible products that are available to everyone, which will lower premiums for the purchaser.

- If there is a minimum standard benefit package required it should not be weighed down by any unnecessary state benefit mandates that have been allowed to accumulate over time. Any federal benefit requirements should be closely scrutinized from a cost-benefit perspective.
- Plan designs should be structured to ensure increased member engagement in the use of healthcare services by means of deductibles and co-pays, etc.
- In cases where there are federal subsidies for individuals and small employers, these subsidies should be fixed, which would incent the user to choose more cost-effective plans. If additional benefits or more costly plans are picked, the consumer/small employer would be responsible for the cost difference.
- Exchanges should have a relatively active purchasing role, with the authority to limit the number of plans participating to a handful based on negotiation or bidding process.
- There should be a combined exchange for both the individual and small business market.

Are standardized products, alone, sufficient?

As noted above, there needs to be some standardized benefit packages that are offered on the Health Insurance Exchange. These standardized packages will allow the purchaser to conduct "an apples to apples" comparison between the plan offerings. This would be similar to websites that provide a consumer an opportunity to compare airline costs for flights between cities.

MCOs should also be allowed to offer innovative/unique products that could appeal to the prospective purchaser from a cost, quality and access perspective. The argument against this approach is that it would confuse the purchaser since it may be difficult to compare these products to the other product offerings on the exchange.

For years, prospective purchasers have relied on information from sources such as Consumer Reports to help them make difficult and important buying decisions. Consumer Reports has done a very respectable job in comparing automobiles using various criteria that reflect cost, quality and service. They also place each of the automobiles into broad categories for these comparisons in order to provide some structure for the reader (e.g. compact, sedan, luxury, etc.).

Applying this "Consumer Reports" approach to the Health Exchange should allow MCOs to offer standardized products as well as unique and innovative products. There should be a brief description of these unique and innovative product offerings (e.g. value-based benefit designs, multiple tiered product

offerings, mandatory disease management/wellness programs linked to financial incentives, provider Centers of Excellences linked to appropriate financial incentives, etc.) with an associated “link” to access additional information.

Health insurance benefits vs. costs

“While the healthcare reform law outlines 10 broad categories of coverage – among them hospital and emergency services, prescription drugs, childbirth and pediatric care – it leaves the specifics to the government. The Obama administration faces a tough balancing act: the benefits package must be broad enough to be comprehensive but not too broad as to be unaffordable. Patient advocates and industry lobbyists already are drawing up wish lists for items they want covered – including autism therapy, obesity treatments, infertility treatments and unlimited chemotherapy visits.

“This is an invitation for all kinds of lobbying from every conceivable disease group and provider group in the country,” says Joe Antos, economist at the conservative American Enterprise Institute.

The Department of Health and Human Services has asked the independent Institute of Medicine for advice. A 17-member IOM panel begins meeting Wednesday behind closed doors, with public sessions scheduled for Thursday and Friday. Panel members include economists, consumer advocates, a state health commissioner and a former CEO of insurer WellPoint. By fall, they’ll make recommendations on factors HHS should consider in drawing up the benefit package.

The required package affects all policies to be sold in state-based insurance exchanges. Those marketplaces, which are to start operating in 2014, initially will be open only to those who buy individual and small-group policies. New policies sold to individuals and businesses outside the exchanges also would be affected.

“The notion that someone has health insurance only has real meaning when the insurance they have provides coverage for their true health care needs,” says Ron Pollack, founding executive director of the liberal advocacy group Families USA. “The broader the benefit package, the higher the cost for families and employers,” says Robert Zirkelbach, spokesman for AHIP.

The law leaves open the question of how detailed the requirements will be and how much flexibility will be left to insurers and employers. Insurers argue for flexibility, but some consumer groups want details spelled out.” (“Obama

Administration's Balancing Act: Health Insurance Benefits Vs. Costs," Kaiser Health News, January 11, 2011)

Tom's Take:

As noted above, ideally MCOs should be allowed to offer minimum standard insurance products on the exchanges, including high-deductible plans (<http://www.ncpa.org/pub/ba738>). I do believe there is merit in evaluating recommendations from the Institute of Medicine (IOM) concerning factors HHS should consider in drawing up the minimum benefit package as it relates to preventive care.

My concern is that this issue can become a political hot potato which could open the door for costly decisions that could further derail the financial underpinnings of healthcare reform and specifically that of the health insurance exchanges.

One of the more politically sensitive areas relating to benefit design involves the coverage of preventive medicine services. We recently discussed this issue in the [April/May 2010](#) issue of Quarterly

The discussion focused on the Congressional Budget Office Report titled, "Cost-effectiveness of Preventive Medicine and Wellness Programs." As noted in the study concerning the value (or "**benefit**") of preventive medicine, "A simple medical test, if given early enough, can reveal a condition that is treatable at a fraction of the cost of treating that same illness after it has progressed. In such cases, an ounce of prevention improves health and reduces spending—for that individual."

The study further states from a "**cost**" perspective, "Preventive care can have the largest benefits relative to costs when it is targeted at people who are most likely to suffer from a particular medical problem; however, such targeting can be difficult because preventive services are generally provided to patients who have the potential to contract a given disease but have not yet shown symptoms of having it."

The debate over the value of preventive services can also generate heated debate from all sides. An example of this would be the recent recommendation (I believe by the Institute of Medicine) relating to annual mammograms for women over 40 years old. A healthcare panel of experts objectively evaluated the merits of recommending that all women over 40 years old (vs. 50 years old) have mammograms. These healthcare experts ultimately determined that from a cost-benefit perspective it would not be good healthcare policy to recommend that all women over 40 have mammograms.

That recommendation created a flurry of condemnations from all sides. I recognize that you just can't neatly package all healthcare policy decisions into a cost-benefit financial model, but we do need to recognize that we do not have unlimited financial resources from a societal perspective. Societal savings from eliminating unnecessary mammograms can then be used to better fund other national priorities (e.g. prenatal care, primary care expansion, educational needs, economy, etc.).

A critical component of the new healthcare law is the promotion and mandating of preventive medicine. We need to recognize, as noted above, the identification of "preventive medicine" benefit mandates has both clinical and political overtones. Given our scarce resources, we need to be willing to take on tough politically unpopular issues. Based upon a clinical cost-benefit perspective, some preventive medicine mandates may make financial and clinical sense only for a certain targeted group of patients.

