

QUARTERLY HEALTH CARE REPORT

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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 health care sector. In it, Professor Campanella summarizes and comments on what's new on the critical issues of health care costs, quality and access to care at the national and international levels, as well as health care news of interest in Ohio and the Northeast Ohio region.

You can access and view the current report on our website by clicking [here](#), by cutting and pasting the following link: <http://www.bw.edu/academics/bus/programs/hcmba/nl/>, or via any of the links below. We strongly recommend reading the Quarterly Health Care Report online as this format provides direct access to some interesting and relevant Health Care websites.

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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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If you have any comments or observations concerning this Quarterly Health Care Report or you are interested in more information on Baldwin-Wallace College's Health Care MBA Program, you can contact Tom Campanella by e-mail at: tcamp@bw.edu

INTRODUCTION

The Quarterly Health Care Report focuses on proactive initiatives that address some of the fundamental issues impacting cost, quality and access in the U.S. This edition of the Quarterly Health Care Report focuses specifically on health care reform initiatives that are currently being debated in Washington, D.C. Healthcare costs represent 16.2% of the GDP which translates to over \$2 trillion annually. This \$2 trillion healthcare industry is primarily financed by the federal and state government, employers and consumers. Conversely these costs represent revenue to other healthcare stakeholders (e.g. hospitals, physicians, managed care organizations, long-term care industry, pharmaceutical/biotech industry, ancillary providers and suppliers of healthcare services, etc.). Each of these stakeholders has a vested interest to be actively involved in the healthcare reform debates.

This issue of the Quarterly will attempt to address the following questions:

- What is the likelihood of “real” national healthcare reform?
- What will be the next generation of healthcare provider reimbursement?
- What will be the “key” issues that will generate the most heated debate between healthcare stakeholders?
- Should there be an Insurance Exchange and Individual and employer mandates?
- What is the best role for the government and private sector to play in healthcare reform?

- Should there be a Public Plan?
- Should healthcare employee benefits be taxed?

Costs

What is the Likelihood of “Real” National Healthcare Reform?

Tom’s Comments:

President Obama wants the House and Senate to pass a healthcare reform bill by their August break. “If you don’t have it (healthcare reform) this year, you won’t have it for four years,” said Iowa Senator Chuck Grassley, the top Republican on the Finance Committee in an interview. He noted that 2010 was a congressional election year and by 2011 the next presidential campaign would be underway, when politicians might be reluctant to cast tough votes. “If we don’t get it done this year we’re not going to get it done,”* Obama said on a May 28th, conference call aimed at rallying his supporters on the issue.

(*”Costs, policy schedules, coalitions could block road to health care,” USA Today, June 1, 2009)

As you review the “Fast Facts” and the article written by Steve Altman, President of the Kaiser Family Foundation, noted below, one can conclude that the culmination of healthcare cost and access to care issues have resulted in the following:

1. Major negative impact on employers from a competitive and profitability perspective;
2. Major negative impact on Federal and State budgets (e.g., Medicare/Medicaid); and a
3. Major negative impact on both the “haves” and “have not’s” in our society.

Sadly, when the healthcare crisis was limited to the “have-nots” there was no sense of urgency in reforming our system. Now that the crisis impacts federal and state government, employers, and the “haves,” there is a catalyst for change.

Steve Altman, President & CEO of Kaiser Family Foundation, wrote the article below titled, “Window of Opportunity?” In this article Steve Altman emphasizes the importance of the timing for healthcare reform. He states

the following: “Beginning this spring (2009), between expected approval of an economic stimulus package and the start of campaigning for the midterm election, there will be a rare window of opportunity for passage of major health reform legislation. History suggests that momentum can be lost if policymakers do not move quickly to seize these rare openings when they occur. There is an opportunity now because the nation has a popular new president, with political capital to burn, who is making health reform a priority. Democratic leaders in control in the Congress want to deliver on health care. And a historic recession has transformed health care into a bread and butter economic issue of real salience to working people and the middle class, who are worried about paying their health care bills and about losing their jobs and their families’ health coverage.”

There is indeed a “window of opportunity” and given the impact of the cost issues noted above on the government, employers and the “haves” there will be a strong societal demand for meaningful healthcare reform. What role will the government and private sector play in the “reformed” healthcare system and how will current and future stakeholders be impacted? Let the “tug-of-war” begin!

Fast Facts:

- Healthcare as a percentage of Gross Domestic Product (GDP):
 1. 1970 – 7.2%
 2. 1980 -- 9.1%
 3. 1990 --12.3%
 4. 2008 - 16.2% (\$2.3 trillion)
 5. 2018 - 21.3% (\$4.3 trillion) (projected based on current trends)
- 50% of U.S. health care expenditures go to treat 5% of the population
- U.S. health care system is currently financed by government programs (46%), private programs (42%) and out-of-pocket (12%)
- Per The Center for Medicare & Medicaid Services, it is projected that the Medicare Part A Hospital Insurance Trust Fund will be depleted by 2016
- Medicaid represents approximately 25% of most state budgets and is growing at an alarming rate
- On average, approximately 70% of state Medicaid budget's support long-term care needs of the elderly
- 16% (46 million) of Americans are uninsured (25 million are underinsured)
- 2000 – 69% of companies provide health insurance to employees
- 2009 – 60% of companies provide health insurance to employees

- 45% of companies < 50 employees provide health insurance to employees
- According to the Business Roundtable Health Care Value Comparability Study ("The Business Roundtable Health Care Value Comparability Study," 2009), as a group employers and workers in G-5 countries (Canada, Japan, Germany, the United Kingdom and France) spend approximately 63 cents for every dollar the U.S. spends on health care. Per the Study countries such as Brazil, India and China spend just 15 cents for every dollar the U.S. spends on health care. Per the Business Roundtable, this disparity of health care expenditures by employers and workers is harming our ability to compete effectively in the global economy. (Sources of the above information include:
<http://employeebenefitsolutions.wordpress.com/2009/06/08>
www.businessroundtable.org)

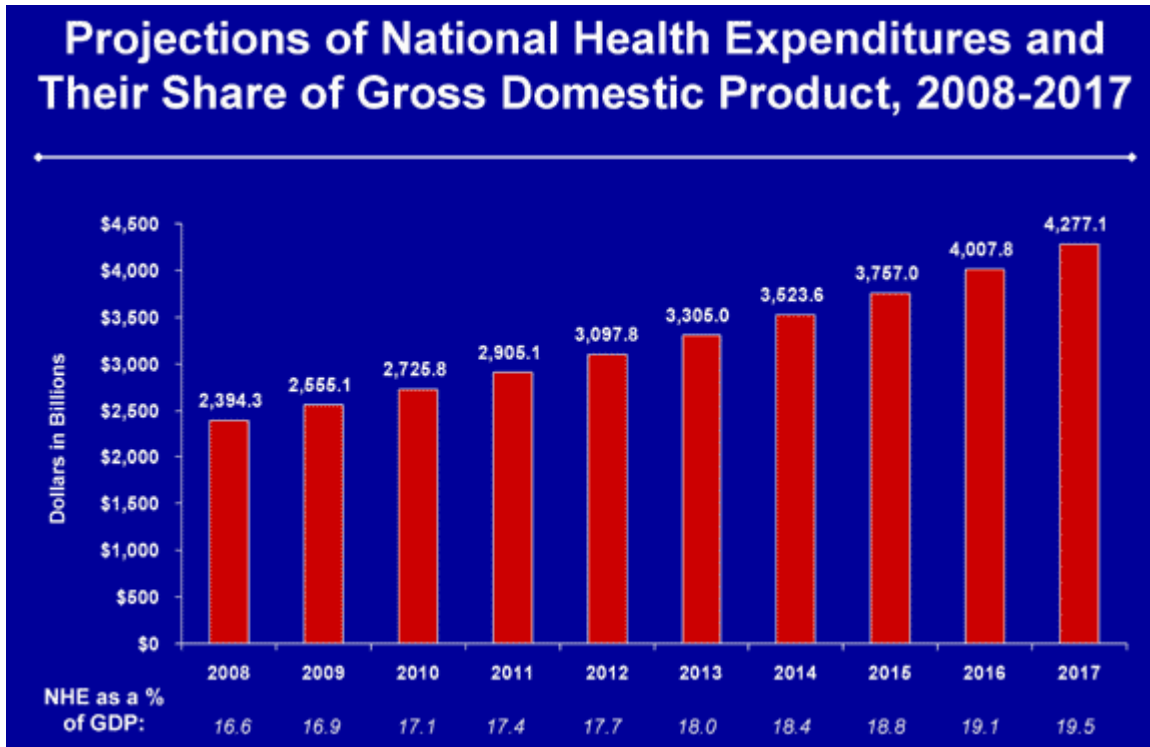
Multiple Agendas for Controlling Health Care Costs

In what would be a domestic policy trifecta, we may be headed for interconnected big debates about economic recovery, entitlement programs and health reform. A core issue in the entitlement and health reform debates is the problem of rising health care costs. President Obama, now apparently fully briefed on the economic, budget and health reform realities he faces, is talking conspicuously about hard choices that may lie ahead. In a short period of time the focus has shifted from the emphasis in the primaries and general election on covering the uninsured and making insurance more affordable to a new focus on hard choices, spending and costs.

As this discussion looms it may be useful to keep in mind the very different -- and sometimes conflicting -- definitions and agendas at play when we talk about health care costs.

For many, especially economists, reducing health care costs means reducing the share of the nation's economy we spend on health, which is 16.6 percent now and is headed for almost 20 percent in 2017 (Figure 1). Growth in health spending has exceeded growth in the economy by about two and a half percentage points for decades, and the worry is that it will squeeze out our ability to spend on all kinds of other priorities at all levels of the economy and government if we do not reduce the rate of increase in health spending.

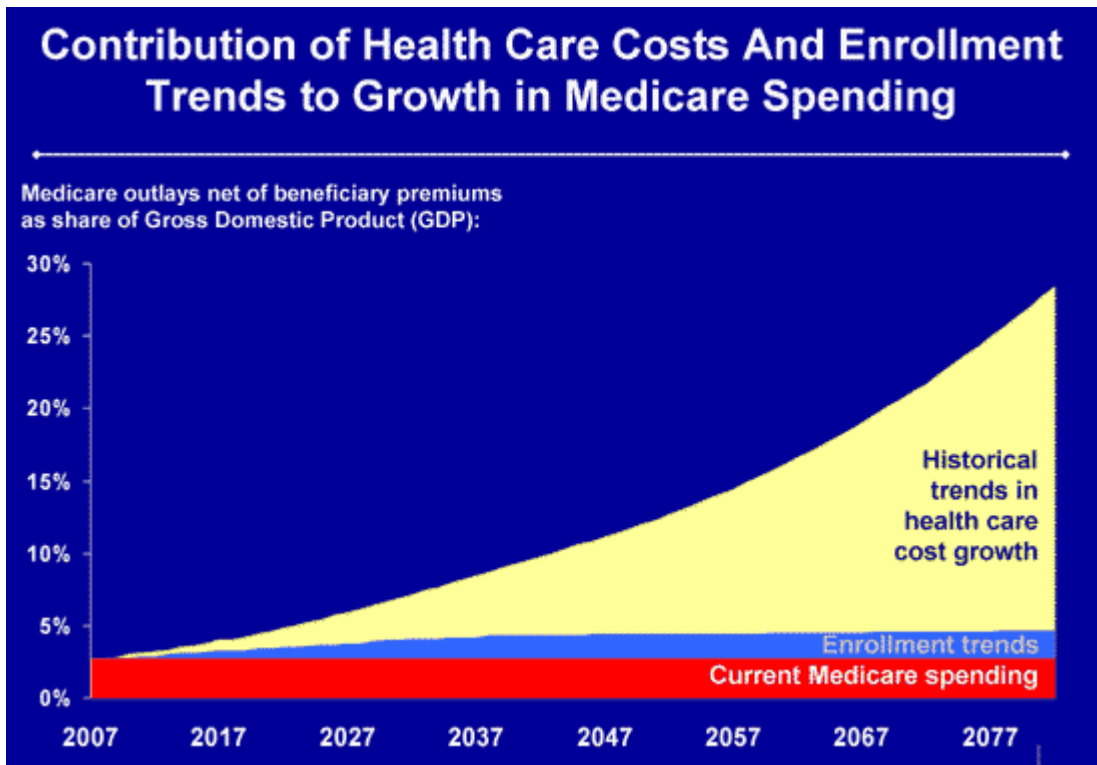
Figure 1



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp#TopOfPage (see Projected; NHE Historical and projections, 1965-2017, file nhe65-17.zip).

Others -- for example, deficit hawks that include many Republicans and the Blue Dog Democrats in Congress -- are focused more on the impact of health costs on federal spending, the budget deficit, and government's ability to meet its obligations. Spending on entitlement programs is the core of their concern. It almost certainly has been pointed out to President Obama that if current projections hold true, Medicare will not be able to pay all its hospital bills soon after the end of his second term. As the CBO chart below makes clear, the underlying issue behind Medicare's projected insolvency is the broader problem of health care costs and not the aging of the baby boomer generation. Public spending for Medicaid and the tax exemption for employer-provided health insurance similarly rise with the underlying cost of health care. This bolsters the argument for linking the debate about health reform and health care cost containment with a discussion of entitlements (Figure 2).

