

QUARTERLY HEALTH CARE REPORT

January/February 2008 Vol. 13

Cost, Quality and Access-to-Care Issues in the U.S. / Ohio / 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 cited in this Quarterly Health Care Report are listed at the end of each article.

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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

This issue of the Quarterly Health Care Report focuses on some of the primary factors that have negatively impacted healthcare costs, quality, and access to care in the U.S. The Quarterly also provides a critical analysis of Senators Clinton, Obama and McCain's healthcare reform

proposals. Finally we will provide the reader with a high-level overview of some other countries' healthcare systems to determine if any of their approaches would make sense for the U.S.

COSTS

Medicare

Tom's Comments:

The article below provides the reader with an appreciation of the magnitude of the problem we are facing with Medicare. Unless major changes are enacted, we could be jeopardizing the long-term future of Medicare, and creating a scenario of a major generational battle. Currently Medicare plays more of a role as a payer in healthcare than that of a "real" health plan. For all intents and purposes, all providers, drugs and technology, etc. are covered by Medicare without real consideration of the value being provided.

As we have discussed in the [last issue](#) of the Quarterly Health Care Report, Medicare reimbursement methodologies offer significant incentives for providing expensive, inefficient health care services irrespective of outcomes. Medicare also does not reward, in fact providers are penalized for, providing quality and efficient care.

If Medicare implements some of the value oriented recommendations noted below (egg. clinical effectiveness linked into payment methodologies, etc.) there will be both winners and losers in the healthcare industry. Given the devastating implications of maintaining the status quo approach in Medicare, there is no other alternative but to focus on value.

Medicare can accomplish this objective by evolving itself from that of a payer to more of a health plan, or Medicare can outsource this role to Medicare HMOs and play more of a facilitator and monitoring role. There will be political challenges with both approaches.

Finally, as we will discuss further in the Quarterly, each of the presidential candidates have at least endorsed the expanded role of the government as a facilitator and the major underwriter of clinical effectiveness research.

The Long-term Outlook for Medicare and Medicare Healthcare Spending

A study prepared by the Congressional Budget Office in November 2007 provides the reader with its projection of federal spending on Medicare and Medicaid and health care spending generally over the next 75 years. The goal of the projections in this study is to examine the implications of continuation of current federal law, rather than making a prediction of the future. CBO believes that the projections nevertheless provide a useful measure of the scope of the problem facing the nation.

The results of CBO's projections suggest that in the absence of changes in federal law:

- Total spending on health care would rise from 16% of gross domestic product (GDP) in 2007 to 25% in 2025, 37% in 2050 and 49% in 2082.
- Federal spending on Medicare (net of beneficiaries' premiums) and Medicaid would rise from 4% of GDP in 2007 to 7% in 2025, 12% in 2050, and 19% in 2082.

The study states that the current financial incentives facing both providers and patients tend to encourage or at least facilitate the adoption of expensive treatments and procedures, even if the evidence about their effectiveness relative to other therapies is limited. For doctors and hospitals, those incentives stem from fee-for-service reimbursement which financially rewards over utilization.

Most analysts agree that the most important factor contributing to the growth in healthcare spending in recent decades has been the emergence, adoption, and widespread diffusion of new medical technologies and services. Major advances in medical science allow providers to diagnose and treat illnesses in ways that were previously impossible. Many of these innovations rely on costly new drugs, equipment, and skills. Although technological innovation can sometime

reduce spending, in medicine such advances and the resulting changes in clinical practice have generally increased it.

Per the Congressional Budget Office publication, "Technology Change and the Growth of Health Care Spending," some medical services could be used more selectively without substantial loss in clinical value. Research on comparative effectiveness could provide a basis for applying new technologies only when they are likely to confer added benefits that are significantly greater than the benefits conferred by less expensive technologies. ("Technological Change and the Growth of Health Care Spending," Congressional Budget Office, January 2008)
<http://www.cbo.gov/ftpdocs/89xx/doc8947/01-31-TechHealth.pdf>

Analysis of comparative effectiveness is simply a comparison of the impact of different options that are available for treating a given medical condition for a particular set of patients (also see CBO report on Comparative Effectiveness at <http://www.cbo.gov/ftpdocs/88xx/doc8891/12-18-ComparativeEffectiveness.pdf> . Such studies may compare similar treatments, such as competing drugs, or they may analyze very different approaches, such as surgery in comparison to drug therapy.

To affect medical treatment and reduce healthcare spending, the results of comparative effectiveness analyses would ultimately have to change behavior of doctors and patients – that is, to get them to use fewer services or less intensive and less expensive services than are currently projected, for Medicare, which would require changes to the current law. ("The Long-Term Outlook for Health Care Spending," Congressional Budget Office, November 2007)
http://www.cbo.gov/ftpdocs/88xx/doc8880/20071120_OrszagPresentation.pdf

Prescription Drug

Tom's Comments:

The authors of this journal article propose a very innovative approach to address the challenges associated with the drug benefit for Medicare. The authors recommend that Medicare establish and administer a stand-alone plan with a restrictive formulary to compete with the private plans.

The authors also correctly identified some of the political perspectives relating to this issue. This hybrid solution is less of a compromise approach, but more of a thoughtful idea that could have a positive ripple effect from both a cost and quality perspective.

The recommended approach would build off a competitive model, but also forces Medicare to operate on a level playing field with the private sector options. As noted in the article, the government would be using Medicare's market power not to set prices, but to ensure that the drugs reflect therapeutic value.

Toward a Rational, Value-Based Drug Benefit for Medicare

Some of the most vigorous criticism leveled at Medicare Part D has been about drug prices. The prohibition on government intervention in price negotiations coupled with high profits by pharmaceutical companies since the inception of Part D have prompted many consumers and policymakers to question whether Part D is actually a benefit for insurers and manufacturers rather than for enrollees. Consequently, there has been strong interest on the part of lawmakers – mostly Democrats – in encouraging the government to negotiate prices for drugs under Part D.

Critics of the larger public role have argued that given the program's size, if the CMS were to negotiate on behalf of all plans, this would be tantamount to price control and would raise antitrust issues. A better approach is to develop a formulary on the basis of evidence and therapeutic value, not price. In a world of limited resources, making decisions on the basis of assessing value for money will increasingly be seen as a sensible decision-making paradigm.

Moving to establish a formulary based on assessing value for money would be a major step forward not only for Medicare Part D, but also toward a more value-based healthcare system. Similar mechanisms are well established in several other countries in the Organization of Economic Cooperation and Development (OECD), where data on comparative effectiveness and cost-effectiveness are submitted by pharmaceutical companies to support formulary-listed processes.