Finally as noted in this study, "Just because a preventive service adds to total spending does not mean that it is a bad investment. Experts have concluded that a large fraction of preventive care adds to spending but should be deemed "cost-effective," meaning that it provides clinical benefits that justify those added costs. "Congressional Budget Office Report on the Cost-effectiveness of Preventive Medicine and Wellness Programs," http://www.cbo.gov/ftpdocs/104xx/doc10492/08-07-Prevention_PSally.1.1.htm

What role will brokers play?

There has been much discussion and political lobbying relating to the role of brokers in regards to health insurance exchanges. The following are thoughts by Uwe Reinhardt, a well-respected healthcare economist, who also writes for the New York Times, on this subject:

"In modern economies, brokers are forever vulnerable to two developments, even in the absence of government regulations that may impinge on their economic turf.

One development is the standardization of the good or service being traded; the other is the power of electronic-information technology to gather and structure information at substantially lower cost.

The recently passed Affordable Care Act seeks to further both developments and adds a third: the regulatory requirement that insurers must limit the fraction of premiums spent on marketing and administration.

Ever since Paul Ellwood and Walter McClure developed and Alain Enthoven refined the concept of managed competition among private health insurers in

the 1970s, policy analysts favoring a private health insurance system have dreamed of a standard benefit package on which competing private insurers would quote risk-adjusted premiums — making it easier for individuals, households and employers to make a cost-conscious choice among insurers.

The Affordable Care Act seeks to follow in that tradition.

First, it specifies a minimum, standard benefit package, albeit with varying degrees of cost-sharing by patients. Second, it calls for electronic, state-based health insurance exchanges designed to facilitate easy choice among insurers.

In principle, such exchanges could be designed in a user-friendly way to provide small businesses and individuals with much of the structured information traditionally provided by brokers. The [Swiss health system](#), for example, relies on that approach for its wholly private health insurance system, as does [the Dutch system](#).

To get a feel for what is possible in the United States, browse the [Web site](#) of the Federal Employee Benefit Program operated by the Office of Personnel Management. Several private-sector electronic health insurance exchanges have also been operating for a decade or so — for example, [eHealthInsurance.com](#).

If I were a broker, however, I would not despair at the prospect of the state-based insurance exchanges for one simple reason: administrative simplicity and efficiency is decidedly not America's strong suit, in either the private or the public health sectors.

So it's a pretty safe bet that the state-based exchanges envisaged in the Affordable Care Act will be so complicated and bewildering that the services of brokers will still be needed. In fact, the Affordable Care Act anticipates this by requiring that the exchanges award grants to "navigators," tasked with educating the public about qualified plans, available subsidies, enrollment procedures and so on.

Noting the need for such navigators, the National Association of Insurance Commissioners [passed](#) on Aug. 17 [a resolution](#), "To Protect the Ability of Licensed Insurance Professionals to Continue to Serve the Public." It recommends that insurance brokers serve as the navigators and "be adequately compensated for the services they provide."

Because it simply would not make sense to consider commissions paid by insurance plans to brokers an outlay designed "to improve health care quality,"

the National Association of Insurance Commissioners treats commissions as a marketing and administrative expense that reduces profits. Brokers fear insurers will put the squeeze on commissions in order to maximize profits within the allowed ratio.

So who actually are these brokers' principals? In principal-agent economic theory, at least, the principal should compensate the agent directly to make sure that the agent always acts in the principal's interests.

"Insurance broker" is sometimes treated [as a synonym](#) for "insurance agent" or even "producer," although that is sloppy usage. Dictionaries describe an [insurance broker](#) as the agent of the insured and an [insurance agent](#) as someone who represents an insurance company.

From conversations with advocates of insurance brokers, I have learned that most brokers consider the insured as their principal, even though their commission is typically paid by the insurer.

This raises the question of why the insured do not directly pay their health-insurance brokers, just as they pay accountants for help with their tax returns or lawyers who help them in legal matters.

If insurance companies, which seem to think of brokers as "[producers](#)," pay different rates of commissions and explicitly reward with bonuses brokers who provide high volume, does that not set up at least the appearance of a conflict of interest that the brokers may wish to avoid? "For Whom Does the Health Insurance Broker Work? [UWE E. REINHARDT](#) , The New York Times, Economix, September 10, 2010 <http://economix.blogs.nytimes.com/2010/09/10/for-whom-does-the-health-insurance-broker-work/> /

Tom's Take:

First of all, I do want to admit that I have had a health insurance license for over 10 years. Given my other work related activities, I have limited my health care insurance consulting activities to a few clients. I have found in my case, it was better to have a renewable year to year contract with the client which clearly states the mutually agreed upon activities that I would perform for them along with the related compensation. The client would then pay me directly for the services I provided based upon the terms of our contract. This approach allowed me to be truly independent as well as avoid confusion relating to client expectations, etc.

In his article above, Uwe Reinhardt recommends that brokers be paid directly from the insured rather than from the insurance company. He states that this approach would address both the independence question as well as the medical-loss ratio restrictions. This idea definitely has merit, but is probably not as simple as it sounds. Over the years some insurance companies have also delegated a number of their sales administration activities to brokers. Obviously an employer would not want to pay for these services. If these administrative services were no longer delegated by the insurance company to the broker, the insurance company would need to build up their internal capabilities.

Brokers also take center stage with the roll-out of exchanges. As Uwe Reinhardt noted above, "In principle, such exchanges could be designed in a user-friendly way that could provide small businesses and individuals with much of the structured information traditionally provided by brokers." As Uwe Reinhardt also noted, and I agree, at least the first generation of state exchanges more than likely will not be designed in a user-friendly way. In theory, the Navigators (which work for or are contracted by the exchange), would be in the position to facilitate the purchasing process for individuals and small employers. The first generation of Navigators, as a result of inexperience, etc., may not be able to effectively fill this role.

There is indeed a potential role for brokers in an exchange. This role should not be embedded into the infrastructure of the exchange, since the prospective purchaser should have the option to go it alone (with the assistance of the Navigators if needed), in order to save money.

One possible scenario that has worked effectively in the mutual fund industry is the use of "loaded" funds. If an individual wants to purchase a mutual fund through a stock broker, in order to get their advice, etc., the broker's fee is embedded in this "loaded" mutual fund. This fee is clearly identified and the broker does not receive any additional compensation from the mutual fund company for "steering" their client to them.