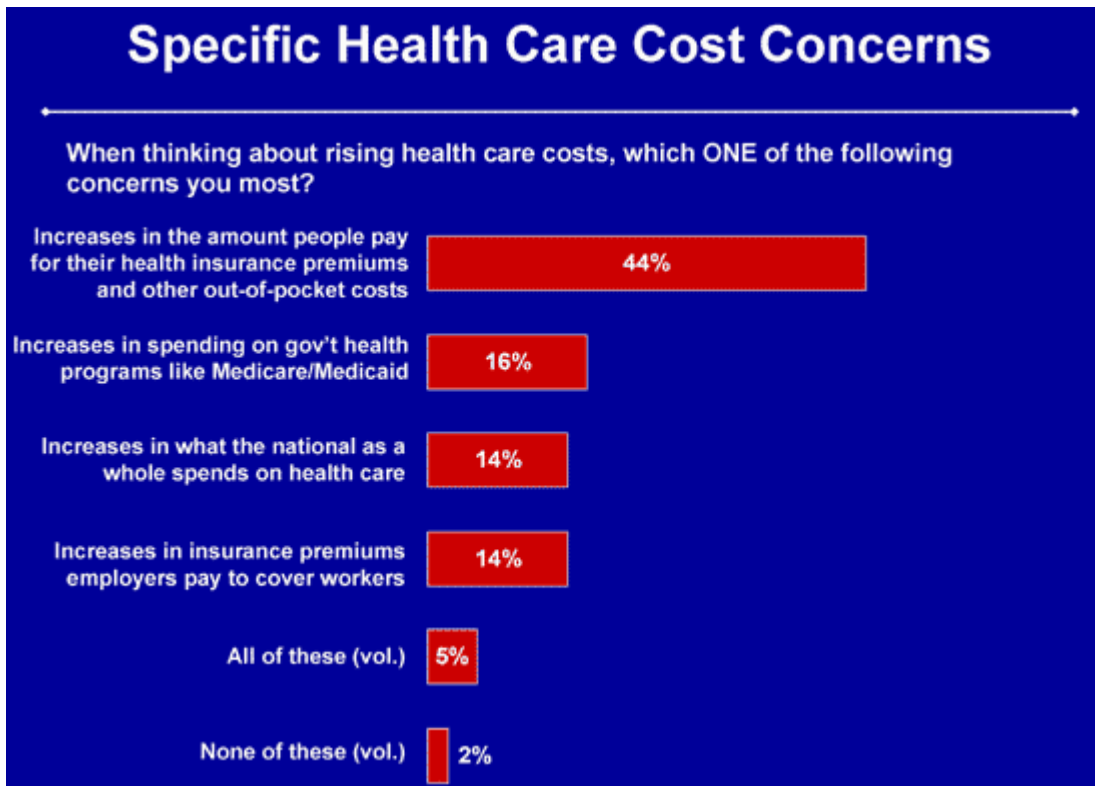
Figure 2



SOURCE: Congressional Budget Office, The Long-Term Outlook for Health Care Spending, November 2007.

The biggest group of all, the American people, is worried about an entirely different problem and has yet again a different agenda: their own health care costs and the rising amounts they have been paying out-of-pocket for premiums, deductibles and co-pays, while at the same time being hit by multiple other economic shocks in the recession. For the worker share of the premium alone, the average amount paid by families increased from \$1,543 in 1999 to \$3,354 in 2008. It is this concern that has propelled health care back to the front of the national agenda and redefined it as a bread and butter economic issue of real salience for working and middle class Americans. Figure 3, from one of our recent tracking polls, makes this crystal clear. It explains why what people mostly want from health reform is for government to come to their rescue -- either through subsidies or regulation or both -- so that they can spend less for their health care and health insurance. People don't really distinguish between subsidies that help to cover the cost of their insurance or cost containment efforts that mitigate the premiums themselves; they just want to pay less.

Figure 3



Source: Kaiser Health Tracking Poll: Election 2008 (conducted Oct 8-13, 2008)
Note: "Don't know/Refused" responses not shown.

A "grand bargain" discussion about health reform and entitlements, if it develops, could create a unique opportunity to pursue all three health cost objectives together. In particular, initiatives developed as part of health reform to contain health care costs hold the promise of helping with the long-term growth of government health entitlements, though the savings may take many years to materialize. [But there is also a risk that the effort will fracture over differences in goals or succeed on some objectives more than others.](#) For example, a deal that would rein in entitlement spending over the long term, in part through promised reforms of the health delivery system, but do little to provide immediate help to the public with their health care bills, is not likely to be very popular with voters who have put health care back on the agenda precisely because of their problems paying for health care today. Of course, the steps often discussed to control entitlement spending itself, such as pushing back the age of eligibility for Medicare, income relating Medicare premiums, or reducing provider payments, have never been an easy sell with the public or the Congress, and would likely be even more difficult in the context of a severe economic recession, and deficit hawks might only buy the bargain if clear triggers for implementing them were written into the legislation.

A grand bargain discussion itself would require looking out over longer time horizons than the Congress normally does in considering the costs and potential savings from legislation; in effect trading a willingness to spend now for savings down the road that will put public programs and the federal budget on a more sustainable long term course. A discussion like this, an attempt at linking so many big issues and interests usually dealt with in Washington issue by issue, committee

by committee, press story by press story, and vested interest by vested interest, would be unprecedented. It would represent an attempt not just at achieving a policy outcome, but at leapfrogging the usual policymaking process.

The problem of health care costs will be central to both the health care reform and entitlement discussions, whether they are separate or joined in a new way. It will be important to keep clearly in focus in these debates that controlling health care costs can mean very different things to a health economist or a deficit hawk or to the public; to keep the public's agenda in mind at all times or risk jeopardizing voter support; and to make an effort to address the different agendas in health care cost containment comprehensively rather than in the usual piecemeal fashion. ("Multiple Agendas for Controlling Health Care Costs," Drew Altman, Kaiser Family Foundation, 1/30/09) (http://www.kff.org/pullingittogether/012809_altman.cfm)

Will the U.S. take Advantage of the Window of Opportunity?

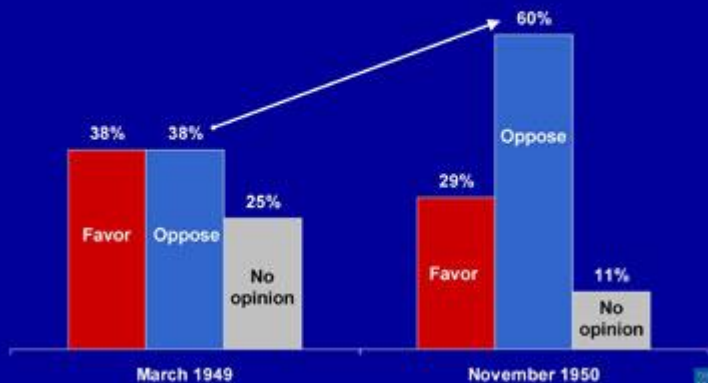
Beginning this spring, between expected approval of an economic stimulus package and the start of campaigning for the midterm election, there will be a rare window of opportunity for passage of major health reform legislation. History suggests that momentum can be lost if policymakers do not move quickly to seize these rare openings when they occur. There is an opportunity now because the nation has a popular new president with political capital to burn who is making health reform a priority. Democratic leaders in control in the Congress want to deliver on health care. And a historic recession has transformed health care into a bread and butter economic issue of real salience to working people and the middle class, who are worried about paying their health care bills and about losing their jobs and their families' health coverage. Many years ago a great political scientist named Aaron Wildavsky wrote an article called "The Two Presidencies" in which he contrasted the relative power of the presidency in foreign policy with its comparative impotence in domestic affairs. But Wildavsky argued that times of crisis such as the economic meltdown the country faces today present exceptions to the rule. There remain serious obstacles to passing major health legislation, not least the challenges of reaching across the aisle and forging consensus on key elements of reform and the very real problem of finding a way to pay for expanding coverage in the current budgetary environment. However, the kind of opportunity the president and Congress have now in health does not come along often.

These two charts, dating from as far back as the Truman era and as recently as the Clinton one, underscore the argument for moving as quickly as possible to take advantage of moments of opportunity before opposition to health reform legislation emerges and public enthusiasm wanes. They show how opposition to the Truman plan rose and support for the Clinton plan fell when debate shifted from consensus about initial goals to disagreement about details. It's inevitable in a drawn out legislative process that media and public attention will shift to the tradeoffs involved in health reform and the difficult business of controlling costs and paying for expanding coverage. A new poll we will release next week will show both the

opportunity for action now, but also the potential for a similar unraveling of support in the face of some of the arguments likely to be made by opponents in the face of a protracted debate about the issues and tradeoffs in health reform. Familiar constants in public opinion always lurk just beneath the surface as well. For example, people do not want to pay more out of pocket as a result of any health reform plan -- in fact, they're looking to pay less -- and they don't want to be forced to change their current health care or health insurance arrangements. As in the past, these and other fears can be exploited by opponents of legislation in an extended debate, whether or not they are actually true. Maintaining support through a lengthy national debate may be even more difficult in the modern era where public opinion can be influenced by interest groups waging ad wars on TV, or now on YouTube, much like in political campaigns. (Click on a chart to enlarge)

Truman Health Reform Plan Debate: Opposition Grows Over Time

Change in public support for Truman Health Reform Plan over time...

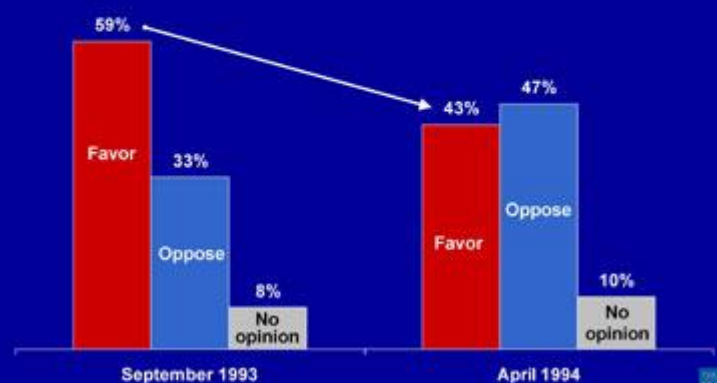


Source: Gallup Polls, 1949 and 1950



Clinton Health Reform Debate: Support Wanes Over Time

Change in public support for Clinton Health Reform Plan over time...



Source: Gallup/CHN/USA Today Polls, Sept. 24, 1993 and April 16, 1994.



Right now, we're mostly in the "happy talk" phase of the health reform debate. All of the major interest groups are in favor of reform of some sort, and the public is supportive of major action. But there are many elements of the plans that have been proposed that could spark opposition – for example, requirements on employers and individuals, a new institute or federal agency with a mandate to conduct research on the comparative effectiveness of treatments, new regulations affecting the health insurance industry, and of course how to finance coverage expansions over the long term. In fact, the notion of creating a public plan like Medicare to compete with private insurance plans has become an early target of the insurance industry. CBO scoring will add to the challenge because in general the measures that will be credited with producing the largest short term savings which political leaders will need to pay for their plans will be the most politically controversial.

While efforts are already being made to rally the public as a counterweight to likely opposition to legislation -- something that didn't happen in a coordinated way during the debate over the Clinton plan -- history suggests that delay and a long

public debate can be the enemy of health reform legislation. That may be truer than ever now, when our economic circumstances appear to have created a unique willingness to invest in health care in the short term as part of an effort to stimulate the economy and address the public's economic insecurities, with the promise of savings as a result of reform over the long term.

Quick action may offend those who think that it's the job of Congress to get things exactly right when legislation is first drafted, or that a long debate and a full vetting is the right way for a democracy to deal with a big issue like health reform. But more than any other single factor it's the recession that makes the environment for this health reform debate different from the last one, and a reading of history suggests that if action rather than another health reform stalemate is to be the outcome, one strategy may be to move fast and seize legislative opportunities when they present themselves, get at least the basics right, and fix whatever problems emerge later on. ("Window of Opportunity?" Steve Altman, Kaiser Family Foundation, January 7, 2009)

http://www.kff.org/pullingittogether/010709_altman.cfm

Mission Critical: A New Reimbursement Model for Providers of Health Care Services

Tom's Comments:

Medicare is largely responsible for the method by which we pay healthcare providers in the U.S. Medicare, by far, is the biggest payer of healthcare services, and the private sector managed care organizations have mostly followed Medicare's lead relating to reimbursement methodologies.

As we have cited in prior issues of the Quarterly, Medicare's payment policies have been a major contributor to the high healthcare costs and inconsistent quality in the U.S. Instead of having a payment system that would incent prevention, wellness, chronic care management, efficiencies, better quality and collaboration, we have a payment system that rewards overutilization, does not factor in quality of services provided, is fragmented and does not pay for preventive and wellness services in a meaningful and comprehensive way.

The thoughtful journal article below provides the reader with an overview of provider payment options that could jump-start healthcare reform and have a positive impact on cost and quality. Global and episode of care reimbursement have the potential to incent collaboration and chronic care management as well as address overutilization in the hospital setting. Episode of care payment methodology would also include reimbursement for pre- and post- hospital care which would create incentives to optimize

care. Combining global and episode of care reimbursement with quality linkages and a comprehensive primary care system that financially rewards prevention and wellness would go a long way in addressing some of the fundamental cost and quality problems we face in healthcare today.

Finally, as stated in the Robert Mechanic and Stuart Altman article below, "In addition to payment policy changes, policymakers need to consider fundamentally restructuring Medicare to be a more effective purchaser. One option would be establishing an independent Medicare board that is separate from both the CMS and Congress. This would be analogous to proposals for a Federal Health Board (FHB) that would make decisions about benefits, coverage, and payment policy based on sound empirical research in the context of national health reform. Among its potential benefits would be insulating Medicare from congressional micromangement."