One way forward that has been suggested is for the CMS to establish and administer a stand-alone plan with a restrictive formulary to compete with the private plans. The CMS plan should have enough critical mass to effectively negotiate drug prices, but the system would still offer competition through multiple providers. The CMS would negotiate prices but only for its own plan, rather than on behalf of the entire program. A CMS plan would require a comprehensive but closed formulary, built on transparent, evidence-based assessment of comparative effectiveness and value for money. Limiting the formulary means limiting choice, but choice is valuable only when it confers utility. Ultimately, the government would be using Medicare's market power not to set prices but to ensure that they reflect therapeutic value. ("Toward a Rational, Value-Based Drug Benefit for Medicare," Ruth Lopert and Marilyn Moon, Health Affairs, November/December 2007)

<http://content.healthaffairs.org/cgi/content/full/26/6/1666>

Electronic Medical Record

Tom's Comments:

The two articles below echo a common theme; we must focus more attention and resources for the U.S. to achieve our goal of a connective Electronic Health Record (EHR) System. Both articles have cited a number of key concerns and issues that could severely impact the implementation timetable.

As discussed later in our analysis of the presidential candidates reform agendas, all of the candidates cite the implementation of a national EHR system as playing a major role in positively impacting cost, quality and access to care in America. The successful implementation of EHR has been the cornerstone of recommendations by the Institute of Medicine.

Per the Institute of Medicine 1998 report, over 100,000 Americans die annually unnecessarily as a result of poor quality in a healthcare setting. This report was recently updated with no major improvements cited. One of the key recommendations was the implementation of an EHR system.

Per the Institute of Medicine recent study, 1.5 million Americans are sickened, injured or killed each year by errors in prescribing, dispensing and taking medication which costs \$3.5 billion a year. The Institute of

Medicine's major recommendation for addressing this issue was also the implementation of the EHR.

The U.S. is approximately 5 to 10 years behind some of the countries that have nationalized systems when it comes to EHR connectivity. These countries identified EHRs as a major priority and allocated sufficient financial resources to establish a national network. These countries have also determined that once implemented the EHR had a positive impact on cost and quality.

We as a nation are placing a lot of faith in the successful implementation of a connective EHR system. As the authors recommend, for this to succeed, the federal government needs to play more of an active role both financially and as a facilitator to ensure that barriers are eliminated and continued progress is achieved. If this added focus does not occur, at best we will have a patch work system, rather than a truly connected system.

Gauging the Progress of the National Health Information Technology Initiative: Perspectives from the Field

Four years ago, President Bush outlined a plan to ensure that most Americans have electronic medical health records within the next ten years. Dr. David Brailer was appointed national coordinator of this initiative. Dr. Brailer identified two crucial elements to achieving the President's vision for Health Information Technology (HIT): inter-operability and the secure portability of health information, and electronic health record (EHR) / electronic medical record (EMR) adoption.

Dr. Brailer further stated in June of 2005, "To address these challenges, Health and Human Services (HHS) is focusing on several key actions: harmonizing health information standards; certifying health IT products to assure consistency with standards; addressing variations in privacy and security policies that can hinder inter-operability; and developing an architecture for nationwide sharing of electronic health information."

The author of this report relied on interviews of key players in the Health Information Technology world during the summer of 2007. As one would expect, there is somewhat of a divergence of opinions, but there is overall

concern about the current pace of progress of this initiative. The interviewees also provided the author with their thoughts on the issues and potential approaches to address their concerns.

The four cornerstones of a digitized health care system are the following:

- Create a Nationwide Health Information Network (NHIN).
- Adopt interoperability standards
- Certify Electronic Health Records (EHRs)
- Reconcile laws

The respondents were very concerned about the progress relating to a Nationwide Health Information Network (NHIN). The most positive conclusion mentioned by respondents was the idea that barriers to the NHIN are not technological but political and organizational.

If EHRs and the other cornerstones of HIT are to be capable of sharing health data reliably and efficiently, a host of technical and clinical standards must be identified, assessed, tested, adopted, and used – either as a result of regulation, or of market forces. Without standards to assure systemic interoperability, the benefits of sharing health care data through HIEs and other avenues will be unobtainable – whether for research, biosurveillance, ready access to relevant patient data, etc.

A common theme of the respondents is that as the big spender in health care, the federal government should exert more influence. There needs to be increased federal mandates and funding that focus on collaboration. The federal government should make better use of its power, both as a purchaser and regulator, to accelerate nationwide HIT adoption. The federal government needs to increase funding as well as implement reimbursement reform which would facilitate the advancement of the HIT initiative.

The challenges of bringing HIT to small physician practices (funding and user issues); reforming reimbursement to encourage HIT, harmonizing the interests of payers, providers and vendors; will require a major focused effort on the part of the federal government.

("Gauging the Progress of the National Health Information Technology Initiative: Perspectives from the Field")
<http://www.chcf.org/topics/view.cfm?itemid=133553>

The State of Regional Health Information Organizations

Electronic clinical data exchange promises substantial financial and societal benefits, but it is unclear whether and when it will become widespread. In early 2007 the authors surveyed 145 regional health information organizations (RHIOs), the U.S. entities working to establish data exchanges. Nearly one in four was likely defunct. Only twenty efforts were of at least modest size and exchanging clinical data. Most early successes involved the exchange of test results. To support themselves, thirteen RHIOs received regular fees from participating organizations, and eight were heavily dependent on grants. The authors' findings raise concerns about the ability of the current approach to achieve widespread electronic clinical data exchange.

Health information technology (IT) holds great promise to help address rising costs by delivering greater efficiencies while simultaneously improving safety and quality. One particular use of health IT has received much attention: electronic health information exchange across provider organizations.

Some have advocated building a national health information infrastructure that will allow all healthcare providers to exchange data with each other. However, most current activities have focused on local efforts through entities known as regional health information organizations (RHIOs). RHIOs are thought to have a greater likelihood of success than other strategies, given that they are locally based, and they may be linked together in the future to enable national exchange.

Despite enthusiasm for RHIOs as the agents that may bring about electronic health information exchange (HIE), there are few empirical data on their activities or their sustainability. Many grant funded RHIOs are processing under the assumption that HIE will create financial value via efficiency gains that can be captured to fund ongoing exchange.

However, key financial beneficiaries (payers and purchasers) are not always involved, and many practical issues act as barriers.