Conversely, if an individual wants to go it alone, they can purchase a "no-load fund." Over the years, an information industry has also developed to aid the consumer with the mutual fund buying decisions (e.g. Morningstar, etc.). Morningstar, for example, has an amazing track record for being user-friendly, affordable, and objective. Morningstar is the "Consumer Reports" of the mutual fund world.

Bringing all of this back to exchanges, products could be identified as “no-load” and “load.” If it is loaded, the additional fees would be paid directly by the exchange to the broker.

Brokers may have a concern about having their groups use the exchange, even if they opt for “loaded” health insurance products for the fear of them transitioning to “unloaded” products over time. If this is the broker’s fear, they need to reevaluate the value they are providing their clients.

The other challenging issue relating to brokers and the exchanges relates to level of compensation. If the level of the broker compensation for these “loaded” health insurance products are significantly lower than what a broker would receive “outside” of the exchange, there would be no financial incentive for a broker to steer their groups into the exchange. This may be driven by self-interest, but it is a reality. If this becomes the case, over time the exchange could degenerate into a high risk pool. There are already legitimate concerns that the exchanges are set-up for failure unless they are able to tap into healthier small to middle size employer groups.

Exchanges should implement a reasonable “market rate” for these loaded funds so as to prevent broker steerage away from the exchanges. As an aside, the broker “market rate” will become less generous over time as a result of a number of factors including the high cost of health insurance, the medical-loss ratio limitations, etc. Many MCOs have already started the process of reevaluating broker compensation.

Finally, there are many great brokers that provide a valuable service to their clients. These brokers also have evolved to become the “Human Resources” department for many small employers. There is definitely a need for good brokers, and rather than looking at healthcare reform and its related initiatives, such as the medical-loss ratio caps, as barriers to their success, brokers should find ways to increase their “true value” in the marketplace.

How much purchasing authority should an exchange have?

As noted previously, per the U.S. Department of Health & Human Services, “An exchange is a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality. By pooling people together, reducing transaction costs, and increasing transparency, exchanges create more efficient and competitive markets for individuals and small employers. **“Initial Guidance to States on**

Exchanges,” U.S. Department of Health & Human Services, November 2010
([http://www.hhs.gov/ociio/regulations/guidance to states on exchanges.html](http://www.hhs.gov/ociio/regulations/guidance%20to%20states%20on%20exchanges.html))

While in theory the language above makes sense, in practice, the approach taken in developing an exchange will ultimately determine its success or failure over the long term. In developing an exchange, states can go in one of two directions:

- “First, an exchange could be a relatively passive market facilitator – accepting any plan that meets specified requirements;
- Second, an exchange could be a more active purchaser with the authority to limit the number of plans participating to a handful based on a negotiation or bidding process.” (“Explaining Health Care Reform: What are health insurance exchanges?” Focus on Health Reform, The Henry J. Kaiser Family Foundation, May 2009)

Tom's Take:

I believe that if exchanges limit their role to a relatively passive market facilitator – accepting any plan that meets specified requirements, it will not meet the needs of the market (in terms of affordable premiums) over the long-term. Individuals and small businesses would be limited to comparing available plan options that are still based off our relatively high healthcare cost structure.

Cost savings for consumers and small business would be limited to any incremental reductions of administrative costs on the part of the MCOs due to economies of scale. Remember, MCOs' administrative costs, on an overall basis, have already been addressed by means of the medical-loss ratio caps that are part of the new healthcare law.

If the financial tension is limited to the MCO administrative expenses, not only will the premium impact be limited, it would create no incentive for providers to enter into innovative/collaborative relations with MCOs that translate to lower healthcare costs.

Alternatively, if the exchanges take more of an active purchaser role, it can become a mechanism to foster aggressive competition between the MCOs, which would, in turn lead to lower costs (or at least trends) and better quality in our healthcare system. If exchanges take an active purchasing role and limit the number of MCOs to a select group that meet cost, quality and access benchmarks, it will create the necessary tension to impact the provider side of the healthcare cost equation.

By limiting the number of MCOs that are made available on the exchange, it will increase the carriers' leverage with providers to incent more innovative and cost-effective collaborations. These MCOs could then build off of the innovative financial arrangements with providers that are being fostered by Medicare (global payments, risk arrangements, ACOs, medical homes, etc.), to truly reinvent our health care system.

Over time, as exchanges increase their penetration in the small and mid-size employer market, it could also foster MCOs creating limited provider networks that could replicate ACOs or integrated networks. These limited provider networks (which would have some of the same characteristics of the HMOs of the 1990s) would further foster "the right type" of competition between providers.

These limited networks could, for example, contract with MCOs by means of a percentage of premium arrangement. The better the provider network, in conjunction with the partner MCO, can address cost issues, the more competitive the MCO health insurance premium becomes that is available on the exchange. The more competitive the MCO health insurance premium, the increased likelihood of individuals and small employers selecting that product on the exchange, which, in turn, increases the number of "customers" for the limited provider network.

In order to foster additional levels of positive provider tension, all MCOs that are selected on the exchange need to make available to their customers user-friendly cost and quality data in order for the consumers to become more prudent purchasers of healthcare services. For example, if a consumer needs to have knee surgery, they should be able to go on their MCO website and compare the total price of that knee surgery (physician/facility charge, etc) among the various provider locations (e.g. tertiary, hospital, free-standing facility, etc.) that are in the network.

In order to further incent consumers to be prudent purchasers of healthcare services, there should be a minimum level of deductibles and co-pays in all benefit designs. Individuals would be entitled based on need to some form of governmental assistance to fully or partially offset the deductibles, but not totally offset the co-pay.

Finally, as we discussed in previous issues of the Quarterly, per the Center for Disease Control, 50% to 70% of healthcare costs are directly or indirectly related to lifestyle diseases. Some form of financial incentives related to member compliance with wellness and disease management programs needs to be built into all insurance products.

INTERNATIONAL

The Emergence of “Hybrid” Health Care Systems

The following are excerpts from a journal article discussing the evolution of healthcare systems into “Hybrid” systems over time. The authors conclude that on an international basis, the three types of healthcare systems that historically were based on the foundation of a nationalized, social health insurance or private health insurance are becoming more similar over time.