Payment Reform Options: Episode Payment is a Good Place to Start

ABSTRACT :

New strategies to control U.S. health spending growth are urgently needed. Although provider payment cuts are likely, cutting fee-for-service (FFS) payments will hurt quality and access. A more sensible approach would be to restructure the delivery system into organized networks of providers delivering reliable, evidence-based care. But restructuring will not occur without payment policy reform. Four policy options are commonly cited: recalibrating FFS, instituting pay-for-performance, creating episode-based payments, and adopting global payments. We argue that episode payments are the most immediately viable approach, and we recommend that payment reforms precede any payment reductions so that new delivery models can gain traction. [*Health Affairs* 28, no. 2 (2009): w262-w271 (published online 27 January 2009; 10.1377/hlthaff.28.2.w262)]

There is strong consensus that the U.S. health care system fails to provide either the quality or the value that it should, and that substantial restructuring is urgently needed. Despite deep dysfunction and numerous public and private reform efforts, the system has been astoundingly resistant to change. But health spending has reached a level where continued annual increases two to three percentage points faster than the nation's economic growth will increasingly limit the ability of employers and public programs to offer health coverage. Unless the forty-year historical spending trend miraculously abates, vigorous expansion of public and private cost control initiatives is inevitable.

Of the strategies capable of immediately slowing growth in health spending, reducing benefits and limiting services run counter to the urgent need to improve health care access. This leaves provider payment cuts as the "least bad" option for achieving short-term savings. However, in

the fragmented U.S. delivery system, cutting fee-for-service (FFS) payments over any sustained time period will hurt both quality and access. A more sensible approach would be to develop a long-term agenda to restructure the delivery system into organized networks of providers capable of delivering reliable, evidence-based care within realistic budgets.

Expanding organized networks will not, by itself, reverse the health care spending trend. But in a future of constrained spending growth, organized networks will be better able to optimize the mix of patient services and preserve quality compared with the current system of unconnected providers, particularly if payers realign financial incentives. Physicians and hospitals now have few incentives to establish or join organized networks. We believe that payment reform is a necessary precondition for the types of delivery system changes needed to bring about a more efficient and effective health care system.

Four payment reform options have been widely discussed: recalibrating FFS; instituting pay-for-performance (P4P); creating episode payments that combine hospital and physician reimbursement; and adopting global payment approaches such as capitation. We briefly summarize each below, according to four criteria: (1) their potential for reducing unnecessary utilization; (2) their potential for encouraging high-quality care; (3) the support they provide for provider integration; and (4) operational feasibility. We also discuss blended approaches, and we conclude by discussing implementation issues.

Option 1: Recalibrate FFS Payments

FFS reimbursement pays for care regardless of whether services are appropriate or of high quality, and it supports wide geographic variations in health care use and spending. It penalizes organizations that try to reduce unnecessary services or shift patients into low-cost settings with reduced revenues and profits, creating a sizable barrier to delivery reform.

FFS also encourages overuse of many costly specialty services while short-changing important but less lucrative areas such as primary care. Well-documented inaccuracies in Medicare hospital and physician payment have made certain services highly profitable and others money-losers. The most profitable have been those with rapidly advancing technology, where new equipment has increased physician productivity and reduced costs. Because prices have remained at their initial levels while costs have declined, use of cardiovascular procedures, orthopedics, and advanced imaging has increased rapidly.

Service-line profitability influences health care investment decisions. Recalibrating Medicare FFS rates to establish more-neutral financial incentives would encourage investments that are better aligned with communities' medical needs. However, in a recalibrated FFS system, providers will still be paid more for doing more rather than for achieving better outcomes. The political challenges of recalibration are also great, as powerful interests will react negatively to potential income reductions.

Option 2: Pay-For-Performance

The concept of P4P has strong intuitive appeal. By 2006, 258 P4P programs were being operated by 140 public and private payers. However, few programs have been formally evaluated, and those that have show mixed results. One early analysis concluded that physician P4P may produce little gain in quality for the money spent, and it may largely reward physicians with higher baseline performance. Many design issues remain unresolved, including whether programs should target individual physicians or groups; the proportion of physician remuneration needed to change behavior; and whether incentives should reward the level of performance or the rate of improvement.

The most important factor limiting P4P's potential, however, is the current lack of meaningful, actionable performance measures. Most programs rely on widely available process measures such as the Healthcare Effectiveness Data and Information Set (HEDIS). Clinical outcome measures such as death and complication rates associated with surgery are more meaningful but are technically problematic. Furthermore, most outcome measures focus on very small subsets of clinical practice. The deficit in performance measurement is a fundamental concern for all payment models discussed in this paper. Broader measures that target multiple dimensions of care and foster shared accountability among caregivers are needed.

In contrast to the modest impact of most P4P programs, Medicare's new policy of withholding hospital payments for services caused by eight secondary conditions it defines as "preventable complications" has important implications for quality improvement. Although financial savings from this effort will be small, it could have a large impact on hospital behavior if seen as an initial phase of future Medicare policy changes that penalize poor performance.

P4P is an important development, but it must evolve beyond its current form to be effective. P4P addresses a major conceptual flaw in FFS by rewarding quality of care. However, P4P programs are unlikely to affect spending trends as long as their primary emphasis is rewarding providers for delivering "underused" services rather than for judicious use of potentially "overused" treatments. Nor is P4P likely to drive substantial provider integration, although programs that reward the adoption of information technology (IT) and care management processes may be beneficial on the margin. In spite of these issues, P4P can be a valuable component of either a modified FFS system or a more global model. However, P4P combined with FFS is not our preferred alternative.

Option 3: Bundled Payment for Episodes of Care

Options 1 and 2 contain few incentives for cooperation among hospitals, physicians, and other care providers. As a result, there is growing interest in bundled payments that include all services associated with an episode of care, such as a hospital admission. This would go beyond hospital diagnosis-related groups (DRGs) by bundling hospital, physician, and other clinical services into a single rate. It would also increase accountability for outcomes by extending the episode to a period of perhaps thirty days beyond the hospital discharge. Payers would develop rates based on the resources needed to provide care that is consistent with established clinical guidelines.

Desirable outcomes from episode-based payments include reducing unnecessary physician and ancillary services, compensating physicians for efficient resource use, and reducing complications and readmissions. Policymakers are concerned, however, about the potential for hospitals to increase admissions, seek to profit by limiting beneficial services, or avoid patients with complicated conditions.

Interest in episode payments has been heightened by a recent Geisinger Health System (GHS) initiative, which the *New York Times* has characterized as "surgery with a warranty." Geisinger's ProvenCare coronary artery bypass surgery (CABG) program promises to follow forty specific clinical processes for all patients undergoing elective procedures. For each case, surgeons must explicitly ensure that surgery is appropriate, document a shared decision-making process with the patient, and initiate post discharge follow-up to ensure compliance with medication and rehabilitation recommendations.

The key aspect of ProvenCare is a flat payment for surgery and all related care for ninety days after discharge. The flat rate assumes that GHS will reduce its historical complication rate by half. An evaluation during the first year found reductions in most adverse events in the ProvenCare patient group, including a 10 percent drop in readmissions, shorter average length-of-stay, and reduced hospital charges. More recent data presented by Geisinger executives suggest a 44 percent readmission reduction over eighteen months. Based on these results, GHS

has expanded ProvenCare to other areas including angioplasty, cataract surgery, and hip replacement.

ProvenCare's success is due in large part to Geisinger's unique structure as a physician-driven, integrated delivery network with a system wide electronic health record (EHR) and dominant market share. This structure addresses a key challenge for health care organizations: how to equitably distribute episode payments across physicians, hospitals, and other providers. Some of the nation's 125 integrated academic medical centers and 1,000 physician-hospital organizations (PHOs) will be able to adapt quickly to episode payments, while others will struggle. Payers will encounter less resistance if they develop episode payments within a quality improvement framework and with substantial physician input. Groups like Prometheus are now developing "evidence-informed" case rates and defining services that should and should not be included in episode payments.

Option 4: Global Payment

The most common form of global payment is capitation: an all-inclusive payment per enrollee for a defined scope of services, regardless of how much care is actually provided. Studies comparing physicians paid under FFS and capitation show that capitation results in lower rates of elective surgery, patient consultations, diagnostic services, and specialist and hospital referrals. A principal concern is that capitation creates financial incentives for physicians to withhold care. This criticism helped fuel the managed care backlash in the 1990s, and it must be addressed if payers are to successfully resurrect capitation.

One model that tries to address these concerns is the Blue Cross Blue Shield of Massachusetts (BCBSMA) alternative quality contract (AQC), which combines a health status-adjusted global payment with performance incentives for meeting quality and safety benchmarks. BCBSMA envisions the AQC as a five-year arrangement in which base payments start at current spending levels and grow by inflation. Contracted delivery systems can improve margins through quality bonuses of up to 10 percent and by reducing spending growth below the level of inflation. As of this writing, BCBSMA has signed preliminary agreements with several multispecialty group practices.

Relative to other options, global payment has the greatest potential for encouraging shifts in health care resource use from low-value to high-value services. To counter the possibility of under treatment, global payment should be implemented in a context of ongoing performance measurement and reporting. Expanding global payment will also encourage providers to become more organized. As FFS rates are restricted, physicians' income prospects may well look better under global payment arrangements. There are obviously important challenges for global payment, including developing credible risk-adjustment mechanisms and finding provider systems willing to accept global risk.

Blended Payment Models

Although the foregoing payment reform options are usually discussed as if they were distinct models, future payment innovations will likely incorporate multiple approaches. Blended models are widely used by physician groups in California that reimburse specialists and primary care physicians using blends of capitation and FFS. Payers can design blended systems to achieve specific policy objectives--for example, combining capitation incentives for spending within budget targets with FFS for promoting preventive services such as mammography, and bonus payments for encouraging providers to meet quality and patient satisfaction targets. Importantly, blended models can be designed to limit physicians' financial risk for aspects of care beyond their control.

The principal goals of payment reform articulated in this paper are (1) controlling unnecessary utilization, (2) encouraging high quality, and (3) supporting provider integration. FFS

reimbursement performs poorly on all of these goals, although a recalibrated FFS system improves on the current model. P4P encourages higher quality for aspects of performance that can be measured but falls short on the other two goals. Episode payments have potential for positively influencing utilization, quality, and provider integration, although the utilization impact is primarily within the episode itself. Global payment has the greatest potential for controlling utilization and encouraging provider integration, but like episode payments, it requires a strong performance monitoring framework and possibly financial incentives to ensure quality. Unfortunately, global payment is also the most challenging to implement on a large scale.

Implementing Payment Reform

Payment reform cannot succeed without Medicare as a major player, because Medicare is the only payer with sufficient market power to drive meaningful delivery system reforms. The Centers for Medicare and Medicaid Services (CMS) strategic plan calls for "achieving a transformed and modernized health care system." However, one cannot underestimate the difficulty of this undertaking--administratively, technically, and politically. Unlike private payers, traditional Medicare has not yet been permitted to establish limited provider networks based on quality and efficiency, or to vary benefit designs to drive patients to efficient providers. Medicare's "big stick" is payment policy. Here we focus on Medicare's role in payment reform, in the belief that private payers will quickly implement successful Medicare payment policy changes.

There is much variability in the readiness of U.S. physicians and hospitals to adapt to major payment system reforms. Although multispecialty groups such as Kaiser Permanente already operate under global payment, most U.S. physicians are in solo practice or small groups, and are ill prepared to manage care under greatly modified financial arrangements. Reforms must be phased in so that providers have a reasonable opportunity to adapt by implementing new models of virtual integration that build on IT and shared financial incentives. Stephen Shortell and Lawrence Casalino describe five common organizational models that could evolve into "accountable care systems" under a modified financial structure.

Although we believe that some form of global payment combined with performance incentives is the best theoretical model, the CMS will have to adopt a more iterative and flexible approach, which we believe can draw on all four payment reform options described in this paper. The CMS could begin by recalibrating payment levels and developing a more dynamic Medicare rate-setting process, including more-rigorous mechanisms for reviewing and updating physician fees, and recognizing changes in the cost of new technologies. For example, the CMS could develop multiyear schedules where payments for new products are automatically adjusted to reflect productivity gains observed in similar technologies unless presented with evidence to the contrary.

Developing more effective P4P models is also a worthy objective that Congress should accelerate by investing in a national center for performance measurement. If P4P becomes a central component of Medicare payment policy, we recommend an explicit focus on trying to measure overutilization and developing incentives to reduce unnecessary care. We recognize that overutilization is very difficult to measure precisely; therefore, the initial focus could be expensive services known to have limited efficacy. The Medicare Payment Advisory Commission (MedPAC) or a national advisory group should be charged with identifying potentially overused services and developing a research agenda to evaluate how to manage these services more effectively. The CMS should also experiment with value-based pricing models that adjust payments based on clinical outcomes. The United Kingdom has used this approach to pay for certain biologic therapies.

In our view, the most promising near-term opportunity for the CMS is to develop an episode-based payment system for Medicare. Doing so would create an environment favorable to advancing episode payments in the private sector and would strengthen incentives for providers to work together toward improving their collective efficiency. Inpatient episode payments would address one of Medicare's most visible quality problems: an 18 percent hospital readmission rate within thirty days of discharge. Reducing or eliminating payments for preventable readmissions could save Medicare up to \$12 billion annually. Both the CMS and private payers could facilitate adoption by working with groups like Geisinger and Mayo Clinic to establish standard clinical protocols for episode payments. They could also offer enhanced payments to "ProvenCare certified" delivery systems.

In the immediate future, global payment models will remain primarily in the private sector. The CMS should encourage these private models and, where appropriate, develop partnerships with health insurers to support and evaluate them. For example, the CMS could establish a voluntary, local Medicare payment option that reinforces BCBSMA's alternative quality contract. The CMS should also expand its use of programs such as the Physician Group Practice demonstration, where participating groups share in savings below a projected budget.