Although interoperability seems to hold great societal benefit, it still might not be possible to implement sustainability under the current approach. In particular, if RHI/Os are to succeed as small businesses, they must be built around sustainable business models, which require both profitability and value creation for participants. ("The State of Regional Health Information Organizations: Current Activities and Financing," Julie Adler-Milstein, Andrew McAfee, David Bates, and Ashish Jha, Health Affairs Web Exclusive, December 11, 2007)

<http://content.healthaffairs.org/cgi/content/full/27/1/w60>

Life Style Diseases

Tom's Comments:

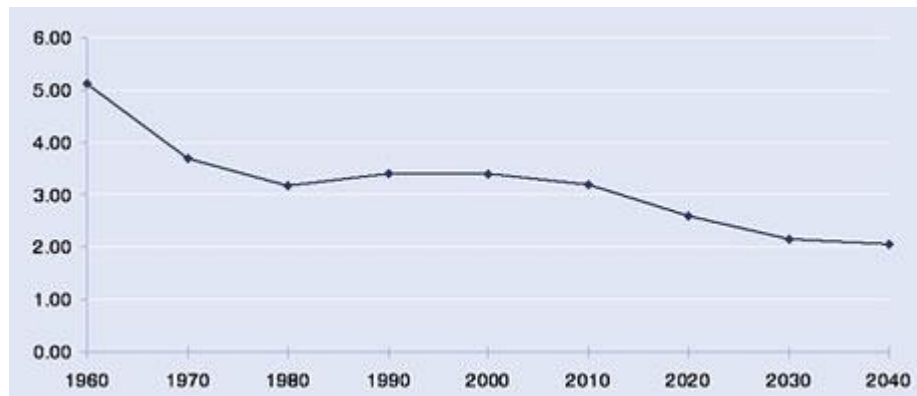
All of the presidential candidates' reform initiatives identify increased reliance on wellness and disease management programs as a critical component of their plan to positively impact cost and quality. The article below reinforces the importance of these initiatives, but it also cites a major concern. Specifically the authors state the following:

"Employers can play an active role in developing wellness programs for their employees that are linked to incentives/sanctions. This will not be an easy task in that lines are already being drawn – at the Federal and state level – on how much "tough love" employers can provide. At the end of the day, implementing a "bona-fide wellness plan" under HIPAA "restrictions" may not be enough to engage consumers and change employee behavior." As we have discussed in prior issues of the Quarterly, the government in its interest to protect the rights of individuals, may have gone too far in becoming an enabler of poor life-styles.

America's Health Crisis: Is Consumer Driven Health Care an Enabler or Antidote?

It is difficult to deny that a potential financial crisis looms for all parties saddled with financing health care in the future – particularly if consumer behaviors and health care cost trends continue unchanged. As the population ages, support ratios of workers to retirees are expected to deteriorate dramatically (see Exhibit 1).

Workers per retiree 1960-2040
Exhibit 1



Source: Social Security Administration (2006)

An important contributor to the looming healthcare crisis is the deterioration in the health profile of our population. Risk factors such as smoking and obesity, as well as diagnosed diseases such as diabetes and

heart disease, can add anywhere between 30 to 200% onto annual healthcare costs. Yet life expectancies have continued to increase. Sicker people are requiring health care for longer periods of time.

According to a University of Michigan study that was published in 2002, there were significant excess sick care costs relating to health risk factors (egg. smoking, obesity, high blood pressure, high cholesterol, etc.) regardless of disease category. Those that had no current disease yet had three to four risk factors, had close to 30% higher claims than those that had zero to two risk factors. Those that had over four risk factors had health care costs over 60% higher than those with zero to two risk factors. The results for those with diagnosed diseases were much higher.

The impact of consumer indifference to life-style issues has been dramatic. Obesity has become a national epidemic. Largely preventable conditions such as arthritis, cancer, diabetes, hypertension and heart disease are all on the rise. In fact, per the Center for Disease Control, approximately 70% of healthcare costs stems from preventable conditions.

Also according to the Center for Disease Control (CDC), behavior determines approximately 50% of health status, and environment determines another 20%. Only about 10% can be traced to genetics.

Employers can play an active role in addressing these issues by developing wellness programs for their employees that are linked to incentives/sanctions. This will not be an easy task in that lines are already being drawn – at the Federal and state level – on how much “tough love” employers can provide. At the end of the day, implementing a “bona-fide wellness plan” under HIPAA may not be enough to engage consumers and change employee behavior.

(“America’s Health Crisis: Is Consumer Driven Health Care an Enabler or Antidote?” JPMorgan, December 13, 2007)

(http://www.jpmorgan.com/cm/Satellite?c=JPM_Content_C&cid=1159329087148&pagename=JPM_redesign%2FJPM_Content_C%2FGeneric_Detail_Page_Template)

Fast Facts:

- An estimated 500,000 Americans traveled abroad for treatment in 2005. A majority traveled to Mexico and other Latin American countries; but Americans were also among the estimated 250,000 foreign patients who sought care in Singapore, the 500,000 in India and as many as 1 million in Thailand. ("Medical Tourism: Global Competition in Health Care," Devon Herrick, National Center for Policy Analysis," November 2007
<http://www.ncpa.org/pub/st/st304/>

QUALITY

Mental Health

Tom's Comments:

Below is an insightful article from one of the most respected organizations in healthcare, Milliman U.S.A. Milliman houses some of the strongest actuaries in the healthcare industry. Milliman clients include major employers, managed care organizations and hospital systems. They are known for objective analysis this is based on hard facts. This introduction is important since many people categorize mental health associated costs as "soft" costs that are not supported by hard data. As stated in this article the linkage between mind and body requires coordinated comprehensive care.

The Mental Health Divide: Mending the Split between Mind and Body

Depression and other major mental and substance-related illnesses can have a paralyzing effect on an otherwise healthy person. As hope and optimism fade, so does the urge to stay healthy. Depression can compound the severity of a problem for people with chronic physical illnesses, which can cost two to three times as much to treat if they are depressed. And depression itself can lead to poor health, as it often leaves people unmotivated and causes high-risk patients to ignore prevention or necessary treatments, opening the door to chronic and acute illness.

The symbiotic relationship between behavioral health and physical health is often not recognized. Instead, the behavioral healthcare environment that has emerged in the last two decades has largely ignored the interconnectedness between mind and body. It doesn't have to be this way. Indeed, a dramatic transformation for the healthcare industry is ahead as a handful of insurers and employers are beginning to identify the opportunities and economic incentives related to (1) providing benefits for behavioral illnesses on par with physical illnesses, and (2) integrating medical and behavioral healthcare for insured populations.

Part of this mental healthcare transformation is embodied by House behavioral health parity bill, the Paul Wellstone Mental Health and Addiction Equity Act of 2007, and the Senate behavioral health parity bill, the Mental Health Parity Act of 2007.

Fifteen years ago, the estimated cost of mandating behavioral healthcare parity would have swallowed the profit margins of most health insurance plans. But the trend in specialty behavioral healthcare has been one of dramatically falling costs, and recent estimates of parity cost are considerably lower today than those of a dozen years ago, when the Clinton administration pushed reform efforts.

Parity would help improve access, but what's really needed is an integrated healthcare delivery system, one where medical and behavioral healthcare providers deliver coordinated healthcare in a collaborative fashion. Evidence is beginning to suggest that the long-term costs of not treating behavioral health problems, or solely treating them in isolation from other medical issues, may result in total healthcare costs that are much higher than necessary. In medical settings, patients may seek repeated and ineffective care from medical or surgical physicians, rather than more effective specialized care from specialty behavioral professionals. ("The Mental Health Divide: Mending the Split between Mind and Body," Steve Melek, Milliman U.S.A. November, 1, 2007) <http://www.milliman.com/perspective/articles/the-mental-health-divide-insight-11-01-07.php>

Managed Care Organizations

Tom's Comments:

There are a number of take home messages associated with this report on BCBS of Minnesota's innovative care management plan.