As the authors stated, “We build on our analysis of twenty-three Organisation for Economic Cooperation and Development (OECD) countries, which reveals broad trends regarding governments' role in financing, service provision, and regulation. In particular, we identified increasing similarities between the three system types we delineate as National Health Service (NHS), social health insurance, and private health insurance systems.

We highlight that health care systems tend to feature specific, type-related deficiencies, which cannot be solved by routine mechanisms. As a consequence, non-system-specific elements and innovative policies are implemented, which leads to the emergence of “hybrid” systems and indicates a trend toward convergence, or increasing similarities.

We elaborate this hypothesis in two steps. First, we describe system-specific deficits of each health care system type and provide an overview of major adaptive responses to these deficits. The adaptive responses can be considered as non-system-specific interventions that broaden the portfolio of regulatory policies. Second, we examine diagnosis-related groups (DRGs) as a common approach for financing hospitals efficiently, which are nevertheless shaped by type-specific deficiencies and reform requirements. In the United States' private insurance system, DRGs are mainly used as a means of hierarchical cost control, while their implementation in the English NHS system is to increase productivity of hospital services. In the German social health insurance system, DRGs support competition as a means to control self-regulated providers. Thus, DRGs contribute to the hybridization of health care systems because they tend to strengthen coordination mechanisms that were less developed in the existing health care systems.

“Explaining Health Care System Change: Problem Pressure and the Emergence of “Hybrid” Health Care Systems,” Achim Schmid, Mirella Cacace, Ralf Gotze, Heinz Rothgang, *Journal of Health Politics, Policy and Law*, Vol. 35, No. 4, August 2010 (<http://jhppl.dukejournals.org/cgi/content/abstract/35/4/455>)

Tom's Take:

As I have stated previously in the Quarterly, no country has found the “silver bullet” in addressing its societal issues of healthcare cost, quality and access to care. While some countries have been more successful than others in addressing some components of cost, access or quality; no country, on a comprehensive sustainable basis, is a long-term success story.

As the authors of the above journal article noted, as a result of these failures countries are now looking at other approaches outside of their historical “systems” to find solutions. The result of which is a gradual emergence of “hybrid” systems and an overall trend toward convergence, or increasing similarities between the healthcare systems of developed countries. In fact, the U.S. in many ways already has a hybrid system. Governmental healthcare programs (Medicare and Medicaid, etc.) represent approximately 50% of our healthcare expenditures.

There is also another trend that is occurring internationally, which would be best described as “two-tier” healthcare systems. The first tier would represent a comprehensive healthcare system, usually framed around public hospitals and clinics and government employed (or contracted) physicians. This first-tier would be available to all citizens of that country. This first-tier would incorporate different approaches to control costs, especially from a macro-budgetary perspective. Ingrained in this first-tier would be some form of rationing (or a rationalizing of healthcare related expenditures from a cost-benefit perspective).

Tier-two would have more of a private sector base, which would include private hospitals, clinics, and physicians (some of the physicians would also be part of the first-tier through governmental contracts). The tier-two would be accessible to those individuals or employers that have private health insurance (which is a growing industry in many of these countries) or through self-pay.

As noted above, there is “no silver bullet” when it comes to healthcare cost, access and quality. As we struggle with our own issues of healthcare cost, quality and access, we need to learn some lessons from abroad, both from their successes and their failures.

When and how provider competition can improve
healthcare delivery

We will now further explore hybrid healthcare systems around the world, and evaluate potential lessons as well as ideas that could help the U.S. healthcare system better address issues of cost, access and quality. The term “health system” in the context of this article refers to the overall “health system” of a country. This research article from the McKinsey Quarterly is a result of the authors’ study of 20 “health systems” around the world. These health systems would predominately have some form of centralized control at the national level.

“Health systems around the world face the same fundamental challenge: how to deliver broad access to health services while improving quality of care and controlling costs. Greater competition has often been proposed as a solution that elegantly addresses each element of that challenge.¹

There is no consensus, however, as to how much competition is appropriate in health care. Too often, the debate is argued based on strongly held ideological presuppositions or vested interests rather than a dispassionate review of evidence, and thus a full consensus on competition in health care may never be reached. Furthermore, countries differ significantly in the values they hold most important and the goals they have for their health systems. Nevertheless, we believe that by examining the available evidence through the lens of economic theory, it is possible to develop a framework that health systems can employ to decide when and how competition can be used to promote access to high-quality, efficient care.

Our focus here is on competition among providers—most often for patients, but in some cases for payor contracts.² We suggest that the level of provider competition that is appropriate will vary based on the nature of the clinical services delivered. For highly specialized services, competition should be limited or used only very judiciously to ensure quality and avoid over delivery. In contrast, greater competition could be an effective mechanism for improving the quality and efficiency of less specialized services, particularly care delivered outside the hospital.

Five core questions need to be considered to establish how much provider competition is appropriate in a given clinical setting:

1. What is the relevant market-segment size?
2. What is the minimum economic scale?
3. What is the minimum clinical scale?
4. Are there significant barriers to market entry or exit?
5. Are there significant barriers preventing patients from switching providers?

The answer to each question varies considerably depending on the clinical setting, even within a given care pathway.¹¹ As a result, the level of competition that is healthy may also vary considerably in different clinical settings—largely (but not entirely) because of the minimum economic and clinical scales needed to ensure high-quality, efficient care delivery.

Consider, for example, the difference between weight-loss services and bariatric surgery in the obesity care pathway. For providers of weight-loss services (Weight Watchers, Slim-Fast, local gyms, etc.), the minimum economic scale is low: setup and overhead costs are small. The minimum clinical scale is also relatively low: the level of training needed to provide nutritional consultations and programs of physical activity is not as substantial as the level required to perform surgery. Furthermore, no minimum throughput of patients/customers is necessary to ensure that the services provided are safe. As a result, weight-loss services can be delivered by a variety of competitors in most cities and towns.

In comparison, bariatric surgery requires a substantial amount of clinical expertise and specialized infrastructure, as well as a relatively high patient throughput, if high-quality care is to be delivered. A bariatric surgery provider requires a population base of about one million people to ensure that an adequate number of patients will request treatment.

In many cases, minimum clinical scale is the decisive factor for determining how much competition is appropriate.