In addition to payment policy changes, policymakers need to consider fundamentally restructuring Medicare to be a more effective purchaser. One option would be establishing an independent Medicare board that is separate from both the CMS and Congress. This would be analogous to proposals for a Federal Health Board (FHB) that would make decisions about benefits, coverage, and payment policy based on sound empirical research in the context of national health reform. Among its potential benefits would be insulating Medicare from congressional micromanagement.

Finally, the federal government should develop a detailed payment reform agenda that sends clear signals to the market. Although provider reluctance is inevitable, the most effective inducement will come from restricting growth in FFS rates, while offering alternative models with greater potential for provider income. Limits on spending growth will require reductions in payment rates, but we recommend that new payment models be implemented first, to allow payment reforms time to gain traction. If payment reform is viewed simply as a way to cut spending, providers will resist as they did during the 1990s. Instead, if the new payment structure allows providers to earn more as part of organized delivery systems than as independent practitioners, the interaction between payment policy and delivery reform could become a virtuous cycle.

Concluding Thoughts

Although payers with market power can reduce spending by cutting FFS payments, doing so in a fragmented system will create serious quality problems. We believe that organized systems are more capable of adapting to the inevitable moderation in U.S. health spending growth while maintaining quality, but that delivery system restructuring will not happen without payment reform. We strongly recommend that payment reforms precede any significant reduction in payment levels. Payment reform must also be accompanied by new investments in quality measurement, comparative and cost-effectiveness research, IT, and techniques for managing complex chronic illnesses. Without such investments, we are not optimistic that the U.S. health system will be able to moderate spending growth while moving toward a delivery system that generates superior value. ("Payment Reform Options: Episode Payment is a Good Place to Start," Robert E. Mechanic and Stuart H. Altman. *Health Affairs*, January 27, 2009) <http://content.healthaffairs.org/cgi/content/abstract/28/2/w262>

QUALITY

Will the Government Reevaluate its Role in Enabling Lifestyle Diseases?

Tom's Comments:

As we have discussed in prior issues of the Quarterly, per the Center for Disease Control, lifestyle related diseases (e.g. heart, diabetes, cancer, etc.) impact anywhere from 50% to 70% of our healthcare costs. More importantly, these lifestyle diseases have a major negative impact on the quality of life of the inflicted. Lifestyle diseases, by their very definition, are developed or aggravated, as a result of individual's behavior. Examples of "bad" lifestyle behavior include: smoking, alcohol and drug abuse, lack of exercise, diet, etc.

Much of the discussion relating to healthcare reform has focused on changing provider (primarily hospitals and physicians) reimbursement methodologies to financially reward wellness and prevention activities as well as reward collaboration between providers of care. Recent legislative proposals also focus on providing tax credits to employers who implement wellness programs for their employees. While these fundamental changes to provider reimbursement and financial wellness incentives to employers are critical, there also needs to be a focus on individual accountability.

Individual accountability for lifestyle choices is a key ingredient to a sustainable strategy to address lifestyle diseases. While genetics play a role in many diseases, individuals in most cases have the ability to mitigate health issues to some degree. Employers, managed care organizations, and Medicare and Medicaid need to also foster an environment of personal accountability to ensure sustainable success against lifestyle diseases. Historically, the federal government, rather than being a catalyst for individual accountability, has been an "enabler" of bad lifestyles.

Over the years the true intent of the American with Disabilities Act (ADA) has been expanded (see article below titled, "EEOC Says that Mandatory Health Risk Assessments Violate ADA") to encompass activities that are truly not disabilities. The Health Insurance Portability Accountability Act (HIPAA) has also played a role in insulating individuals from their poor lifestyles (See the article below titled, "Congress Plans Incentives for Healthy Habits")

The articles noted below appear to cite a trend that hopefully will foster an environment that will incent increased accountability by the individual. Employers continue to push the card relating to increased incentives and sanctions linked to programs that help address lifestyle disease in a proactive manner through wellness and disease management initiatives. The key to success of any of these initiatives is patient compliance. Employers are increasingly motivated to implement wellness and disease management programs for their employees in order to address the high cost of healthcare. The value of these investments is eroded when employees do not take ownership of their own lifestyle.

As noted in the article below titled, Moving Boldly to Stem Health Care Spending, “Strategic companies will redesign their incentive plans to either make participation in health-related activities mandatory or increase employee contribution rates and allow employees who stop smoking to fill our risk assessments and commit to health behaviors to “earn back” those contribution increases.”

Not everyone agrees with programs that incent increased accountability for lifestyle diseases. In the article below titled, Congress Plans Incentives for Healthy Habits, Lewis Maltby, president of the National Workrights Institute, a research and advocacy group, said “Financial rewards and penalties were often a form of lifestyle discrimination.” Per Mr. Maltby, “You are supposed to be paid on the basis of how you do your job, not how often you go the gym or how many cheeseburgers you eat.”

While I respect Mr. Maltby’s opinion, eating too many cheeseburgers can have an impact on both employers’ and employees’ financial wellbeing. The following is an example I have used in class which has real world implications related to it. Small companies which have been especially hard hit by the high cost of healthcare. Only a few “high risk” individuals employed by a small company can negatively impact its insurability and overall healthcare costs. Let us assume there is a small company (e.g. 20 employees) struggling to financially survive on a daily basis in a very competitive market place. Let us also assume there is one employee at this company who is very overweight. This employee also smokes two packs of cigarettes a day, and has already had one heart attack. We will also assume that this employee eats fast food for lunch every day, usually two large cheese burgers with a large fry. This employee also refuses to participate in any wellness or disease management programs, since it is his right as an American,

Now let us assume you are one of the employees of that company who is struggling to support your family. The lifestyle decisions by your fellow employee will either result in your company paying higher healthcare

costs, which in turn increases healthcare costs for all of its employees (including you), or possibly results in your employer not being able to afford health insurance for its employees. While this is a fictitious case, it is also too real of a scenario. There is definitely a role for increased accountability in this all too real example.

As the laws are written today, many of the proactive strategies that employers would like to implement to incent compliance with wellness and disease management programs are greatly limited. Can rewards and penalties be used in an ethical manner to ensure personal accountability as it relates to lifestyle issues?

Per the article below titled, [Congress Plans Incentives for Healthy Habits](#), “Federal officials insist that the rewards and penalties can be used in ethical ways. Ethics experts at the National Institute of Health have developed guidelines for assessing workplace wellness programs. In a recent issue of the Journal Health Affairs, the experts, Steven D. Person and Sarah R. Lieber, say the unhealthy behavior of some employees can affect co-workers by driving up costs for the group as a whole.”

“The core ethical justification for the penalty programs is that employees should be held responsible for voluntary actions that cause harm to others,” they write. But, they add, employees should be exempt from penalties when it is “unreasonably difficult or medically inadvisable” for them to meet a particular standard.”

Finally, as discussed in the commentary below relating to Clinical Effectiveness Research, an independent agency could play a proactive role in evaluating best practices (e.g., evidence-based medicine), that would have a positive impact on preventing and managing lifestyle related diseases. Clinical Effectiveness Research can also help develop the guidelines that would prevent discrimination relating to the diseases, etc. that are truly genetically based.

This is obviously a political sensitive issue, but if the government is sincere in its fight against high healthcare costs and for better quality, it needs to address this issue in a proactive model. A key component of fighting lifestyle diseases is finding ways to incent increased accountability (not enable it) in order to optimize the success of wellness and disease management initiatives. Remember the ultimate goal of wellness and disease management programs is a “win-win:” a “win” for the employer in lower healthcare costs, but more importantly a “win” for the person that is struggling with health issues.

Moving Boldly to Stem Health Care Spending

Most finance executives recognize that there are two parts to the health-care cost equation: management of the supply side of care; and management of demand for care. Over the last five years, organizations have been successful at holding overall health-care cost increases to single-digit levels by tightly managing provider networks, holding down provider reimbursement levels, pushing for increasingly deeper discounts and taking other steps to drive cost-efficient delivery of health care services.

And while a 6% to 7% annual rate increase represents a victory of sorts after the dramatic 12% to 15% rate of cost growth seen in the late 1990s and early 2000s, it's still twice that of the CPI – far too high for a recessionary economy.

While organizations may be able to wring additional cost efficiencies from the supply side, far greater savings opportunities exist for employers that can reduce the demand for health care services.

Getting employees to take on the increased responsibility required for success is not easy. And some organizations have worried that mandating changes in employee behavior with too heavy of a hand would alienate – rather than engage – their workforce. But as financial pressure on employers increase and labor trends turn in their favor, employers are well-positioned to be much bolder in defining and drawing the line on, how and when they spend health care dollars on behalf of employees.

According to Towers Perrin 2009 Health Care Cost Survey, only 28% of respondents use health-risk assessments to a large degree and only 22% emphasize health improvement initiatives such as smoking cessation and weight management. When they do make these programs a focus, employers tend to extend attractive “carrots,” such as \$100 awards, to encourage employees to participate.

Going forward, however, employers will become far more aggressive in ensuring employee participation in these beneficial activities. Hundred-dollar incentives will become less common. After all, why should

companies spend scarce dollars encouraging employees to do something proven to be in their best interest and the organization's best interest? Many more organizations will make risk assessments mandatory, or require higher contributions levels from employees who continue to smoke or engage in other unhealthy activities.

Strategic companies will redesign their incentive plans to either make participation in health-related activities mandatory or increase employee contribution rates and allow employees who stop smoking to fill our risk assessments and commit to health behaviors to "earn back" those contribution increases.

Overall, organizations that employ strategic thinking and innovative solutions to address both the supply and demand sides of the cost equation can achieve competitive advantage and deliver measurable value to the organization in the short and long term. ("Moving Boldly to Stem Health-Care Spending," Dave Guilmette and Ron Fontanetta, Financial Executive, January/February 2009) (www.financialexecutives.org)

EEOC Says that Mandatory Health Risk Assessments Violate ADA

Many employers are implementing wellness programs that include health risk assessments, sometimes offering inducements to complete these assessments. In an informal letter, the EEOC said that making health risk assessments a prerequisite for health coverage would violate the Americans with Disabilities Act (ADA) but confirmed that certain voluntary wellness programs are permissible under the ADA. Although the letter does not constitute an official opinion of the EEOC, it does reflect the agency's current thinking on the issue. "EEOC Says that Mandatory Health Risk Assessments Violate ADA," Buck Consultants, Buck Research, Volume 32, Issue 26, May 14, 2009)

<http://www.buckconsultants.com/buckconsultants/spanidNavService.aspx/tabid/133/Default.aspx>

Congress Plans Incentives for Healthy Habits

In its efforts to overhaul health care, Congress is planning to give employers sweeping new authority to reward employees for healthy behavior, including better diet, more exercise, weight loss and smoking cessation. A web of federal rules limits what employers and insurers can do now.

Congress is seriously considering proposals to provide tax credits or other subsidies to employers who offer wellness programs that meet federal criteria. In addition, lawmakers said they would make it easier for employers to use financial rewards or penalties to promote healthy behavior among employees.

Frank B. McArdle, a health policy expert at Hewitt Associates, a benefit consulting firm, said, "Wellness and prevention programs have become mainstream part of the benefits offered by large employers, and it's virtually certain that Congress will include incentives for such programs" in its bill. The goals of such programs are to help people control blood pressure, fight obesity and manage diabetes and other chronic conditions.

Under Senator Harkin's (D – Iowa), employers would obtain tax credits for programs that offer periodic screenings for health problems and counseling to help employees adopt healthier lifestyles. Programs could focus on tobacco use, obesity, physical fitness, nutrition and depression, he said.

Lewis Maltby, president of the National Workrights Institute, a research and advocacy group, said financial rewards and penalties were often a form of life-style discrimination. "You are supposed to be paid on the basis of how you do your job, not how often you go the gym or how many cheeseburgers you eat," Mr. Maltby said.

But federal officials insist that the rewards and penalties can be used in ethical ways. Ethic experts at the National Institute of Health have developed guidelines for assessing workplace wellness programs. In the current issue of the journal *Health Affairs*, the experts, Steven D. Person

and Sarah R. Lieber, say the unhealthy behavior of some employees can affect co-workers by driving up costs for the group as a whole.

“The core ethical justification for the penalty programs is that employees should be held responsible for voluntary actions that cause harm to others,” they write. But, they add, employees should be exempt from penalties when it is “unreasonably difficult or medically inadvisable” for them to meet a particular standard.

If an employer offers financial incentives to employees for lowering cholesterol, losing weight or stopping smoking, the amount of such rewards generally may not exceed 20% of the cost of coverage. Many employers would like to offer larger incentives, and many in Congress want to let them do so. (“Congress Plans Incentives for Healthy Habits,” Robert Pear, The New York Times, May 10, 2009)
(<http://www.nytimes.com/2009/05/10/health/policy/10health.html>)

What is the Role of Clinical Effectiveness Research?

Tom's Comments:

As noted in the article below, “The \$787 billion economic stimulus bill approved by Congress will, for the first time, provide substantial amounts of money for the federal government to compare the effectiveness of different treatments for the same illness.”

“Under the legislation, researchers will receive \$1.1 billion to compare drugs, medical devices, surgery and other ways of treating specific conditions. The bill creates a council of up to 15 federal employees to coordinate the research and to advise President Obama and Congress on how to spend the money.”

“The program responds to a growing concern that doctors have little or no solid evidence of the value of many treatments. Supporters of the research hope it will eventually save money by discouraging the use of costly, ineffective treatments.”