- Chronic disease is a major cause for escalating healthcare costs
- Many people (especially the elderly) will have multiple chronic diseases (Note: Much of the rise in Medicare costs has been associated with the rise in chronic diseases among its members).
- Managed care organizations, such as BCBS of Minnesota, have the expertise, data, technology, and resources to be a major facilitator in healthcare in positively impacting cost and quality
- A key to success for any such initiative is proactive communication and collaboration between the MCO, physicians, and the patient.

Blue Cross & Blue Shield of Minnesota Designs a 'BluePrint' for the Future

Blue Cross & Blue Shield of Minnesota which is noted for its innovative approaches to healthcare management implemented a population health management initiative a few years ago. Population health management addresses some of the weaknesses of traditional disease management by introducing three key changes:

- Coverage includes a wider range of chronic conditions.
- Patients with co-morbid chronic conditions have one contact point for coordinated care instead of having a different disease manager for each chronic disease.
- Predictive modeling identifies at-risk individuals prior to their being diagnosed with a chronic condition or having an acute episode.

Instead of taking on the handful of chronic diseases that usually are found in a disease management program, BluePrint initially included 17 different conditions. These are then further subdivided into two categories: core and impact.

Core encompassed the traditional disease management conditions of diabetes, asthma, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, and end-stage renal disease.

Impact included 11 diseases and disorders not usually included in disease management programs: osteoarthritis, low back pain, osteoporosis, fibromyalgia, atrial fibrillation and anticoagulant therapy, chronic hepatitis and cirrhosis, incontinence, acid-related stomach disorders, pressure ulcers, irritable bowel syndrome, and inflammatory bowel disease.

Once at-risk members are identified using a variety of data screening approaches (egg., medical and pharmacy claims, physician referrals, case manager referrals, results from personalized health risk assessment questionnaires, etc.), BluePrint stratify these members into four levels of risk.

BluePrint enrolls the members in their program by employing an opt-out model to ensure their participation. Opt-out models commonly have a participation rate of 95%.

The program actively solicits the participation of physicians. BluePrint sends a standard of care outline, which is reviewed by their physician advisory council, to the enrollees and their physicians. Physicians receive ongoing reports and can speak with care managers at any time of the day or night via a toll-free number. BluePrint also sends a one-page form to the doctor's office that includes current prescription and over-the-counter medications the patient is taking, as well as recommended diagnostic tests.

BluePrint also has a team of nurses that travel throughout Minnesota to meet personally with doctors. These nurses, known as "provider service managers," explain the program to doctors and bring to their attention issues regarding specific patients.

The success to-date of BluePrint has been very positive both from a cost and quality perspective. At this point, Blue Cross & Blue Shield of Minnesota claims to be close to the 80-20 rule, covering chronic ailments affecting close to 20% of its population and accounting for nearly 80% of its health care claim costs. ("BCBS of Minnesota Designs a 'BluePrint' for the Future," Managing Benefit Plans, Issue 08-02, February 2008)

www.IOMA.COM/HR

Blue Cross & Blue Shield of Minnesota's Website description of BluePrint:
http://www.bluecrossmn.com/bc/wcs/groups/bcbsmn/@mbc_bluecrossmn/documents/public/mbc1_ps_hprgm.hcsp

Fast Facts:

- Per Dr. James Rippe, cardiologist and founder of the Rippe Lifestyle Institute, on average, overweight people have 13.8% higher annual health care costs than those at a healthy weight. The number more than doubles to 37.7% for obese individuals. Per Dr. Rippe, obesity causes 40% to 70% of the hypertension cases, over 50% of blood lipid problems, over 80% of Type 2 diabetes and almost 100% of metabolic syndrome cases.
(<http://ebn.benefitnews.com/asset/article-print/30805/printPage.html>)

ACCESS TO CARE

A Critical Analysis of Clinton's, Obama's and McCain's Healthcare Reform Proposals

Tom's Comments:

The last issue of the Quarterly Health Care Report identified a proposed template to evaluate the various healthcare reform initiatives:

- How does it impact cost, access and quality?
- Does it promote innovation and efficiencies in our healthcare system?
- Is there a greater likelihood of better "value" in the form of optimum cost and quality as a result of the initiative?
- Does the initiative promote personal health accountability?
- Are the resources identified to finance the "reformed healthcare system" sufficient and sustainable to ensure the long-term success of the initiative?

In evaluating the healthcare reform proposals of Senators Clinton, Obama and McCain, I first identified some of key elements of their plans. Within the context of the summary I have inserted **(in bold font with initials)**

my comments and thoughts about specific aspects of their proposals. My comments are also linked to the overall template that was identified above that can be used to as a tool to evaluate the various healthcare reform proposals.

On an overall basis, Senator Clinton's plan provides the most specifics. In providing the most specifics, she is also open to more criticism and disagreement about her approach to healthcare reform. Senator Obama's and Senator Clinton's healthcare plans are almost identical with the major difference relating to individual mandates. Senator Clinton is committed to individual mandates as part of universal coverage and Senator Obama believes a stepped approach would be more realistic. He would start by mandating coverage for all children, with the eventual possibility of full mandates if incentives, subsidies and cost controls fail to achieve universal coverage. Both Clinton and Obama would require large employers to provide insurance or contribute towards the cost of a public plan. Both Clinton and Obama would require small companies to provide health insurance to their employees but there would be generous tax credits available to ease the financial pain. Finally, both Clinton and Obama would make available a Public Plan and an array of private insurance options (similar to the Federal Employee Health Benefit Plan that is available for federal employees). Obama's Public Plan would be only available to the uninsured and Clinton's Public Plan would be available to everyone. At a high level while Clinton's and Obama's plan address cost, quality and access to care issues, the primary focus of the plans is to increase access to healthcare.

Senator McCain's plan is focused on market-based reform. His plan would expand the role of HSAs, etc. to address the cost side of the equation and tax credits to increase access. His stated goal is to work to make the healthcare system more efficient which would in turn make it more affordable and increase access.

High Level Comments Based on Health Care Reform Template

(Caveat: Given the lack of specificity of all three plans, I had to make some assumptions based on the information provided by the candidates).

- How does the healthcare reform plan impact cost, access and quality?
 1. All three healthcare reform plans, as presented, will have a minimal impact on healthcare system costs. None of the three plans provided concrete ideas to address the key issues

that are driving healthcare costs (egg. life-style diseases, end-of-life cost issues, out of control costs linked to high-end technology, fragmented healthcare system, disparities in practice patterns that are not based on evidence-based medicine, a healthcare system that is heavily reliant on specialists and sub-specialists vs. primary care, etc.). All three of the candidates address some of these issues in a general way, but their lack of specifics makes it very difficult to judge their level of commitment. Looking at cost from the tax payer's perspective, Senator Clinton's plan, as a result of her focus on universal coverage, would have the greatest increase on costs, at least in the short-term. In theory, universal coverage, over time, should have a positive impact on overall healthcare costs.