For example, a provider can deliver routine childhood immunization services safely to a relatively small population (perhaps 10,000 or 20,000 people). By contrast, a high-quality inpatient pediatric service that offers 24/7 access to specialist staff requires a much larger population (probably about 500,000 people) to ensure that the staff takes care of enough children to keep its skills sharp. Consequently, a small city could safely support multiple providers of childhood immunization services but only one hospital offering inpatient pediatric care.

We have come to believe that as health care markets become less specialized and less reliant on expensive infrastructure, they can support an increasing number of providers. Pragmatically, this means there should be less competition when care is delivered in highly specialized hospital settings and more competition when care is delivered outside the hospital.

Changing the competitive structure of a market is rarely sufficient on its own to generate the ideal level of provider competition. The system must also take steps to reduce the barriers to competition. Our analyses suggest that **six steps** can help almost any health system capture the opportunities that provider competition may offer.

Ensure information availability. Effective functioning of a health system requires accurate data on both the cost and quality of the services delivered. Without this kind of data, it is impossible to spot problems, shift system resources, or identify and disseminate best practices. In many health systems, however, this kind of data is still hard to obtain; it is frequently unavailable for care delivered outside the hospital and sometimes unavailable even for hospital care.

Reform reimbursement mechanisms. Reimbursement mechanisms should be designed to ensure that all providers are encouraged to behave in ways that promote the interests of the overall system (for example, they should not be rewarded for offering unnecessary procedures and thereby driving up demand for care). It is also important that funding is linked to and follows each patient; otherwise, providers have little reason to compete with each other for patients.

Build primary care capacity and capability. As health systems increasingly attempt to shift the balance of care from hospital to nonhospital settings, much of the competition individual hospitals will face will come not from other hospitals but from non-acute providers. To spark competition both within primary care and between primary care and acute care providers, most health systems will need to increase their primary care capacity to handle higher volumes and to improve the capabilities of their primary care clinicians and managers.

Align incentives for payors. If competitive pressure is to exert the maximum influence on quality and productivity, the purchasers of health services (payors) must have the freedom to buy selectively and be given incentives to seek value for money.

Reduce barriers to patients switching among providers. The ability of patients to change providers can be an important driver of improved quality. In many health systems, patients are discouraged from switching by legal or bureaucratic obstacles, such as geographic restrictions and complex re-registration requirements. Health systems should ensure that patients can change health care providers as easily as they can switch mobile-phone networks.

Reduce barriers to entry and exit. Finally, it is important that health systems reduce unnecessary barriers to market entry and exit. Allowing poor-performing providers to exit the market and high-performing providers to enter it is critical for encouraging innovation and providing incentives for high performance. In some cases, however, market exit may not require a facility's closure; a change in management may be sufficient to achieve the desired outcome.

What does this mean for care delivery?

As we have shown, the level of provider competition that is healthy varies depending on the clinical setting. Thus, health systems should use different strategies for different types of care.

Highly specialized care

For health services that require a relatively high level of specialization, competition could inadvertently encourage excess capacity and duplication of infrastructure. In developed countries, overcapacity in the acute sector is often more common than under-capacity; introducing new providers would therefore be a mistake. Health systems should instead seek, whenever possible, to sharpen the competitive dynamic among existing acute care providers.

Less specialized hospital care

For less specialized acute services, more classic models of competition are usually suitable. Most markets, for example, can sustain a number of efficient and safe providers of elective surgery. Thus, encouraging sharper competition among existing providers or even, in some cases, introducing new providers could yield improved efficiency and better health outcomes. Competition for less specialized acute services will not achieve its desired ends unless mechanisms are in place to allow some providers to reconfigure the services they offer or, if necessary, exit the market entirely.

Primary and community care

We believe that the case for encouraging the intensity of competition and the emergence of new providers is clear-cut for care delivered, now or in the future, outside the hospital. This is the area in which competition can be introduced most easily and is likely to have the biggest impact—an important consideration given that, as mentioned earlier, it is the area in which health systems are seeking the greatest improvements in quality and productivity.

New providers of community-based services can be added in a variety of ways. For example, health systems can increase the number of family doctors they train and/or allow ancillary health providers (nurse practitioners, for example) to offer primary care services. In addition, they can introduce or encourage the expansion of new delivery formats, such as polyclinics, ambulatory surgery centers, retail health clinics, and telephone- or Internet-based care provision. Public-sector health systems can reshape their ownership rules to allow private-sector providers to enter the market. “When and how provider competition can improve health care delivery,” Penelope Dash, MD, and David Meredith, *McKinsey Quarterly*, November 2010

https://www.mckinseyquarterly.com/When_and_how_provider_competition_can_improve_health_care_delivery_2690

Tom's Take:

The above article may also provide some valuable lessons for the U.S. As we look for ways to consolidate our fragmented healthcare system through initiatives such as Accountable Care Organizations (ACOs), we must also recognize that there is not a "one size fits all solution." The trend in the U.S. is to incent the consolidation of primary care and community care providers, with less specialized hospital care and specialized hospital care into one integrated system.

While there is some definite merit to this approach (increased likelihood of coordinated care (e.g. for chronic diseases, etc.)), we don't want to lose an opportunity to achieve better non-specialized hospital care and primary/community care through the use of competition and innovation.

I believe there is some middle ground relating to this issue. There is a benefit to having large integrated healthcare systems in some communities. There is also some real benefit to the ongoing presence of independent primary care and community care providers.

There should not be any artificial roadblocks (legal moratoriums, financial disincentives, etc.) that unnecessarily limit the growth of independent primary care/community care providers (including clinics, etc.). These independent providers should also not be blocked from competing with full services hospitals for less-specialized hospital services. This competition would increase the likelihood for better value in the marketplace, especially as consumers have more of a financial stake in the game and also have increased access to user-friendly cost and quality information.

Cost issues relating to highly specialized care markets could be addressed more effectively through payer (e.g. Medicare, MCOs) reimbursement methodologies that have a solid risk component (global payments, capitation, etc.). Over time, payers (Medicare, MCOs) could also develop centers of excellence for highly specialized care that are based on cost and quality parameters.

Finally, as discussed in my Quarterly Rave, hospitals like the Cleveland Clinic and University Hospitals should be encouraged to extend their reach (as well as to compete) both regionally, nationally and, in some cases, internationally in the specialized hospital care market.