The last issue of the Quarterly (January/February of 2009) included an Issue Brief from the American Academy of Actuaries (“Health Insurance Coverage and Reimbursement Decisions,” Issue Brief: American Academy of Actuaries, September 2008, <http://www.actuary.org/pdf/health/comparative.pdf>) on Clinical Effectiveness Research.

The authors of the Issue Brief stated, “Comparative effectiveness research can not only help in determining what treatments are most effective but, linked to the most appropriate clearinghouse, information could be made available to and used by clinicians in a timely manner.” Currently, per the authors, “Studies indicate that an average of 17 years passes before research-generated knowledge, such as that from randomized clinical trials, is incorporated into widespread clinical practice—and even then the application of the knowledge remains uneven.”

As the authors further stated, “New comparative effectiveness research can add more value and improve upon the information already available by increasing the body of primary research of head-to-head trials that compare new treatments and technologies to those already existing. It can provide insights into whether certain treatments are more effective than already existing options.”

“The research also has the potential to provide information on which patients respond better to specific treatments. Because much of the health care currently provided does not have an underlying evidence base, new comparative effectiveness research should also include studies of existing treatments and technologies. Such analyses could lead to a greater development of evidence-based treatment protocols and a reduction in practice variations.”

The fear of some of the healthcare stakeholders (e.g. pharmaceutical companies, etc.), is that the outgrowth of this research would be incorporated into Medicare payment policies which has the potential of creating financial havoc for those companies’ products that don’t make the “preferred list.” These fears are not necessarily unfounded since many countries (e.g. Great Britain) have incorporated clinical effectiveness research into reimbursement decisions relating to their national health plans.

There is also a legitimate concern, not necessarily only driven by self-interest, that if comparative effectiveness gets incorporated into Medicare’s payment policies, that it could actually stifle innovation. The rationale based on this fear is that if risks increase as a result of possibly “not making the cut” from a clinical effectiveness perspective, only those

organizations that are well financed would invest in innovative drugs, devices, etc. that could be the next block buster.

While I can understand this potential negative impact on innovation if clinical effectiveness research is tied to Medicare's payment policies, I do not believe that this should be a reason to block the development of a Clinical Effectiveness Research institute. We cannot keep our heads in the sand, when it comes to finding better approaches to quality cost-effective care. One of the major priorities of such Clinical Effectiveness Research would be to focus on the healthcare cost disparities in the U.S. that have been well documented by research published in the Dartmouth Atlas of Health Care.

Dartmouth Atlas of Health Care has over a 20 year track record of investigating health cost disparities in the U.S. We dedicated a large portion of one of our prior issues of the Quarterly ([May/June 2008](#) – See commentary and journal article titled, "Tracking the Care of Patients with Severe Chronic Illness" to dissecting the Dartmouth research. It is estimated that over 30% of our healthcare costs could be reduced with no negative impact on quality if we practiced evidence-based medicine as a nation.

To illustrate this case, I was recently forwarded an article from one of my Health Care MBA students relating to healthcare cost disparities in the U.S. The article was written by Dr. Atul Gawande in the June 1, 2009 issue of The New Yorker

(http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande?currentPage=all)

The article provides the reader with some interesting insight into healthcare cost disparities by initially focusing on a poor border town of McAllen, Texas which was the country's most expensive place for health care.

U.S. to Compare Medical Treatments

WASHINGTON — The \$787 billion economic stimulus bill approved by Congress will, for the first time, provide substantial amounts of money for the federal government to compare the effectiveness of different treatments for the same illness.

Under the legislation, researchers will receive \$1.1 billion to compare drugs, medical devices, surgery and other ways of treating specific

conditions. The bill creates a council of up to 15 federal employees to coordinate the research and to advise [President Obama](#) and Congress on how to spend the money.

The program responds to a growing concern that doctors have little or no solid evidence of the value of many treatments. Supporters of the research hope it will eventually save money by discouraging the use of costly, ineffective treatments.

The soaring cost of health care is widely seen as a problem for the economy. Spending on health care totaled \$2.2 trillion, or 16 percent of the nation's gross domestic product, in 2007, and the [Congressional Budget Office](#) estimates that, without any changes in federal law, it will rise to 25 percent of the G.D.P. in 2025.

Dr. Elliott S. Fisher of Dartmouth Medical School said the federal effort would help researchers try to answer questions like these:

Is it better to treat severe [neck pain](#) with surgery or a combination of [physical therapy](#), exercise and medications? What is the best combination of “talk therapy” and prescription drugs to treat mild depression?

How do drugs and “watchful waiting” compare with surgery as a treatment for [leg pain](#) those results from blockage of the arteries in the lower legs? Is it better to treat chronic [heart failure](#) by medications alone or by drugs and home monitoring of a patient's [blood pressure](#) and weight?

For nearly a decade, economists and health policy experts have been debating the merits of research that directly tackles such questions. Britain, France and other countries have bodies that assess health technologies and compare the effectiveness, and sometimes the cost, of different treatments.

[Hillary Rodham Clinton](#), as a senator, was an early champion of “comparative effectiveness research.” Mr. Obama, who is expected to sign the stimulus bill Tuesday, endorsed the idea in his campaign for the White House.

As Congress translated the idea into legislation, it became a lightning rod for pharmaceutical and medical-device lobbyists, who fear the findings will be used by insurers or the government to deny coverage for more expensive treatments and, thus, to ration care.

In addition, Republican lawmakers and conservative commentators complained that the legislation would allow the federal government to intrude in a person's health care by enforcing clinical guidelines and treatment protocols.

The money will be immediately available to the [Health and Human Services Department](#) but can be spent over several years. Some money will be used for systematic reviews of published scientific studies, and some will be used for clinical trials making head-to-head comparisons of different treatments.

For many years, the government has regulated drugs and devices and supported biomedical research, but the goal was usually to establish if a particular treatment was safe and effective, not if it was better than the alternatives.

Consumer groups, labor unions, large employers and pharmacy benefit managers supported the new initiative, saying it would fill gaps in the evidence available to doctors and patients. ("U.S. to Compare Medical Treatments," Robert Pear, The New York Times, February 15, 2009) <http://www.nytimes.com/2009/02/16/health/policy/16health.html>

Access to Care

What will be the “Key” Issues that will Generate the Most Heated Debate Between Healthcare Stakeholders?

Tom's Comments:

The “hot topic” in Washington D.C. is healthcare reform. There are some obvious reasons why it is a “hot” topic, but ultimately escalating healthcare costs that have had a crippling impact on Medicare and Medicaid budgets, and on employers both large and small, as well as 16 million uninsured head the list.

While the focus of the healthcare reform discussions is on initiatives that would positively impact healthcare costs and access to healthcare services, the real action is occurring behind the scenes between the various healthcare stakeholders (e.g. hospitals, physicians, managed care organizations, pharmaceutical/Biotech companies, long-term providers, ancillary providers and suppliers of healthcare services, supplies, and technology, etc.). One only needs to remember that the \$2.1 of annual healthcare related expenditures translates to revenue and ultimate financial survival to the many people and companies that makeup the healthcare industry.

The healthcare reform initiatives that are currently being debated in Washington D.C. include some of the following:

- **The “public” plan:**
- **Individual mandates:**
- **“Play or Pay” Employer Mandates:**
- **Formation of a Health Insurance Exchange:**
- **Underwriting Reforms for Individual and Small Group Markets:**
- **Individual and Small Business Premium Subsidies:**
- **Raise Medicaid Eligibility Thresholds:**

- **Promotion of Wellness and Prevention Services and More Coordinated Care:**
- **Tax Treatment of Health Benefits**

Healthcare cost, quality and access to care define the overall effectiveness of a healthcare system. History has shown us that it is critical to address issues of healthcare costs, quality and access of care in a comprehensive and coordinated manner. Healthcare cost, quality and access to care are inter-related, and if one focuses reform initiatives on only one of these areas there is likelihood that it would create major problems in the other areas.

On a high-level, the following initiatives noted above have a strong likelihood of being included in any healthcare reform initiatives that are passed by Congress and signed by President Obama:

- **Underwriting Reforms for Individual and Small Group Markets (All parties mostly agree that change need to occur in this area to help address the problem of the uninsured. Individual and Small Group underwriting reforms would also be a requirement if individual mandates are implemented.);**
- **Individual and Small Business Premium Subsidies (Subsidies for individual and small businesses would be a requirement if the Health Insurance Exchange initiative is passed, which is likely.);**
- **Raise Medicaid Eligibility Thresholds (The debate will focus on how much of an increase);**
- **Promotion of Wellness and Prevention Services and More Coordinated Care (a no brainer, all parties agree that this will be part of any reform package);**

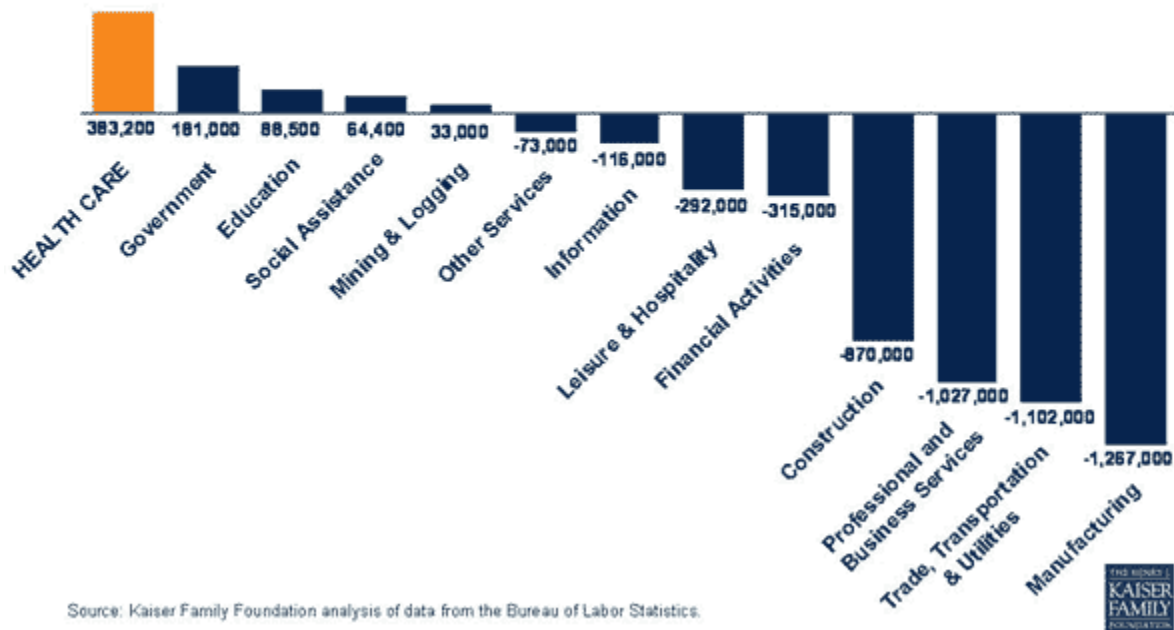
The articles below will address a few of the key healthcare initiatives that are the most “hotly debated.” Those initiatives are the following:

- **Health Insurance Exchange**
- **Individual Mandates**
- **The Public Plan**
- **Employer Mandates**
- **Taxing of Healthcare Benefits**

Finally, as healthcare reform initiatives are proposed to reduce healthcare costs, one needs to be sensitive to the potential negative impact on employment in the healthcare industry. As the chart below shows, employment in the healthcare industry is one of the few bright spots in our national economy. This dependency on healthcare industry employment becomes even more critical in the big (e.g. Cleveland) and small cities throughout America.

Health Care Jobs Up, As Jobs in Most Industries Fall

Job Gains/Losses during January 2008 - February 2009:



Should there be an Insurance Exchange and Individual and Employer Mandates?

Tom's Comments:

There is a strong likelihood that some form of national or regional Insurance Exchange would be a major component of any healthcare reform initiative to address the uninsured and underinsured problem in the U.S. Overall both Democrats and Republicans like the idea of an Insurance Exchange, although probably for different reasons. Ultimately, it

appears that the majority in Congress, as well as President Obama, believe that the Insurance Exchange is the best vehicle to achieve universal coverage.

The article below titled, “Addressing Health Care Market Reform through an Insurance Exchange,” provides the reader with a good overview of both the role and merits of an Insurance Exchange. As noted in the article, “The goal of a health insurance exchange is to shift the market for health insurance from competition based on risk to competition based on price. Proponents hope that competitive insurance markets will drive price competition in the health care services markets as well.”

If one goes down the road of an Insurance Exchange, as again noted in the article, individual mandates would be a base-line requirement to make this delivery system work effectively. As again stated in the article, as it relates to the Insurance Exchange concept, “To realize its potential, everyone needs to be in the risk pool, with individuals required to obtain statutorily acceptable insurance coverage for themselves and their dependents or face significant financial consequences.”

Individual and small group reform, including guaranteed issue would also be a necessary first step as part of the implementation of an Insurance Exchange model. Another core component of an Insurance Exchange whose goal is to achieve universal coverage would be individual and small business premium subsidies.

From a societal perspective, I believe that all Americans should be required to have health insurance. The societal benefit would outweigh any “personal freedoms” that may be violated by requiring health insurance coverage. An analogy can be made in comparing health insurance coverage requirements to car insurance coverage requirements at the state level. While some people may have had issue with the mandate for car insurance coverage, it is mostly now an accepted part of societal responsibilities.

Obviously, if you require individual mandates you will need to have the ability to purchase affordable insurance which is the linkage to individual and small group underwriting reform as well as the use of the Insurance Exchange framework.