2. Senator Clinton's and Senator Obama's plans would also increase healthcare costs since they are mandating relatively rich (vs. most private sector plans) healthcare benefits for their Public Plans and National Choice Plans that would equate to what is currently offered to federal employees, including Congress.
 3. Senator Clinton's plan would have the greatest impact on access to care. Senator Obama would be somewhat less aggressive.
 4. Open issue – Will McCain's reliance on HSAs have a negative impact on access to care? HSA's as currently structured are much more attractive to the young, healthy and wealthy. Wide-spread reliance on HSAs could potentially increase the risk pool for the "other half" which would result in higher premiums and decreased access to care.
 5. There were insufficient specifics to evaluate the impact of the three plans on quality.
- Does it promote innovation and efficiencies in our healthcare system?
 1. All three plans, as currently structured, would have minimal impact on innovation and efficiencies in our healthcare system.
 2. Senator Clinton's plan relies more on an active role of federal government (directly through her Public Plan option and indirectly through other approaches) to incent efficiencies and cost savings in our healthcare system. As noted in the [Medicare article](#) in this issue of the Quarterly, past history has shown that the government through

Medicare has not only not been a catalyst for increased efficiencies and innovations in our healthcare system, it has actually been one of the major reasons we have an inefficient costly system.

3. Senator Obama's plan, as noted earlier, is similar to Senator Clinton's plan, but he has the government playing a lesser role specifically in regards to his Public Plan as well as in regards to individual mandates. Ultimately, it appears that his plan will only have a minimal impact on innovation and efficiencies in our healthcare system.
 4. Senator McCain's proposal provides the least number of specifics vs. his competitors'. It appears that while he talks about increased efficiencies and innovation, his proposals appear to just perpetuate the status quo.
- Is there a greater likelihood of better "value" in the form of optimum cost and quality as a result of the initiative?
 1. All three plans, as currently structured, would have minimal impact on a value proposition relating to cost-effective quality services.
 - Does the initiative promote personal health accountability?
 1. Senator McCain's plan potentially should have the greatest impact on personal accountability through his reliance on HSAs.
 2. Open issue – Will the McCain's reliance on HSAs have a negative impact on access to care.
 3. None of the three candidates were willing to take on the politically tough issue of federal laws that might be enabling bad health life-styles.
 - Are the resources identified to finance the "reformed healthcare system" sufficient and sustainable to ensure the long-term success of the initiative?
 1. Primary concern relates to Senator Clinton's plan which is the most aggressive in that she is proposing financing universal coverage.
 2. Senator McCain's plan involves fewer governmental resources, but it also will have a minimal impact on the uninsured.

Concluding Thoughts

As you will note from my above comments, I am disappointed with all three presidential candidates' proposals. In their defense, I am sure they

were counseled to be as general as possible with their recommendations. Many of the needed changes to our healthcare system would involve winners and losers which is politically very sensitive. Also, whenever you are attempting to change the status quo, and this status quo is tied to stakeholders that have millions/billions of dollars on the line, it is difficult, if not impossible, to take them on during a presidential campaign. Finally, in comparing these reform plans to the basics of the proposed plan by the Committee for Economic Development (that was evaluated in the [last issue](#) of the Quarterly), I see a basic difference. The Committee for Economic Development Plan appears to have a greater potential to foster innovation and increase the efficiencies of our healthcare system. It also seems to have a systematic approach overtime to get to universal access. Their overall premise is that you first need to put the key elements into place that would foster collaboration and break down the barriers between the various healthcare stakeholders, and then you can gradually overlay it with broader access in stages. All of this does not mean that you neglect the uninsured. There are many initiatives, including changes in insurance regulations, expansion of SCHIP, increased emphasis on clinics in rural areas and the inner-city which would help address the issues of the current uninsured. I explain in much more detailed fashion, my views of the Committee for Economic Development Plan in the [last issue](#) of the Quarterly.

Senator Hillary Clinton

Summary

Senator Clinton would enact “universal coverage” by requiring everyone to have insurance (large employer mandates and individual mandates). Mandatory coverage for all Americans would be achieved by building on the current employer-based system. Her plan would require large employers to provide coverage or contribute to the cost of coverage. Workers without employer coverage could receive coverage from the government. Tax credits would be available for small employers and working families. Insurance companies would be required to cover individuals without preexisting limitations or exclusions for health conditions.

The Specifics

- Establishment of a Health Choices Plan (linked to the Federal Employee Health Benefit Program) which would be available to businesses, employees and the uninsured.
 1. Consumers would select from a number of health plans sponsored by Managed Care Organizations. **(TC: The Federal Employee Health Benefit Program (FEHBP) is very popular with employees especially because of its level of benefits and the choices it provides in plan structure (HMO/PPO, etc.) and sponsoring MCOs)**
 2. Benefits will be equivalent to those offered to members of Congress, including mental health, dental, and high priority preventive services **(TC: The FEHBP health plan has rich benefits which would add to the costs of the overall program)**
 3. There would also be a Public Plan Option (modeled off of Medicare) which will compete with the private managed care plan options. **(TC: There are pluses and minuses to this approach. Competition based on a level playing field, could foster better efficiencies and quality in the healthcare system. Competition would also be healthy if the Government uses this as an opportunity to implement innovative provider payment mechanisms that would incent better cost and quality. Some fear that this could also be the start of a one payer system, if the Government is able to leverage its market power to drive down prices below market and force providers to cost shift to Managed Care Organizations. This phenomenon occurs today as providers attempt to cost shift their Medicaid and Medicare losses to the private sector MCOs.) If the Government Plan includes all providers (as currently exists today under Medicare), they would also have an unfair advantage from a consumer choice perspective, if MCOs from a practical perspective could offer only PPO and HMO panels which are based on limited choice. Ultimately, private MCOs would not be in the position to provide competitive prices and choices to the consumers which would result in a shift to the Government Plan over time.**
- Implement changes in health insurance regulations.
 1. Requiring guarantee issue – cannot deny coverage; automatic renewal and strong rating protections – Prohibited from charging large premium differences based on age, gender, health risk factors or occupation. **(TC: Would positively impact a certain percent of the uninsured. Incremental costs relating to this health insurance regulation would be borne by other members of the MCO (buried in their rates). If renewal issues are linked to life-style disease (egg.**

smoking/lung cancer), would these regulations enable unhealthy life styles?).