Accountable Care Organizations

As discussed in the September/October 2010 QHCR, the hot topic in healthcare today is Accountable Care Organizations (ACOs). The health reform act instructed the Centers for Medicare and Medicaid Services (CMS) to create a national voluntary program for ACOs by January 2012.

ACOs are provider groups that accept responsibility for the cost and quality of care delivered to a specific population of patients cared for by the group's clinicians. ACOs are rewarded in the form of shared savings if the group provides care to beneficiaries for less than the Medicare benchmark cost while meeting criteria for patient service and quality of care. ACOs are seen as one way to reduce the rate of increase in health care costs over time, while also improving the coordination and quality of care of the patients.

California has had a long history with integrated networks (mostly physician lead) that have many of the same characteristics as ACOs. What has been California's experience with these ACO type provider organizations, and what can we learn from them both from a provider and public policy perspective?

There was a recent study by the Integrated Healthcare Association (2010), which provided the reader with a number of lessons from the California experience.

“Lesson One: A variety of organizational structures are effective at delivering high quality coordinated care; at least as important to success as structure are an organization's capabilities, culture and infrastructure, as well as the alignment of goals between the organization and its individual physicians.

Lesson Two: In California, a range of relationships exist between physician organizations and hospitals. Alignment of incentives between physician organizations and hospitals offer important opportunities for performance improvements across the entire continuum of care.

Lesson Three: As a method of payment, capitation can be effective at encouraging coordinated care, but payment methods should vary across ACOs depending on an organization's ability to assume risk.

Lesson Four: Health plans acting in concert on payment methods and performance measurement helped facilitate the growth of California's provider

organizations, and should also play an integral part in fostering ACO development nationally.

Lesson Five: ACOs are not a panacea for healthcare spending control.

Lesson Six: ACOs must be agnostic to insurance type; most provider organizations in California have focused on commercial, Medicare and Medicaid HMO plans for their patients, but for ACOs to be viable across the country, mechanisms must be found to encourage PPO and traditional Medicare and Medicaid patients to use their services.

Lesson Seven: Balancing patient choice with the desire to decrease costs and effectively coordinate care is difficult. California's experience underscores the challenge of promoting care coordination in an environment of unrestricted provider choice.

Lesson Eight: Regulation of the financial solvency of provider organizations is important to ensure market stability.

Lesson Nine: Consumer protections from capitated provider organizations need to be balanced, not overburdening.

Lesson Ten: Special attention must be given to establishing ACOs in areas with social and economic challenges"

"Accountable Care Organizations in California – Lessons for the National Debate on Delivery System Reform," James C. Robinson and Emma L. Dolan, Integrated Healthcare Association, 2010
(<http://www.beckershospitalreview.com/hospital-physician-relationships/acos-in-california-10-lessons-for-the-national-debate-on-delivery-system-reform.html>)

Tom's Take:

The above ten lessons, while somewhat simplistic have very practical overtones. The lessons apply to both the organizations that take on an ACO structure as well as for the federal government in their design decisions relating to guidelines for these models.

Specifically as it relates to federal guidelines, it is also important that the federal government does not create a model that over the long-term actually has a negative impact on cost, access and quality. Referring back to "Tom's Take" as it relates to the value of "competition" in the [International](#) section of this Quarterly, as we look for ways to consolidate our fragmented healthcare system through initiatives such as Accountable Care Organizations (ACOs), we must

also recognize that there is not a “one size fits all solution.” While the theory behind ACOs makes sense, it should not be at the expense of losing our independent providers who have the ability to compete effectively in the non-specialized hospital care and primary/community care market.

Fast facts:

- Top Requested Diseases & Conditions (Center for Disease Control) <http://www.cdc.gov/DiseasesConditions/>
- A good source for healthcare for a variety of healthcare information is the Institute of Medicine <http://www.iom.edu/About-IOM.aspx>

STATE

Public-sector Retirees Health and Pension Benefits – The Heat is on!

The following are excerpts from various newspaper articles relating to public retiree health and pension funding crisis:

- “The moment was a particularly illuminating one in Cincinnati City Hall’s protracted and often acrimonious budget debate. An increasingly cranky City Council, agitated several days before Christmas over being forced to make the kind of choices no politician relishes, worked deep into the night to try to erase a projected \$54 million deficit from its \$340 million budget, sifting through potential layoffs, service cuts and other equally unpalatable alternatives.

During a few of those hours, about 75 feet away in a small meeting room on the third floor of City Hall, some of Cincinnati’s pension trustees discussed strategies for pressuring council into spending an extra \$10 million or more a year on the city’s generous retirement plan. As details from the pension board meeting filtered around the corner back to the council chambers, some council members and their aides simply shook their heads and asked, in so many words: What planet are those guys on?

“There seem to be people who persist in being out of touch with reality.” Councilwoman Roxanne Qualls said later, “Everyone has had to adjust downward. But some are still trying to avoid the inevitable.” If nothing else,

the stark contrast in perspective in the two rooms last month underscores how the daunting challenge of rescuing a pension system facing a \$1 billion-plus long-term shortfall has evolved, for some, into a classic case of "give-me-mine-and-I-don't care-how" thinking.

"It sounds like they're saying, lay off a lot of other people, reduce public safety, cut programs as long as I can have my gold-plated pension," said Cincinnati City Councilman Jeff Berding. "I'm certainly not going to go along with that, and if we did, citizens would rebel. And I wouldn't blame them." With experts warning that the \$2.1 billion pension plan could be insolvent within two decades unless major changes are made, Cincinnati Retirement System trustees are considering proposals to raise retirement ages, lower annual cost-of-living adjustments, shift a greater share of health costs to retirees and alter pension calculation formulas.

The panel is expected to forward its recommendations to council in early February, setting the stage for another painful - and, in an election year, politically risky - economic decision that, in scope, dwarfs the recent budget morass. Five of the 11 trustees are city employees or retirees who have strongly resisted changes, saying any reduction in benefits must be tied to substantial increases in the city's annual contribution to the pension fund, which in recent years has generally fallen short of a "required" figure based on projected long-term expenses and revenue.

"All required contributions, past, present and future, should be made," said trustee Mike Fehn, a city building inspector. The pension system's deepening financial woes, however, have lifted that figure to politically and fiscally unrealistic heights two to three times the roughly \$26 million that the city struggled to pay last year. Any sizable increase, council members say, is unlikely for the foreseeable future. "Can we afford another \$20 million, \$50 million, \$100 million a year for the pension fund?" asked Qualls, who as chairwoman of council's Budget and Finance Committee will oversee the planned overhaul of the retirement system. "The answer is no. We can't do anything even close to that."