There has been some debate relating to employer mandates to provide health insurance. I do not believe that this initiative would receive the necessary votes in Congress given the concern about the potential negative impact on employers at this time. I believe that if an Insurance Exchange is established along with some of the other key initiatives (e.g.

small group reform, small group tax credits to purchase insurance on the Exchange, etc.), there would not be a need to pass employer mandates at this time. Employer mandates may ultimately be part of the natural evolution of the Health Insurance Exchange. As part of this natural evolution there will also be continued debate about the potential of decoupling employers from health insurance and ultimate use the Insurance Exchange as the framework for such purposes.

Finally, the Government should not use the framework of the Insurance Exchange and modified community rating to insulate individuals from accountability for their bad lifestyles and the related diseases. As discussed [previously in this issue](#), lifestyle related diseases per the Center of Disease Control impact 50% to 70% of our healthcare costs on an annual basis.

Addressing Health Care Market Reform through an Insurance Exchange

To address expanding coverage to individuals who do not qualify for employment-based coverage or government programs, and to address the general affordability of coverage, policymakers and others have suggested reforming health insurance markets by a creating health insurance exchange. The exchange concept builds on the idea of *managed competition*, originally developed by Stanford University Professor Alain Enthoven and others. Managed competition is a term that describes a wide variety of models for reforming the health insurance market.

Enthoven's model of managed competition entailed sponsors acting on behalf of groups of individuals to negotiate with insurers and offer participants a menu of choices among different plans. Individuals could purchase health insurance through a new marketplace relying on information provided about each plan's quality of care and price. The exchange could also provide information on consumer satisfaction, provider networks, provider choice, benefits covered, specialized care programs, geographic coverage, coverage exclusions, and various other measures of quality.

A health insurance exchange can be organized at the national level, state level, or some combination of the two. Ultimately, the goal of a health insurance exchange is to shift the market for health insurance from competition based on risk to competition based on price. Proponents hope that competitive insurance markets will drive price competition in the health care services markets as well.

Issues to Consider

A number of issues regarding adverse selection and affordability of health insurance coverage need to be addressed if an exchange that uses managed competition has a realistic change of reducing costs, improving quality, and expanding coverage.

Individual Health Mandates

For managed competition to realize its potential, everyone needs to be in the risk pool, with individuals required to obtain statutorily acceptably insurance coverage for themselves and their dependents or face significant financial consequences.

Aside from the questionable fairness of allowing people to avoid contributing when healthy and imposing costs on others when sick, healthy people opting out of the market would raise the average premium for those who remain, in turn increasing the number of people for whom opting out was desirable.

Implement Effective Risk Adjustment

Today's health insurance markets punish plans that attract – strategically or not --- sicker enrollees and reward those that attract healthier enrollees. Guaranteed issue and modified community rates (discussed in more detail below) both put a premium on attracting favorable risks; the former prohibits avoiding bad risks and the latter prevents charging more on them. Effective risk adjustment is therefore essential to eliminate risk selection as an insurance business model – forcing competition on costs and quality – and would improve market stability by acting as a kind of reinsurance for small plans that might get a “bad draw.”

Risk adjustment would function in the background to move funds from plans that enrolled predictable high-cost people. It would also reduce incentive to avoid chronically ill and disabled enrollees and seek out healthy ones. However, risk adjustment is easy to say, and much harder to

do. For example, it requires distinguishing between high costs attributable to *having sicker enrollees* and high costs attributable to *inefficient care provision*. Risk adjustment should not punish plans that achieve low costs through efficient management rather than selection.

No risk adjustment scheme will ever be sensitive enough to match the variation in health costs across individuals, meaning that there will always be financial incentive to figure out what distinguishes the high-cost people in any group from the low-cost people. But risk adjustment need not be perfect; it need only make risk selection a less effective way to control costs than care management and other efficiencies.

Focus on Benefit Comparability

Just as it is necessary to limit variation in premiums that individuals can be charged to make guaranteed issue viable, so too it is necessary to specify what the insurance benefit covers. Without a standardized means of comparison, it may be very difficult (is not impossible) to judge the value of one complicated insurance policy against 20 others.

Subsidize Insurance for Low-income Individuals and Families

A mandate to purchase health insurance would only be feasible – and only be fair, many would argue – if it did not impose undue financial hardship. For low- and middle-income workers, premiums for even a modest package of benefits could easily consume an unreasonable share of income.

Subsidies introduce a host of difficult technical and policy questions about how to pay them (refundable tax credits, payments directly to insurers and /or employers, and so on, at what level of income to phase them out (too slowly is expensive, too quickly discourages work through high implicit marginal tax rates), and whether they reinforce or counteract competitive forces (fixed-dollar subsidies maximize price sensitivity but leave individuals at risk for rising premiums if care costs go unchecked).

Require Modified Community Rating

Modified community rating would allow premiums to vary somewhat across demographic groups (such as age and perhaps gender and health behaviors such as tobacco use) but not within them and not to the same extent that costs vary. It would thus be embed some income transfers to sicker people through lower insurance premiums, rather than

explicit subsidies. But it would also allow for larger risk pools and lower transactions costs (a real efficiency gain). How many groups and how much variation to permit are open policy questions.

The situation regarding rating is complicated by the presence of self-insured and association plans, both of which limit coverage to defined groups. A desire to build on the current system – or at least minimize disruption of currently insured people – suggests leaving arrangements alone. But allowing healthier-than-average groups to opt out of the community pool would make it more difficult to maintain affordable competitive insurance markets than a situation in which insurers had to take all comers.

Guarantee Issue of Insurance

Given an individual mandate – and only in the presence of such a mandate – effective managed competition would require insurers in a geographic area to sell statutorily acceptable insurance coverage to any individual or family in that area seeking to purchase it. The simple rationale for this argument is that a requirement to buy is meaningless without a requirement to sell; otherwise, high-risk individuals would be excluded from the market.

The Role of the Sponsor and the Exchange

Ensuring effective competition would entail a set of governance functions undertaken by the sponsor and a set of operational functions handled by the exchange. Some of these exist today and some would require new capacity. These functions include, but are not limited to:

Governance

- Enforcing the individual mandates
- Specifying permissible benefit designs
- Determining eligible subsidies
- Providing for fallback coverage
- Make risk adjustments for insurers

Operational

- Administering subsidies
- Providing accurate and objective premium and benefit information to consumers

- Enforcing guaranteed issue and ensuring rating compliance
- Auditing or handling cash flows

Achieving Long-Term Cost Containment

Absent mechanisms to restrain growth in the underlying costs of care, the combination of universal coverage and subsidized premiums would produce even faster cost growth than the current system. After all, the point of expanding coverage is to pay for health care services that people are presumed not to be getting now. In the short-run, policymakers may well judge the additional expenditures worth it to expand access to coverage. But in the long-run, failure to address the underlying drivers of costs would make the expansion unsustainable.

What has been missing in many discussions is the need to align the payment for health care services by public and private insurers to the desired outcomes. When health care is purchased one service at a time, it is always in providers' financial interests to charge as much as possible and to furnish as many services as patients demand and insurers pay for.

Medicare, over a 40 year period, has evolved from paying providers their costs to having fee schedules for virtually all of the services it buys. But paying "efficient" costs for an avoidable hospitalization or an unnecessary imaging service is not efficient. Ultimately, cost containment will require payment reform that entails bigger bundles of services and moves away from fee-for-service.

("Addressing Health Care Market Reform Through an Insurance Exchange: Essential Policy Components, the Public Plan Option, and Other Issues to Consider," Paul Fronstin, EBRI, and Murray N. Ross, Kaiser Permanente Institute of Health Policy, Employee Benefit Research Institute, June 2009, Issue no 330)(www.ebri.org)

What is the Best Role for the Government and Private Sector to Play in National Health Care Reform?

Should there be a Public Plan?

Tom's Comments:

While it is critical to address areas of cost, quality and access to care in a comprehensive manner, In order to have sustainable healthcare reform, it needs to address the healthcare cost drivers on both a short and long-term basis. In prior issues of the Quarterly, we have identified what we believe are the major healthcare cost drivers. In reviewing the above initiatives, we will attempt to overlay those initiatives against these cost drivers.

Major Healthcare Cost Drivers

1. The inappropriate use of high cost technology;
2. End-of- life heroic efforts vs. the more effective utilization of hospice services;
3. Medicare and Managed Care Organizations' physician and hospital payment methodologies that incent overutilization and do not reward quality or prevention;
4. Unhealthy life styles;
5. Chronic disease;
6. An inefficient fragmented health care system that often results in a stagnating tug-of-war between the health care stakeholders (e.g. hospitals, physicians, Managed Care Organizations, government, employers, consumers, etc.) which also adversely impacts both costs and quality;
7. Clinical practice pattern variation that has had a negative impact on cost and quality;
8. The lack of real engagement of the consumer in the health care purchasing decision;

9. The lack of a coordinated and comprehensive primary care system that is focused on wellness and prevention.

As noted in the [September/October 2008 Quarterly](#), a few fundamental changes could have a major impact on the above cost drivers. The combination of how we pay for healthcare services and linking that payment where applicable to clinical effectiveness research would positively impact the following cost drivers noted above: 1, 2, 3, 5, 6, 7, and 9. Also see [commentary on payment reform](#) and [Clinical Effective Research](#) in this issue of the Quarterly

Addressing unhealthy life styles (#4) above requires a combination of initiatives. First, some of the payment reform and clinical effectiveness initiatives would incent and lay the foundation for a primary care system that would better address wellness and chronic diseases (such as diabetes). There also need to be programs available to assist the consumer in addressing their life style diseases (smoking, obesity, etc.).

Some personal accountability also needs to be built into the system. The government should not play the role of an enabler of unhealthy life-styles. Read [commentary](#) on the role of government in enabling lifestyle diseases in this issue of the Quarterly. If individuals want to continue to engage in unhealthy life styles (e.g. smoking), and not participate in good-faith in smoking cessation programs, then they should be held accountable for their actions by paying significantly higher premiums for their health insurance. This is no different than what already occurs today in the life insurance, car insurance and property insurance industries. Higher risks pay higher premiums.

As stated in the last issue of the Quarterly, in order to have a true primary care system we need to incent our medical students to choose these specialties. As part of this incentive, we should set up a system that affords medical students the opportunity to have their student loans forgiven if they choose a primary care specialty. We need to partner these physicians with physician's assistants, nurse practitioners, clinical educators, etc. to have a true primary care system.

The real debate, as noted previously, is identifying the appropriate roles for government and the private sector in the "reformed" healthcare system. In order to better determine the applicable role of each of the sectors one should look at their track record in addressing the major cost drivers noted above.

As stated previously in this issue, Medicare is largely responsible for the method that we pay healthcare providers in the U.S. Medicare, by far, is the biggest payer of healthcare services, and the private sector managed

care organizations have mostly followed Medicare's lead relating to reimbursement methodologies.

As we have cited in prior issues of the Quarterly, Medicare's payment policies have been a major contributor to the high healthcare costs and inconsistent quality in the U.S. Instead of having a payment system that would incent prevention, wellness, chronic care management, efficiencies, better quality and collaboration, we have a payment system that rewards overutilization, does not factor in quality of services provided, is fragmented and does not pay for preventive and wellness services in a meaningful and comprehensive way.

The government, as noted previously in this issue, also has also played a major role in enabling "bad lifestyles," which also has been a major contributor to higher healthcare costs. Finally, government policies relating to payment for primary services have had a negative impact on the development of a comprehensive primary care system in the U.S.

The managed care industry has its faults, and there definitely needs to be a watchful eye on its activities, but in many ways it follows the lead of Medicare in addressing issues of cost control and quality. The private sector, when given the opportunity, has the ability to build upon Medicare initiatives in an innovative fashion.

I believe that the best role for government is that of a facilitator. The government has the resources, clout, regulatory and tax ability to develop a framework of a healthcare system that is guided by the principles of cost efficiencies, quality and access to care. The government would, in effect, set the rules of the game to ensure efficiencies, quality and equity/access to care, but once the rules are set, then the private sector should be allowed to maximize their profits in providing value in the marketplace.

Two of the reform initiatives that are being discussed in Washington D.C. are underwriting reforms for individual and small group markets and the establishment of an Insurance Exchange. Both of these initiatives are examples of the government playing a facilitating role. As noted by the authors of the article below titled, [Addressing Health Market Reform through an Insurance Exchange](#), "The goal of a health insurance exchange is to shift the market for health insurance from competition based on risk to competition based on price."

Another example of the government playing a facilitating role in addressing healthcare cost issues would be the reform initiatives that suggest we place a cap on the tax exemption of healthcare benefits for employees (see commentary and article below on this issue).

Finally, there are a number of healthcare initiatives for which the government can play a lead role that would positively impact healthcare costs, quality and access to care. Some of these initiatives would include the following:

- Advancement of the Electronic Medical Record;
- Establishment of an Institute of Clinical Effectiveness Research;
- Malpractice reform;
- Depository of quality information on providers as well as championing the use of price and quality information for consumers of healthcare services;
- Strengthening our Public Health system;
- Advancing the use of Telemedicine;
- Establishment of a comprehensive Community Health system; and
- Advancing the use of hospice and palliative care services, as well as including as a Medicare benefit end-of-life family counseling.

Finally, I would like to address the initiative that has created the most heated debate in Congress, that is, the establishment of a Public Plan to compete with the private plans in the Insurance Exchange. I believe that this initiative is not a good use of the government's resources, time and political capital.

While people may have legitimate issues with managed care companies they are not one of the major cost drivers. As noted above, if the government did what they do best, by addressing issues that need to be addressed such as provider payment reform, enabling issues relating to lifestyle diseases, establishment of an Institute of Clinical Effectiveness Research, establishment of an Insurance Exchange, individual and small group insurance reform, strengthening our Public Health system, etc. there would be significantly lower healthcare costs and better quality and increased access to care.