2. Require minimum stop-loss ratios which focus on excess profits of Managed Care Organizations. **(TC: If health insurance regulations require guarantee issues, automatic renewal and strong rating protections, there should be no limitations on MCO profitability. Limitations on profits (return on investments) would discourage innovation and risk taking on the part of the MCO).**
- Quality initiatives
 1. Providers participating in federal programs would be required to adopt private, secure, and interoperable technology. An up-front and phased-out \$3 billion per year investment fund would be provided to help providers adopt and implement a health information technology system. **(TC: Government needs to take more of an active role in this process. (Note: See articles relating to EMRs under “Cost” section of this Quarterly. Other developed countries have had a connective Electronic Medical Record (EMR) for five to ten years. At best the current approach to incent EMR implementation nationally through grants, etc. to individual hospital/hospital systems and physicians would result in a patch work system that may have limited benefit due to connectivity issues, etc. The Government may want to be more directly involved in the implementation (similar to the approaches used by other countries) and both aggressively fund and mandate implementation and connectivity.)**
 2. Prioritize prevention in the Health Choice Plan noted above as well as in the Public Plan Option **(TC: Would have both short and long-term positive impacts on healthcare costs and quality.) (Note: See article relating to enabling life-styles in the “Quality” section of this Quarterly).**
 - Improved chronic care management as part of the Health Choice Plan noted above and the Public Plan Option **(TC: Healthcare costs relating to chronic diseases are a major cause of escalating healthcare costs. Many of these chronic diseases are life-style oriented and, while disease management programs can be effective, many times patient compliance negates any benefits to the programs. Government may need to reevaluate laws/regulations that could potentially limit incentives to employees for actively participating in the programs.) (Note: See article relating to enabling life-styles in the “Quality” section of this Quarterly).**

- Fund and distribute independent research to compare effectiveness of treatments. **(TC: A very appropriate role for the Government. Studies have shown that there is a wide variation of practice patterns, etc. by regions in this country which contribute to higher costs and poorer quality. The Government would be a “facilitator” for better cost and quality by funding research initiatives, etc. relating to clinical effectiveness.) (Note: See article relating to Medicare in the “Cost” section of this Quarterly).**
- Promote shared responsibility
 1. Managed Care Organizations and drug companies cannot discriminate **(TC: Discussed elsewhere)**
 2. Require individual mandates **(Primary impact would be on individuals in the 20 to 29 age range, since other aspects of the Clinton plan would address much of the balance of the uninsured. This age bracket represents a significant percentage of the uninsured. Having these younger (mostly healthy) individuals in the insurance pool would lower rates for all. Under the current system, these young individuals would be able to access the safety-net of hospital systems, which further strains these providers overall mission. Overall approach of mandates is similar to Social Security and Medicare the young and healthy would be helping those that are less fortunate. If individual mandates are required, ideally there should be basic health benefits packages that would be focused on the 20 to 29 age group. Ideally, these benefits should be free from state mandates that would add few benefits to this age group, but added costs to their premiums. Finally, an additional criticism of individual mandates relates to the potential additional administrative costs and bureaucracy that would be needed to implement such a program. I would assume that a relatively efficient process could be implemented that would be tied to the tax system. An additional open issue would be the size of the penalty for non-compliance).**
 3. Large employers must provide an employee health plan or contribute to the cost of coverage. **(TC: This is sometimes called the “Pay or Play approach”. Large companies are in better position to absorb these costs, and most large companies (not sure of Clinton’s definition of a large company) already provide healthcare benefits to their employees. Unknown if large employers must provide a minimum type of benefit package, if benefit requirements are greater than what employer currently offers to employees it would result in incremental costs to the employer.)**

4. Small employers offered tax credits to be applied against price of insurance. Most small employers are not required to offer or contribute to coverage costs, but are offered incentives in the form of tax credits to do so. **(TC: Only approximately 45% of employers with fewer than 50 employees offer insurance to their employees. Tax credits would provide incentives to these smaller employers to provide insurance which in turn would positively impact the number of uninsured in the U.S.)**
 5. Government will institute tax credits that will ensure that individuals'/families' health insurance costs will not be greater than a certain percentage of annual income. **(TC: Specifics were not available).**
 6. Government will strengthen Medicaid and State Health Insurance Program to serve all low-income individuals **(TC: Specifics were not available).**
 7. A "retiree health legacy initiative" would provide qualifying public and private sector employers with a tax credit to offset catastrophic health expenditures, "as long as savings are dedicated to workers and competitiveness." **(TC: Could enable companies to continue to offer retiree healthcare plans. Government (taxpayers) would in effect be subsidizing or "bailing out" public and private sector employers for poor financial planning of retiree healthcare programs.)**
- Financing of the Clinton reform initiative
 1. Initiatives in themselves will create savings **(TC: Some of the initiatives (promoting preventative care, disease management programs, clinical effectiveness research, etc.) would result in savings (especially long-term savings), but it will be very difficult to estimate potential savings especially those impacting the long-term).**
 2. Phase-out Medicare over-payments to MCOs **(TC: Is the current "excess" payments a give-away or an investment in proactive care. It appears that MCOs have received a short-term windfall from Medicare "over-payments." Ultimately, though, it would be best for the government to incent private payers to stay in both the Medicare and Medicaid market since these players are in better position to innovate (which has a positive impact on the quality of services provided to the Medicaid recipient) and incent better efficiencies in the healthcare system. Government should reevaluate how they are paying private MCOs (payment methodologies, etc.) so as to incent them to provide better "actual" value in the market place.)**

3. Dedicate a portion of the savings achieved to reduce need for uncompensated care payments to hospitals (disproportionate share hospitals) **(TC: Need to be sensitive to safety-net providers that have proactively invested in inner-city programs, clinics, etc.)**
4. Applying Medicare purchasing leverage to reduce prescription drug costs **(TC: Will it evolve to price controls that stifle innovation and new products? Maybe focus should mostly be on increased competition that is linked to clinical effectiveness of drugs which would result in fewer but better options for seniors.) (Note: See article relating to value-based drug benefit in “Cost” section of this Quarterly).**
5. Align Medicare payments with performance to promote quality and reduce the geographic variations in care **(TC: In theory this sound great, but it will be difficult for the Government to accomplish if it is done in the correct manner. Ideally, Medicare should pay hospitals, physicians, etc. for value provided. Given Medicare’s financial leverage (egg. 60% of a hospital’s revenue) it would financially destroy some providers as well as have a negative impact on hospital programs, etc. All of this would translate to fewer jobs in healthcare or a reconfiguration of employers, etc. In the long-run this would probably be beneficial to the system, but the short-term economic and jobs impact could be politically intolerable). (Note: See Medicare article in “Cost” section of this Quarterly).**
6. Government would provide patients with information on provider performances through databases and decision tools **(TC: In theory, idea has a lot of merit, but again it would be very politically difficult for the government to take a lead role in providing “useful” cost and quality on providers to consumers.)**
7. Government will crack down on misleading direct to consumer prescription drug advertising **(TC: Focus of advertisements should be educating the public.)**
8. Redirect tax breaks from households making more than \$250,000 to help finance healthcare reform **(TC: Societal issue)**
9. Limit tax exclusion for high income Americans if they have healthcare benefits greater than the “typical plan” **(TC: Should focus on all high benefits health plans that contribute to excess healthcare costs no matter the income level of the recipient).**

Senator Barack Obama

Summary

Senator Obama proposes to achieve universal coverage through a stepped approach starting with a mandate to cover all children, with the eventual possibility of full mandates if incentives, subsidies and cost controls fail to achieve universal coverage. His proposal keeps the private insurance system already in place but requires insurers to offer comprehensive coverage to any applicant at a stable, reasonable premium. Employers would contribute to the cost of coverage for all employees and there would be a national program available to individuals and small businesses. The proposal calls for income-based subsidies to aid those who cannot afford coverage.