At the heart of the dispute over how to prop up the system - and how much of the burden should be borne by city employees, retirees and taxpayers - is a fundamental disagreement over the cause of its long-term deficit. From the perspective of most city workers and retirees, the primary blame lies with the city, particularly with council's repeated failure to fund the pension system at a level that fluctuates yearly.

Although city law mandates that council make that annual payment, to date there has been no legal consequence to not doing so in full, in part

because the issue could essentially put the city in the position of suing itself. Fehn, though, has gone so far as to question whether council's actions constitute theft in office. Retirees also accuse the city of deliberately underestimating future investment earnings to justify reducing benefits. Both arguments run counter to the facts.

Consultants have concluded that the city's "underfunding" is responsible for only about 1 percent of the pension plan's problems, and from 2000 to 2009, investment earnings failed in half of the years to meet an 8 percent goal that many experts consider unrealistically high. In contrast, many top city leaders attribute the deep financial hole to Cincinnati being too generous for too long with its 80-year-old retirement plan, which predates Social Security and is the only city-run pension system in Ohio.

As evidence, they point to policies that allow some workers to retire with pensions of up to 90 percent of their three highest years' salary, guaranteed 3 percent annual increases, lifetime health coverage at negligible cost and other benefits far beyond those found in most private and public retirement plans. Combined with soaring health coverage costs and increasing life expectancies, those policies strain the system's resources to the breaking point, particularly after catastrophic losses in the 2008 stock market meltdown, they say.

"The city's contributions are an easy target, but it's also easy to allow that to become a distraction and to use that to avoid the really hard and tough decisions that have to be made," Qualls said. "If the city had paid in every dollar it was supposed to, the situation would be almost unchanged. The real problem is that the level of benefits has grown over the years to where they're no longer sustainable." Not surprisingly, most current or prospective beneficiaries of the city's retirement system disagree, though some grudgingly acknowledge the need to adjust benefits - changes they would prefer to see directed largely at future city employees, not them.

"It's not a matter of general fund (money) not being there," said trustee Karen Alder, interim director of the city's risk management office. "It's a question of how they're choosing to use the general fund." Similarly, Fehn complains the pension system's stability has been undercut by council "spending the money somewhere else."

Often lost in that discussion, however, is, to borrow a phrase from former Vice President Al Gore, "an inconvenient truth" - that every extra dollar that the city spends on a pension system for roughly 7,600 workers, retirees and their beneficiaries necessarily comes at the expense of services and

programs for more than 330,000 Cincinnatians. Workers' and retirees' complaints about potential changes that still would leave the city with a very attractive pension plan are unlikely to draw much sympathy from Cincinnatians facing closed public pools, cutbacks in roadside weed trimming, elimination of school nurses and other reduced services as a result of council's recent budget decisions.

"A lot of people in the city have lost jobs, seen their own pensions disappear, their 401(k)s shrink," Berding said. "Yes, we have to do right by our current and former employees, but we can't ignore that bigger picture. The city doesn't stop with just the people who work for us." "City must weigh pension needs against taxpayers," Cincinnati Enquirer (Cincinnati.com), Barry Horstman@enquirer.com, January 23, 2011 <http://nky.cincinnati.com/article/AB/20110123/NEWS01/101240321/City-must-weigh-pension-needs-against-taxpayers->

- Ever since Marie Corfield's confrontation with Gov. [Chris Christie](#) this fall over the state's education cuts became a [YouTube classic](#), she has received a stream of vituperative e-mails and [Facebook](#) postings.

"People I don't even know are calling me horrible names," said Ms. Corfield, an art teacher who had pleaded the case of struggling teachers. "The mantra is that the problem is the unions, the unions, the unions."

Across the nation, a rising irritation with public employee unions is palpable, as a wounded economy has blown gaping holes in state, city and town budgets, and revealed that some public pension funds dangle perilously close to bankruptcy. In California, New York, Michigan and New Jersey, states where public unions wield much power and the culture historically tends to be pro-labor, even longtime liberal political leaders have demanded concessions — wage freezes, benefit cuts and tougher work rules.

It is an angry conversation. Union chiefs, who sometimes persuaded members to take pension sweeteners in lieu of raises, are loath to surrender ground. Taxpayers are split between those who want cuts and those who hope that rising tax receipts might bring easier choices.

A brutal reckoning awaits, they say." "Public workers face outrage as budget crises grow," Michael Powell, The New York Times, January 1, 2011 http://www.nytimes.com/2011/01/02/business/02showdown.html?_r=1&nl=todaysheadlines&emc=thq2

- “Unlike cities, states are barred from seeking protection in federal bankruptcy court, but proponents of the effort say some states are so burdened that the only feasible way out may be bankruptcy. Beyond their short-term budget gaps, some states have deep structural problems, like insolvent pension funds, that are diverting money from essential public services like education and health care. Some members of Congress fear that it is just a matter of time before a state seeks a bailout, say bankruptcy lawyers who have been consulted by Congressional aides, according to the Times.

The news report notes that bankruptcy could permit a state to alter its contractual promises to retirees, and it could provide an alternative to a no-strings bailout. Along with retirees, however, investors in a state’s bonds could suffer, possibly ending up at the back of the line as unsecured creditors.

In addition, discussions about something as far-reaching as bankruptcy could give governors and others more leverage in bargaining with unionized public workers.

“They are readying a massive assault on us,” Charles M. Loveless, legislative director of the American Federation of State, County and Municipal Employees, told the Times. “We’re taking this very seriously.”

David A. Skeel, a law professor at the University of Pennsylvania, who published an article, “Give States a Way to Go Bankrupt,” in The Weekly Standard, explained in the news report it is possible to envision how bankruptcy for states might work by looking at the existing law for local governments. Called Chapter 9, it gives distressed municipalities a period of debt-collection relief, which they can use to restructure their obligations with the help of a bankruptcy judge. Unfunded pensions become unsecured debts in municipal bankruptcy and may be reduced.” “State Bankruptcies Could Alter Pension Promises,” Rebecca Moore, Plansponsor.com, January 21, 2011
<http://www.plansponsor.com/print.aspx?id=6442476837>

- [Moody's Investors Service](#) has begun to recalculate the states’ debt burdens in a way that includes unfunded pensions, something states and others have ardently resisted until now.