All of this does not mean that managed care organizations (MCOs) receive a free ride. If MCOs collectively attempt to abuse the system, there needs to be recognition by the MCOs that sometime in the future the government could potentially add a Public Plan to the Insurance Exchange.

The article below by Uwe Reinhardt will provide the reader with additional information and issues relating to a Public Plan. The link to the Lewin

Report will provide the reader with a detailed analysis of some of the issues relating to the Public Plan.

Pricing a Medicare-Like Public Health Plan

By [Uwe E. Reinhardt](#)

[Uwe E. Reinhardt](#) is an economics professor at Princeton.

As luck would have it, on the very day Economix published my [previous comment](#) on the politics surrounding the public health plan promised by then-presidential candidate Barack Obama, the Lewin Group, a respected policy research firm in Washington, published results from [simulating the economic impact of such a plan](#).

These simulations neatly illustrate the unpleasant choice faced by President Obama and Congress in their effort to overhaul health care.

The Lewin Group assumes that the benefit package would be similar to the one now enjoyed by members of Congress and their staff under the Federal Employee Health Benefit Plan. Voluntary enrollment in the plan would be available to all nonelderly in the United States — be they unemployed, self-employed or employed in small or large companies. Finally, the plan would pay doctors, hospitals and other health care providers the same fees that Medicare pays.

Family premiums under the new public plan would average \$761 a month, and \$970 (27 percent more) under private health insurance.

The private insurance option would be more expensive for two reasons.

First, according to the Lewin Group, private insurers now pay hospitals on average 41 percent more than Medicare does for the same care, and they pay doctors 23 percent more than Medicare. To be sure, a public health plan would broaden the revenue base for providers of health care by covering 28 million of hitherto uninsured Americans. But taking into account the lower fees paid by the public plan, its net effect would be to *reduce* overall hospital revenue by 4.6 percent below current levels, and physician revenue by 6.8 percent.

We should not expect the providers of health care to accept this reduction in revenue peacefully.

Second, including the profit margins and brokers' commissions that private insurers must set aside, overall administrative costs are assumed in the Lewin report to equal 31.2 percent of claims paid in private plans, but only 13.2 percent in the public plan.

Spending on brokers' commissions by the private plans, however, would probably be reduced, if not eliminated, by the National Insurance Exchange proposed by President Obama. Such an exchange would be modeled on the federal health plan, the "framers market" in which members of Congress and their staff shop for health insurance. The exchange would present prospective customers with a well-organized, user-friendly menu of choices from which they can choose without the help of a broker. The exchange would also regulate the insurers offering their products.

An insurance exchange to replace brokers would reduce somewhat the premium advantage of the public plan, and so might adverse-risk selection against that plan. If relatively sicker people preferred the public plan or if private competitors managed somehow to end up with a healthier risk pool — as private health plans serving Medicare beneficiaries apparently did in the 1980s and 1990s — then the premium advantage of a public plan would shrink further.

Be that as it may, according to the Lewin Group, the premium advantage of the public plan would enable it to attract some 130 million or so enrollees in the market for individually purchased health insurance. At the same time, the private insurance industry would lose 119 million clients from its current base of about 180 million nonelderly insured.

One should not expect the industry to roll over passively in the face of a 67 percent erosion of its business.

Simulations are merely passive computer models whose output is driven by the behavioral assumptions researchers feed into it. The crucial driver in this case is the assumed sensitivity of Americans to insurance premiums in choosing among insurance options. The Lewin Group cites prior empirical research, according to which a 1 percent reduction in premiums under one option would draw 2.47 percent more enrollees to the lower-cost plan.

Pity the policy makers who would have to impose this possibility on the health care sector, under our form of democracy. But what would be the alternative?

A compromise, also simulated by the Lewin Group, would force the new public health plan to pay providers the average level of fees that private insurers pay, rather than Medicare fees. In that situation, the premium cost advantage of the public plan would shrink to 9 percent from 22 percent. It would not disappear entirely because the load of administrative costs of a public plan would be lower.

At the smaller premium advantage estimated by the Lewin Group, the public plan is projected to attract 20.6 million enrollees, rather than 131 million. That estimate, however, assumes that premiums are the only factor involved in the decision.

If, as I have argued in my [previous post](#), some or many Americans who are shell-shocked by the recent doings in the private sector have greater trust in the permanence and stability of a public health insurance plan, then the Lewin Group will have underestimated the number of enrollees drawn to the public plan even in this compromise.

The alternative preferred by insurers and providers would be to forgo the enactment of a Medicare-like public health plan altogether. I shall look at that option in the next post. ("Pricing a Medicare-Like Public Health Plan," Uwe E. Reinhardt, New York Times Blog, April 10, 2009) (<http://economix.blogs.nytimes.com/2009/04/10/>)

Should Employee Health Care Benefits be Taxed?

Tom's Comments:

Lawmakers are considering varied approaches to taxing employer-provided health insurance as a means of paying for an overall of the health system. Kaiser Health News reports, "Currently, workers who get health insurance from their employers don't pay income or payroll taxes on the cost of the policy. Self-employed people can deduct the cost of their

insurance premium. But workers who buy their own policies because they don't get coverage through their jobs generally don't get the tax break. Ideas for changing the current policies fall into three broad categories: Taxing health benefits above a certain dollar amount, taxing only wealthier people or replacing the tax break with a tax credit.”

<http://www.kaiserhealthnews.org/Daily-Reports/2009/june/08/taxes.aspx>

The two articles below will provide the reader with more information on this issue. I believe that some type of dollar value benefit cap above which the employee would be taxed makes a lot of sense both from a federal revenue perspective and as a way to positively impact unnecessary utilization of healthcare services. As you will note from the articles below, any of the approaches to address the taxation of benefits has its pitfalls, but in weighing the pros and cons, the cap approach appears to be the fairest.

Finally, if the cap approach is implemented there probably should be a grandfathering of healthcare benefits that exceed the dollar cap for a short period of time for those benefits that were part of any collective bargaining agreement.

Capping the Tax Exclusion for Employment-Based Health Coverage: Implications for Employers and Workers

Current Tax Treatment of Health Coverage

The tax treatment of health coverage in the United States has been written into the Internal Revenue Code through a series of laws and rulings that date back to the 1920s. However, it was during World War II that many employers began to offer health coverage. Because the National War Labor Board (NWLB) froze wages during the war, employers

sought ways to get around the wage controls in order to attract scarce workers. In 1943, the NWLB ruled that employer contributions to insurance did not count as wages, and thus did not increase taxable income to workers, and could therefore be offered in addition to wages and salaries. As a result, employers began to offer health coverage to their workers to be competitive in the labor market, and the number of persons with employment-based health coverage started to increase.

Currently, employers that are subject to taxes can deduct from taxable income the cost of providing health coverage as a business expense. This means that whatever an employer spends on health insurance or health coverage on behalf of workers is considered a business expense – just as wages and salaries are business expenses.

Employers do, however, get a break on Social Security and Medicare payroll taxes when compensation is provided in the form of health coverage instead of wages and salaries. Employer savings related to the Social Security and Medicare payroll tax savings accounted for about \$73 billion in 2006.

For individuals who do not receive employment-based health coverage, total qualified health care expenses (including premiums) are deductible only if they exceed 7.5 percent of adjusted gross income (AGI) and only the amount that exceeds 7.5 percent of AGI is deductible. This deduction is allowed only when an individual itemizes deductions on his or her tax return.

A primary goal of capping the tax exclusion of employment-based health coverage is to reduce the cost of healthcare and therefore health coverage. The expectation is that workers would choose to ask employers to offer health plans that are valued at or below the cap in order to avoid paying taxes on excess health coverage. In order to reduce the value of health coverage, employers could offer less comprehensive coverage, and workers and their families would use fewer health care services as a result.

There are a number of reasons why health insurance premiums in a fully insured plan or the value of health coverage in a self-insured plan would be above the tax cap that are completely independent of the comprehensiveness of the coverage. The cost of health coverage is known to vary with firm size, employee health status, average age of the group of employees, and geographic region. To the degree that

individuals face higher taxes as a result of these factors, it would not be “equitable.”

In conclusion, past experience shows the risk of not carefully anticipating the results of making major changes to the complex system of employee benefits. Policymakers should be aware of the implication and unanticipated consequences of any changes to the tax treatment of health insurance and employment-based health coverage. (“Capping the Tax Exclusions for Employment-Based Health Coverage: Implications for Employers and Workers,” Paul Fronstin, Employment Benefit Research Institute (EBRI), January 2009) (www.ebri.org)

Should Health Benefits Be Taxed?

By [Uwe E. Reinhardt](#)

[Uwe E. Reinhardt](#) is an economics professor at Princeton.

There are many third rails in the politics of health reform, but probably none with quite the high voltage of one proposal: the idea of taxing part, or all, of the health insurance premiums paid by employers on behalf of their employees.

Some members of Congress — notably the Democratic chairman of the Senate Finance Committee, [Max Baucus](#) — are now stretching their hands gingerly toward that third rail, and sparks are flying even before the rail has been touched.

Under current law, employers can treat the contributions they make to the premiums for their employees' health insurance as a tax-deductible business expense. On the other hand, employees do not pay income taxes or payroll taxes on this contribution, though it clearly is part of the employees' total compensation.

In 2007, this tax preference reduced federal tax revenues by an estimated [\\$250 billion or so](#). Estimates for 2010 have been as high as [\\$297 billion](#).

Most economists (myself included) and many other health policy experts have long looked askance at this tax preference.

Making expenditures on any particular good or service tax-deductible lowers the after-tax price from P , the price charged by the vendor, to $(1-C)P$, where C is the marginal tax rate the buyer pays on income and payroll taxes combined.

That form of public subsidy has two effects that economists find problematic.

First, the price reduction drives up the demand for the subsidized commodity — for example, for generous health insurance packages. It becomes one of several cost drivers in health care.

Second, and much more problematic, in dollar terms the price reduction is larger for high-income employees in high marginal tax brackets than for lower-income workers.

In other words, the benefits of such “tax expenditures” (as the tax-revenue loss triggered by tax-deductibility is called) accrue disproportionately to higher-income groups. Very low-wage workers hardly benefit at all from the tax exclusion. Their bosses benefit handsomely. It can be asked why lawmakers favor this distributional effect.

So far, health policy wonks have been the sole opponents of this tax preference in health care. They have been howling into the wind, so to speak, because that subsidy has been staunchly defended by a powerful coalition of unions and employers, along with politicians and policy experts left of center on the ideological spectrum.

Employers favor the tax preference, because employer-sponsored health insurance is a major come-on in the labor market. The tax subsidy to these programs gives employers an added advantage, in addition to the economies of scale they already have in the assembly of information on the market for health insurance.

Unions, along with left-of-center politicians and policy experts, have defended the tax preference in spite of its regressive nature, in the belief that its abolition would erode employer-sponsored health insurance and in that way eliminate the only larger risk pools that exist outside government-sponsored insurance.

Given the formidable coalition against limiting or eliminating this particular tax preference, why do some politicians now dare to raise the issue, at least for public debate?

The answer is sheer desperation over financing the promised march toward universal health insurance.

The 10-year outlay for providing universal coverage has been estimated to fall between \$1.2 trillion and \$1.8 trillion. That range depends on (a) the number of American families requiring public subsidies toward the premiums for their health insurance, (b) the generosity of the minimum benefit package to be guaranteed all Americans and (c) the generosity of the public subsidies toward the purchase of health insurance.

In his February budget message, President Obama spoke of a \$634 billion “down payment” toward universal coverage, as if that sum were securely stashed in a lockbox. On closer inspection, however, this down payment is more in the nature of 634 sparrows in a tree that the president tries to catch.

About half of these sparrows are expected from “greater efficiency” in the delivery of health care. Alas, because one person’s “greater efficiency” is another person’s “income loss” (since lower spending on health care translates to less in earnings for health care providers), these sparrows are not easily caught.

The remaining sparrows represent the higher tax revenues the administration proposes to collect by limiting the savings taxpayers can reap on itemized deductions, including charitable donations. Already one can hear the [mournful chorus](#) of museum directors, religious leaders, university presidents and heads of other nonprofit groups, protesting the very idea.

But even if all 634 sparrows could be caught and put into a lockbox, an additional \$600 billion to \$1 trillion might be needed over the next 10 years for truly universal coverage. This prospect makes the tax preference granted employer-sponsored insurance now an inviting target for a raid by Congress.

No one is proposing to eliminate this tax preference altogether, much as some policy wonks might favor it. Instead, the idea is to recapture at least

some of tax loss — say, \$80 billion to \$100 billion or so a year — to help finance health care for the now-uninsured.

This could be done in one of two ways.

First, Congress could stipulate that the tax exclusion be capped at a certain level for all employees. If that cap were, say, \$10,000 for family coverage, and an employer contributed \$12,000 toward the premium for family coverage, then \$2,000 would be added to the employee's taxable income on the W-2 form.

A major problem with this approach, however, is that per-capita health spending in this country varies by more than a factor of 2. Thus, the cap would probably have to be adjusted for regional per-capita health care costs.

An alternative would be not to tax employer-provided health benefits for employees below a certain income level — e.g., \$75,000 — but to add an ever larger fraction of the employer's contribution to the employee's taxable income, as income rises. For employees earning more than, say, \$200,000, the entire employer contribution to health insurance might be added to the employee's taxable income. (“Should Health Benefits be Taxed?” Uwe E. Reinhardt, New York Times Blog, May 22, 2009) (<http://economix.blogs.nytimes.com/2009/05/15/>)

INTERNATIONAL HEALTH CARE

Tom's Comments:

The first link below will provide you healthcare comparisons between the United States and selected countries.