The Specifics

- Establish a new Public Plan (with healthcare benefits similar to the Federal Employees Health Benefits Program (FEHBP)), available to Americans who neither qualify for Medicaid or State Children Health Insurance Program (SCHIP) nor have access to insurance through their employers, as well as to small businesses that want to offer access to health insurance to their employees. **(TC: The FEHBP health plan has rich benefits which would add to the costs of the overall program)**
- Facilitate the development of a National Health Insurance Exchange to help individuals who wish to purchase a private insurance plan. The Exchange will act as a watchdog and help reform the private insurance markets by creating rules and standards for participating insurance plans to ensure fairness and to make individual coverage more affordable and accessible. All plans offered under the National Health Insurance Exchange must be at least as generous as the new Public Plan discussed above. **(TC: The National Health Insurance Exchange has merit in that it could foster good competition between the MCOs and possibly foster increased collaboration between MCOs and providers. The minimum benefits package required for National Health Insurance**

Exchanges is rich compared to most private sector health benefits. These rich benefits would add to the costs of the overall program at least in the short-run).

- Income-based sliding scale subsidies will be provided for people and families who need it for both the public plan and the private plans in the National Health Insurance Exchange. **(TC: Good)**
- Require that all insurance companies not be allowed to turn away prospective members as a result of illness or pre-existing conditions. **(TC: Would positively impact a certain percent of the uninsured. Incremental costs relating to this health insurance regulation would be borne by other members of the MCO (buried in their rates). If renewal issues are linked to life-style disease (egg. smoking/lung cancer), would these regulations enable unhealthy lifestyles?).**
- Require all employers to contribute towards health coverage for their employees or towards the cost of the public plan. **(TC: Unknown if there will be a minimum requirement for employer health benefit plans. Would have less of an impact on larger companies since most currently provide health insurance to their employees. Would have a major impact on smaller and medium size companies. Would negatively impact employment especially for employees that work for small and mid-size companies.)**
- Mandate that all children have healthcare coverage. Young people will be allowed to be on parent coverage until the age of 25 **(TC: Idea makes sense but it will result in cost sharing on the part of the balance of MCO business).**
- Expand eligibility for the Medicaid and SCHIP programs **(TC: Good idea but it will add costs to the program).**
- Allow flexibility for state health reform plans **(TC: Good idea! It will encourage innovation at the state level).**
- Reimburse employer health plans for a portion of the catastrophic costs they incur above a threshold if they guarantee such savings are used to reduce the cost of workers' premiums **(TC: Would enable companies to continue to offer healthcare benefits to employees. Government (taxpayers) would in effect be subsidizing or "bailing out" public and private sector employers for poor financial planning of healthcare programs.)**
- Require full transparency of hospital and physician quality and costs as well as preventable medical errors **(TC: Idea makes sense, but we need more specifics).**
- Facilitate the realignment of government and managed care organizations payment policies by developing and disseminating best practice information on quality care which is also linked into performance awards for providers. **(TC: A very appropriate role for**

- the Government. Studies have shown that there is a wide variation of practice patterns, etc. by regions in this country which contribute to higher costs and poorer quality. The Government would be a “facilitator” for better cost and quality by funding research initiatives, etc. relating to clinical effectiveness and by designing innovative payment policies.) (Note: See article relating to Medicare in the “Cost” section of this Quarterly).
- Establish an independent institute to guide reviews and research on comparative effectiveness. (TC: A very appropriate role for the Government. Studies have shown that there is a wide variation of practice patterns, etc. by regions in this country which contribute to higher costs and poorer quality. The Government would be a “facilitator” for better cost and quality by funding research initiatives, etc. relating to clinical effectiveness.) (Note: See article relating to Medicare in the “Cost” section of this Quarterly).
 - Reform medical malpractice laws (TC; Need more specifics)
 - Will invest \$10 billion a year over the next five years to move the U.S. healthcare system to a broad adoption of standards-based electronic health information systems. (TC: Government needs to take more of an active role in this process. (Note: See articles relating to EMRs under “Cost” section of this Quarterly. Other developed countries have had a connective Electronic Medical Record (EMR) for ten plus years. At best the current approach to incent EMR implementation nationally through grants, etc. to individual hospital/hospital systems and physicians would result in a patch work system that may have limited benefit due to connectivity issues, etc. The Government may want to be more directly involved in the implementation (similar to the approaches used by other countries) and both aggressively fund and mandate implementation and connectivity.)
 - Develop safety protocols that permit re-importation of drugs to keep competition vigorous (TC: Idea has merit in that currently the U.S. is subsidizing other countries’ drug costs. Ultimately, there needs to be a way to address this issue since other countries’ drugs costs are artificially low due to price controls and the U.S. drug costs are artificially high due to the subsidization of other countries’ drug programs. Could potentially have a negative impact on drug companies’ profits as well as innovations in the industry)
 - Phase-out Medicare over-payments to MCOs. (TC: Are the current “excess” payments a give-away or an investment in proactive care. It appears that MCOs have received a short-term windfall from Medicare “over-payments.” Ultimately, though, it would be best for the government to incent private payers to stay in both the Medicare and Medicare market since these players are in better

- position to innovate (which has a positive impact on the quality of services provided to the Medicaid recipient) and incent better efficiencies in the healthcare system. Government should reevaluate how they are paying private MCOs (payment methodologies, etc.) so as to incent them to provide better “actual” value in the market place.)**
- Medicare would be able to negotiate directly with drug companies in order to positively impact costs to the consumers. **(TC: Will it evolve to price controls that stifle innovation and new products? Maybe focus should mostly be on increased competition that is linked to clinical effectiveness of drugs which would result in fewer but better options for seniors.) (Note: See article relating to value-based drug benefit in “Cost” section of this Quarterly)**
 - Would partially finance healthcare initiative by allowing tax cuts for households with incomes of \$250,000 and above to expire and with revenue from the employer contribution. **(TC: Societal issue)**

Senator John McCain

Summary

Senator McCain is a proponent of market-based reforms that would remove the advantages reserved for employer-sponsored health plans and provide tax credits to encourage individuals to buy coverage. His plan would expand health savings accounts and allow people to buy insurance nationwide, across state lines. The plan would also allow organizations and associations to offer coverage.