States do not now show their pension obligations — funded or not — on their audited financial statements. The board that issues accounting rules does not require them to. And while it has been working on possible

changes to the pension accounting rules, investors have grown increasingly nervous about [municipal bonds](#).

[Moody's](#) new approach may now turn the tide in favor of more disclosure. The ratings agency said that in the future, it will add states' unfunded pension obligations together with the value of their bonds, and consider the totals when rating their credit. The new approach will be more comparable to how the agency rates corporate debt and sovereign debt. Moody's did not indicate whether states' credit ratings may rise or fall.

In making the change, Moody's sidestepped a bitter, continuing debate about whether states and cities were accurately measuring their total pension obligations in the first place. In adding together the value of the states' bonds and their unfunded pensions, Moody's is using the pension values reported by the states. The shortfalls reported by the states greatly understate the scale of the problem, according to a number of independent researchers.

In a report that is being made available to clients on Thursday, Moody's acknowledges the controversy, pointing out that governments and corporations use very different methods to measure their total pension obligations. The government method allows public pension funds to credit themselves for the investment income, and the contributions that they expect to receive in the future. It has come under intense criticism since 2008 because the expected investment returns have not materialized. Some states have not made the required contributions either.

http://www.nytimes.com/2011/01/27/business/27pension.html?_r=2&scp=3&sq=pension&st=nyt

Tom's Take:

In order to get a good sense of the hostility surrounding these issues of public employee retiree pension and health benefits click on the following link relating to the Cincinnati retiree pension article noted above.

There are 82 comments from readers (at last count) concerning the pension issue. As you review a [sample of these comments](#) you will sense the hostility relating to these issues from all perspectives: the retiree (who fears for the loss of HIS/HER benefits), the current public employee (who fears that he/she will be paying for some of the abuses of the retirees with lower pay, fewer benefits and possible job loss), and the private sector tax payer (who fears for higher taxes and lost services as a result of these abuses).

I believe that the real culprit in all of this is less the retirees, but the politicians at all levels of government who did not have the courage to say "No!" As I discussed in my "Rant" in the last issue of the Quarterly, there is a "good, bad and ugly side of self-interest." It is only natural for public employees unions, etc. to argue for increased pay and retirement benefits for their members. The problem is that states have never had effective check and balances in place that would ensure prudent decisions during these negotiations. It is much easier to give into these employee demands than to face a strike. It is much easier to allow future administrations, legislators or generations to bare the brunt of these fiscally irresponsible decisions than to address them now.

We are coming closer to the time when we will all be paying for the sins of the past. If we continue to ignore this financial debacle, it will only get worse. The cynic in me questions if the major reason we allowed these abuses to perpetuate is the fact that the legislative, executive and the judicial branches (our so called system of checks and balances) all drink from the same retiree pension and health trough.

To be fair there are separate pension/retiree healthcare benefits plans among sectors (e.g. police/fire, public employees, teachers, etc.). Some of these plans, depending upon the state, are more fiscally responsible than the others. In Ohio, depending upon the particular Plan, there are also differences in approaches in addressing these financial concerns.

All governmental retirement plans, even those that are managed prudently, have a vested interest in addressing the overall solvency of these programs. As some plans go down the road of bankruptcy, there will be widespread anger by the citizens as they see their taxes increase significantly and their governmental services cut back dramatically. That anger (as shown in the reader commentary in the Cincinnati lawsuit article above), could carry over to all retiree programs, no matter how fiscally prudent they are being managed.

Mental Health Services in Ohio

A newly released, comprehensive study of the status of behavioral health in Ohio offers a thorough overview as well as specific recommendations. The study, *By the Numbers: Developing a Common Understanding for the Future of Behavioral Health Care*, was conducted by two Ohio-based organizations – the Mental Health Advocacy Coalition and The Center for Community Solutions.

The study includes specific funding and policy recommendations aimed at optimizing behavioral health care treatment in Ohio.

Recommendations include:

- Fully support integration of behavioral health care and physical health care to increase access to care and improve health outcomes.
- Align behavioral health care Medicaid match with other health care Medicaid match and fully fund community-based mental health and alcohol and other drug addiction services so that cost-efficient services can be delivered in Ohio's communities and not in more expensive, less effective settings.
- Reduce hospital readmissions by creating step-down care. This would improve the continuum of care and transition between appropriate levels of care.
- Increase funding for capital, operating and supportive housing services for individuals with severe behavioral health disorders
- Centralize behavioral health information from the child welfare system so policy makers are better equipped to make prudent decisions to support children and families.

"Study shows growing need for mental health services in Ohio," Mental Health Advocacy Coalition, January 26, 2011

<http://www.mentalhealthadvocacy.org/reports/ByTheNumbersJan2011.pdf>

NORTHEAST OHIO

Hospital Community Benefit Programs

The national health reform legislation requires tax-exempt hospitals to conduct a community needs assessment at least once every three years. Per Michael Bilton, Executive Director of the Association of Community Health Improvement of the American Hospital Association, "Hospitals will also have to demonstrate they have a strategy to meet the needs identified by assessment." "The Evidence-Based Road – Available date can drive successful community benefit programs," Susan Birk, Healthcare Executive, July/August 2010.

Tom's Take:

"Historically, tax-exempt hospitals have had a siloed approach to addressing their community benefit legal requirements. In order to truly impact the health of the community, tax-exempt hospitals need to collaborate. Hospitals should not only collaborate with each other, but also with appropriate local governmental and non-profit entities that have similar community missions. This collaboration, in identifying and addressing the health needs of the community, would dramatically increase the likelihood of success in this challenging arena. "The Evidence-Based Road – Available date can drive successful community benefit programs," Susan Birk, Healthcare Executive, July/August 2010

Baldwin-Wallace College Expands its Health Care Programs to BW-East in Beachwood

Baldwin-Wallace College is excited to announce the expansion of its Health Care programs to our Eastern Campus starting in 2011. Baldwin-Wallace East is located at the intersection of Richmond Rd. and Science Park Drive in Beachwood.

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<http://www.bw.edu/academics/bus/programs/hcmba/>

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Or

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**If you are interested in enrolling in or would like more information about the Health Care
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