The second link will provide you access to a comprehensive report by the World Bank on International Health Care Financing. This report assesses health financing policies for their ability to improve health outcomes, provide financial protection, and ensure consumer satisfaction – in an equitable, efficient, and financially sustainable manner. It is intended to equip policy-makers at global and country levels with the tools for navigating this extremely complex domain by providing an overview of

health financing policy in developing countries and is a primer on major health financing and fiscal issues.

The World Bank report can be especially enlightening as we debate healthcare reform in the United States. As we discussed in this issue of the Quarterly, the short and long-term financing of any healthcare reform plan will ultimately determine the likelihood of a sustainable healthcare system in the U.S. The U.S. should attempt to learn as much as possible from both the success and failures of healthcare initiatives in other countries.

- International Health Comparisons:
http://www.npr.org/news/specials/healthcare/healthcare_profiles.html
- World Bank - International Health Care Financing:
<http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/EXTHSD/0,,contentMDK:20200211~menuPK:376811~pagePK:148956~piPK:216618~theSitePK:376793,00.html>

STATE HEALTH CARE

Medicaid

Tom's Comments:

Below is a guest editorial that appeared in the May 3, 2009 edition of the Cleveland Plain Dealer. The author of the guest editorial is John Begala, Executive Director of the Center for Community Solutions. He is a former member of the Ohio Commission to Reform Medicaid and the Ohio Medicaid Administrative Study Council. John is also an Adjunct Professor, in Baldwin-Wallace's Health Care MBA program.

As I stated in the last issue of the Quarterly, ([January/February 2009](#)), the future financial outlook of Medicaid for many has been under the radar screen for a number of reasons. Sadly, since Medicaid focuses on the have-nots, unlike Social Security and Medicare which impact all Americans, Medicaid's financial stability becomes less of a concern for most Americans. Medicaid funding of long-term care could potentially impact a wider selection of Americans, but long-term care needs is an area that most American do not focus on until the need arises. The financial future of Medicaid in most states, while it may be under the radar

screen for most Americans, is actually under more financial stress than Social Security and Medicare.

John Begala's thoughtful article below focuses in on Ohio's Medicaid program. He both identifies some of the problems with Ohio's Medicaid program and he has proposed some "real world" solutions. As noted previously, John is the Executive Director of the Center for Community Solutions. He is a former member of the Ohio Commission to Reform Medicaid and the Ohio Medicaid Administrative Study Council.

Medicaid and the impending train wreck in Ohio government

Some see a cliff, others a train wreck, and still others a train going over a cliff. However one imagines it, Ohio's state fiscal crisis, already enormous, will be worse in two years unless action is taken now to fix it. Increased taxes will have to be part of that solution -- a reality legislators in both parties privately admit. But so will containing the cost of Medicaid and the rest of the health care system.

THE PROBLEMS:

After two months of hearings on the governor's proposed budget, the Ohio House has yielded to the temptations of another round of Medicaid politics-as-usual. The House's substitute budget bill proposes concessions to hospital and nursing home interests through a baffling array of payment gimmicks. Along with other proposed House changes, the net effect on Department of Job & Family Services' Medicaid spending would be an increase of about \$1.6 billion over the biennium. And yet, more than 1 million Ohioans would remain uninsured.

These costs are not sustainable by Ohio's taxpayers -- not even close. Based on historical rates of state tax revenue and Medicaid growth, Medicaid's share of the state budget will increase from 40 percent to 75 percent of all state spending by 2020.

If the Medicaid provisions in the substitute budget bill are adopted, the long-range impact could be catastrophic for several reasons:

- Ohio is about to enter its third consecutive biennium of government spending more than it takes in. With that structural deficit, the gap is covered only by temporary and one-time revenue, much of it federal stimulus dollars.

- That revenue gap is growing, projected to be well over 10 percent of the budget -- as much as \$4 billion per year -- by the end of fiscal 2011.
- Medicaid costs are projected to continue growing by several percent per year, even after several years of major initiatives to contain costs, and even as the economy contracts and state revenues fall. Total Medicaid spending will reach \$16 billion annually by the end of the approaching biennium.
- The largest component of federal stimulus dollars for the states is a temporary, two-year increase in the federal matching rate for Medicaid. The increase in state dollars that will be needed to offset the loss of this federal assistance when it runs out in two years will be about \$1.6 billion over the next biennium. And that's just to keep Medicaid going at *current* caseloads and payment rates.

THE SOLUTIONS:

It has been argued that increasing Medicaid spending over the governor's proposed budget will stimulate the economy, but this is precisely the *wrong* part of the economy to be stimulating: The upward spiral of health care spending represents a constraint on growth in other sectors of the state's economy.

There's a better way -- one that might allow Ohio to sustain eligibility and covered services without breaking the bank. From 2004 through 2006, two bipartisan commissions recommended a series of reforms to Ohio Medicaid, some of which were adopted. Those that were ignored included proposals to zero in on fundamental changes to get a better deal for taxpayers and beneficiaries alike, and force efficiencies on a bloated, under producing health care system.

It's time to get back to this unfinished business. Here are some ideas the Senate should consider as it takes up the budget legislation:

- Coordinate state government's enormous purchasing power to stabilize health care costs through a Cabinet-level Ohio Department of Health Plans to purchase health services on behalf of Medicaid beneficiaries and state employees. Long-range plans could be made for collaborative health purchasing opportunities for local governments, school boards and public retirement systems.
- Establish a physician-led medical division within the new department charged with adopting evidence-based health care protocols to prevent and manage disease; aligning payments with protocols; providing large-

scale physician, nurse and allied health training on protocols and payment reforms; and tracking results for preventive and primary care services, as well as care management for chronic conditions beginning with diabetes, chronic obstructive pulmonary disease and chronic heart disease.

- Adopt and stick to five-year health care spending targets for Medicaid and public employees, aimed at bringing changes in health care costs into line with changes in the overall economy. Factors used in establishing spending targets might include Medicaid monthly costs for each eligibility category; the Consumer Price Index; and, very importantly, projected changes in state revenues.
- Beginning in fiscal 2010, move state and federal Medicaid appropriations into a single set of line items within the new state agency, including unified appropriations for institutional and community-based long-term care. Interagency agreements should govern management of Medicaid funds flowing to partner agencies and systems.
- Adopt competitive purchasing procedures, including direct contracting with integrated health systems and managed care organizations, and selective contracting with providers based upon quality and price (which will require lobbying for changes in federal and state law).
- Start implementing the recommendations of the Ohio Health Quality Improvement Team that were released last month, especially those aimed at aligning payments with medical homes.
- Create an Ohio Public Health Reform Commission, along the lines of the Ohio Commission to Reform Medicaid, to recommend policy and funding priorities aimed at aligning the work of Ohio's public health departments and programs with preventive medical services.

Few, if any, public policies can stand for all times, and what appears to be a solution to a problem today may come back as a problem itself as the years pass. The history of Ohio Medicaid is replete with examples. Creating a standing, bipartisan health policy council to advise the governor, the General Assembly and the director of the new state department would add a critical, ongoing monitoring function. Excluding the usual suspects -- the various provider lobbies and professional advocates -- and charging the members of such a body only with representing the interests of the public could help restore public purpose to the mix of special interests (necessary though they may be) that control the levers of health policy in the Statehouse. ("Medicaid and the

Impending Train Wreck in Ohio Government," John Begala, Cleveland Plain Dealer, May 3, 2009)

http://www.cleveland.com/opinion/index.ssf/2009/05/medicaid_and_the_impending_tra.html

Public Health

Tom's Comments:

I am the first to admit that I am not an expert on Public Health. I do know that Ohio does have many fine and dedicated experts in this field. The report below appears to provide some very interesting data relating to Public Health expenditures and outcomes on a state by state basis. I know enough about data that it is not always possible to perform apple to apple comparisons as a result of many underlying factors, especially as it relates to health indicators. The authors of this report believe that they have been able to produce such a data base that would allow policymakers to perform state-by-state comparisons.

Shortchanging America's Health

A State-By-State Look at How Federal Public Health Dollars are Spent and Key State Health Facts

The nation's public health system is responsible for improving the health of Americans. However, the public health system has been chronically underfunded in the United States for decades. There has been a shortfall of \$20 billion annually – across state, local, and federal government – in funding for critical U.S. public health programs according to an analysis by The New York Academy of Medicine (NYAM) and the Trust for America's Health (NFAH), conducted in consultation with a panel of leading experts in 2008.

The analysis found that federal, state, and local public health departments have been unable to adequately carry out many core functions, including programs to help prevent disease and prepare for

health emergencies. Approximately \$1 billion of this short-fall is due to cuts to the U.S. Centers for Disease Control and Prevention (CDC) budget over the past five years.

In this report, TFAH examines how much the federal government spends to try to keep the country well. A state-by-state review of fiscal year 2008 spending reveals that federal spending (through CDC) for public health varies, often significantly, with a per capita low of \$12.74 to a per capita high of \$52.78. The national average is \$17.60 per person, a fraction of what is spent on health care costs. **(Note: Ohio is 49th out of 50 states with a per capita rate of \$12.76).**

The report also examines state funding for public health. Each state allocates and reports its budget in a different way. States also vary widely in the level of specific detail they provide, which makes comparisons across states a challenge. This analysis looks at ways to begin comparing budgets across states, how increased transparency and accountability could help create an understanding of how spending on public health programs can have a positive impact on people's health. The median state spending on public health is \$33.71 per person, with a range of \$3.37 per person in Nevada to \$172.21 per person in Hawaii. **(Note: Ohio is 46th out of 50 states with a per capita rate of \$15.05).**

To demonstrate the variation in health across states, this report examines a sample of key health indicators in each state. For instance, an examination of state data finds that adult obesity rates range from a low of 18.4% in Colorado to a high of 31.7% in Mississippi **(Note: Ohio has the 17th highest adult obesity rate (26.9%).** ("Shortchanging America's Health – A State-by-State look at How Federal Public Health Dollars are Spent and key State Health Facts," Trust for America's Health, Robert Wood Johnson Foundation, March 1, 2009)

<http://healthyamericans.org/report/61/shortchanging09>

NORTHEAST OHIO

MedCity News

Tom's Comments:

It is important for people in and outside of the healthcare industry in Northeast Ohio to have available to them the most up-to-date information regarding healthcare happenings. Healthcare is not only a diverse industry in itself, but as noted previously in the Article titled, "Jobs, A reason to Fast Track Health Care a Reform," healthcare is the economic life-blood for many communities.

We are fortunate in Northeast Ohio to have MedCity News. MedCity News is a news service focusing on business, innovation and influence in health care. It covers medicine and health care as the economic engine of major U.S. cities, starting in Cleveland, Ohio.

That means MedCity writes about promising medical devices, staffing innovations at hospitals and how health care reform could affect the industry. The service publishes its stories at its Web site which is also where you can register for daily e-mail updates -- www.medcitynews.com MedCity is developing a syndication model to distribute its work to content buyers, such as media companies. MedCity also produces custom content, mostly for corporate and institutional clients.

MedCity was started in mid-December 2008 by two experienced medical writers from the Cleveland Plain Dealer newspaper -- Chris Seper and Mary Vanac. The two have spent a combined 35 years in newspaper journalism and want to help their former industry recreate itself during a time of unprecedented economic and industry upheaval. MedCity now includes Amanda Todorovich as vice president of business development and marketing.

New Undergraduate Health Care Management Major/Minor at Baldwin-Wallace College

Baldwin-Wallace College is proud to announce that we have a new undergraduate major/minor in our Business Division. The Healthcare Management Major/Minor was developed in cooperation with the Northeast Ohio healthcare community. A key input source for the curriculum was four focus groups that represented a cross-section of professionals from all areas of the healthcare community (e.g. hospitals, long-term care, physician, managed care, pharmaceutical, social service agencies, etc.). The ultimate conclusion by the participants of the focus group was that a major/minor in health care management was of extreme importance to the Northeast Ohio healthcare industry.

The Health Care Management Major promotes an understanding of America's complex and evolving health care system and increases the competencies of students pursuing careers as managers and leaders in that field. Students will analyze perspectives, methods, and values associated with the delivery, management and finance of health services. They will evaluate health data, payments systems, management practices, ethical principles, public policies, promotional strategies and system designs to discover ways to meet the demand for effective, affordable, efficient and responsible health care.

The major promotes organizational insight and managerial ability for those who desire leadership positions in health-related enterprises. The curriculum is designed to meet the needs of both health care professionals with technical/clinical degrees as well as those of traditional undergraduate students. The curriculum in total is also geared toward enhancing the students' oral and written presentation skills as well as overall problem solving skills.

The link below will provide you access to a detailed overview of the Health Care Management Major/Minor as well as the related business program requirements.

<http://www.bw.edu/academics/bus/ug/hc/>

Finally, if you interested in Baldwin-Wallace College visiting your organization to provide an overview to your employees of the

undergraduate healthcare management major please contact Tom Campanella at tcamp@bw.edu

MARK YOUR CALENDAR

If you are interested in possibly enrolling in the Health Care MBA program at Baldwin-Wallace College, contact Barb Peterson at 440-826-2064 or e-mail her at bpeterso@bw.edu

Keep track of upcoming events in the Business Division of Baldwin-Wallace College on our website: <http://www.bw.edu/academics/bus/events/>

MBA Open Houses

Learn about the B-W [Health Care MBA Program](#).
Visit our website for current [MBA Open House Information](#)

MBA Open Houses:

**6 p.m. / August 11, 2009
Strosacker College Union
120 E. Grand St. Berea, OH 44017**

Or

**6 p.m. / August 13, 2009
Landmark Center
25700 Science Park Drive #100
Beachwood, OH 44122
Please call for more information 440-826-2392**