The Specifics

- Make public more information on treatment options and require transparency by providers regarding medical outcomes, quality of care, costs, and prices **(TC: Need to know more specifics)**
- Facilitate the development of national standards for measuring and recording treatments and outcomes. **(TC: A very appropriate role for the Government. Studies have shown that there is a wide variation of practice patterns, etc. by regions in this country which contribute to higher costs and poorer quality. The Government would be a “facilitator” for better cost and quality by funding**

- research initiatives, etc. relating to clinical effectiveness and by designing innovative payment policies.) (Note: See article relating to Medicare in the “[Cost](#)” section of this Quarterly).
- Reform the payment systems in Medicare to compensate providers for diagnosis, prevention, and care coordination. Medicare should not pay for preventable medical errors or mismanagement. Medicare could pay a single bill for high-quality coordinated care in which providers collaborate to produce the best health outcome for a patient. **(TC: In theory this sound great, but it will be difficult for the Government to accomplish if it is done in the correct manner. Ideally, Medicare should pay hospitals, physicians, etc. for value provided. Given Medicare’s financial leverage (egg. 60% of a hospital’s revenue) it would financially destroy some providers as well as have a negative impact on hospital programs, etc. All of this would translate to fewer jobs in healthcare or a reconfiguration of employers, etc. In the long-run this would probably be beneficial to the system, but the short-term economic and jobs impact could be politically intolerable. (Note: See Medicare article in “[Cost](#)” section of this Quarterly). One possible way to address this issue is to gradually move most of Medicare to private plans. These private plans would have the added leverage to positively impact cost and quality through innovative payment methodologies. The government would need to monitor these arrangements to make sure that MCOs are not exploiting this added leverage for their own financial gain. Ideally, such a system could incent MCOs and providers to establish more of a collaborative relationship vs. the “tug-of-war” environment that exists today.)**
 - Dedicate federal research on the basis of sound science resulting in greater focus on care and cure of chronic disease **(TC: Good!)**
 - Encourage use of private insurance in Medicaid **(TC: Medicaid HMOs may be in the best position to develop innovative payment methodologies that incent cost and quality on the part of the providers. Ultimately the financial rewards for Medicaid HMOs should be linked to providing value to the Medicaid system and specifically to the Medicaid recipients. Medicaid HMOs would need to be strictly monitored by the states to ensure that value is being provided).**
 - Support clinics in retail outlets **(TC: Competition on price and service will have an overall positive impact on the system. There should be some form of oversight when it comes to quality).**
 - Focus on telemedicine and community and mental health clinics in areas where services and providers are limited. **(TC: Agree)**
 - Develop safety protocols that permit re-importation of drugs to keep competition vigorous **(TC: The idea has merit in that currently**

- the U.S. is subsidizing other countries' drug costs. Ultimately, there needs to be away to address this issue since other countries' drugs costs are artificially low due to price controls and the U.S. drug costs are artificially high due to the subsidization of other countries' drug programs. Could potentially have a negative impact on drug companies profits as well as innovations in the industry)**
- Pass tort reform to eliminate frivolous law suits and excessive damage awards. Provide a safe harbor for doctors that follow clinical guidelines and adhere to patient safety protocols **(TC: Ideas have merit especially the safe harbor exemption for following clinical guidelines).**
 - Reform the tax code to eliminate the bias toward employer-sponsored health insurance, and provide all individuals with a \$2,500 tax credit (\$5,000 for families) to increase incentives for insurance coverage. **(TC: Idea has merit)**
 - Families should be able to purchase health insurance nationwide, across state lines **(TC: Idea has merit)**
 - Require any state receiving Medicaid to develop a financial "risk adjustment" bonus to high-cost and low-income families to supplement tax credits and Medicaid funds **(TC: Idea has merit)**
 - Facilitate the formation through purchasing alliances and encourage professional associations, etc. to offer health insurance to their members **(TC: Idea has merit)**
 - Expansion of Health Savings Accounts (HSAs) **(TC: HSAs are a piece of the puzzle, but as of now a relatively small piece. Currently HSAs appeal primarily to the young, healthy and wealthy. HSAs will also only have a limited impact on the overall costs and quality of the healthcare system for five basic reasons. First, the primary users of HSAs are the young, healthy and wealthy who already have on average less utilization than their counterparts (egg. the old, unhealthy and poor). Second, high cost claims of HSA consumers will easily be greater than their deductible which will then be 100% covered. Third, high priced technology is one of the major drivers of healthcare costs and HSAs would have little or no impact on these services. Fourth, there is minimal user-friendly cost and quality information available to the consumers that would truly evolve them to prudent purchasers of healthcare services. Fifth, while HSAs promote accountability, they will have minimal real impact on those people who have unhealthy life-styles and are non-compliant. (Note See article on enabling poor life-styles in the "Quality" section of this Quarterly).**

Website sources of information relating to reform proposals of all three candidates:

- "Health Care Reform Discussion," International Foundation, February 8, 2008 (<http://www.ifebp.org/Resources/News/Health+Care+Reform+Discussion>)
- <http://www.hillaryclinton.com/feature/healthcareplan/americanhealthchoicesplan.pdf>
- <http://www.barackobama.com/issues/pdf/HealthCareFullPlan.pdf>
- http://www.barackobama.com/pdf/Obama08_HealthcareFAQ.pdf
- <http://www.johnmccain.com/Informing/issues/19ba2f1c-c03f-4ac2-8cd5-5cf2edb527cf.htm>
- <http://www.johnmccain.com/Informing/News/Speeches/8f5febd6-cdca-4136-b0d8-a97f5287235d.htm>
- http://www.commonwealthfund.org/usr_doc/Collins_envisioningfuture2008candplans_1092.pdf?section=4039
- <http://www.health08.org/sidebyside.cfm>

National Health Insurance Lessons from Abroad

Tom's Comments:

There is no "Silver Bullet" when it comes to healthcare reform. All countries in the world are struggling with issues of cost, access and quality to varying degrees. This does not mean we cannot learn from the experiences of other countries. Many of these countries have much more sophisticated processes in place to deliver primary and preventive care. Some of these countries have implemented a fully connected Electronic Medical Record (EMR) throughout their country. Some of these countries have also implemented a centralized program for Comparative Clinical Effectiveness which is still in the talking stages in the U.S. Most of these countries have also established universal healthcare for all of their citizens.

As I noted above, while these initiatives are impressive, these countries still are struggling with issues of cost, access and quality to varying degrees. Below is a link to a publication from The Century Foundation that attempts to provide the reader with an overview of some international healthcare systems. The Century

Foundation is a proponent of universal healthcare in the U.S., but no matter what your views are on this subject, you may find this publication both interesting and informative.

("National Health Insurance Lessons from Abroad," The Century Foundation Press, 2008)

<http://www.tcf.org/Publications/HealthCare/healthcarebasics.pdf>

STATE HEALTH CARE

Fast Facts:

- If you are interested in finding information relating to healthcare reform issues, policies, etc. in Ohio you can access the state's website at: www.healthcarereform.ohio.gov
- Another good source for information on Ohio's health care policy initiatives and issues is the Health Policy Institute of Ohio <http://www.healthpolicyohio.org>

NORTHEAST OHIO

MARK YOUR CALENDAR

If you are interested in possibly enrolling in the Health Care MBA program at Baldwin-Wallace College for the session starting in January of 2009 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/>

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Please call for more information 440-826-2392