

QUARTERLY HEALTH CARE REPORT

July/August 2007 Vol. 11

Cost, Quality and Access-to-Care Issues in the U.S. / Ohio / Northeast Ohio

BY TOM CAMPANELLA

Director, Health Care MBA Program, Baldwin-Wallace College

Baldwin-Wallace College provides Professor Tom Campanella's Quarterly Health Care Report as a courtesy to those in the health care sector. Comments, opinions, emphasis and content decisions are solely those of Tom Campanella.

IN THIS ISSUE

INTRODUCTION

COSTS

- Total Medical Costs for Families Increase Eight Percent in 2007
- Research on Comparative Effectiveness of Medical Treatment: Options for an Expanded Federal Role
- BCBSA Supports Creation of a Private Institute Focused on Clinical Effectiveness
- Reflections on Science, Judgment and Value in Evidence-Based Medicine Decision Making
- Fast Facts

QUALITY

- Employers Look for Ways to Put More Muscle into their Wellness Programs
- Employer to Fine Unhealthy Workers
- Hospitals Asked to Account for Errors on Their Watch
- Fast Facts

ACCESS TO CARE

- Fast Facts

STATE HEALTH CARE INITIATIVES

- Massachusetts' Universal Health Care Law – Is This a Template for Other States?
- Ohio Health Insurance Plan Proposed
- Ohio Pushes Long-term Care Insurance as Medicaid Reels

NORTHEAST OHIO

Baldwin-Wallace College's Open Houses: **Berea**- August 28th & October 30th, 2007; **Beachwood**- August 15th & November 1st, 2007

Visit our website for more information: www.bw.edu/openhouse

SOURCES

Sources cited in this Quarterly Health Care Report are listed at the end of each article.

[Tom Campanella](#) joined Baldwin-Wallace College as 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 and has over 20 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.

[Baldwin-Wallace College](#), founded in 1845 in Berea, Ohio, combines the personalized attention of a small school with the degree and course options of a large university. The Business Division's Health Care MBA, International MBA, Executive MBA, Entrepreneurship MBA, Accounting MBA and Human Resources MBA programs, as well as undergraduate programs, provide a unique blend of business theory and hands-on application, calling on a distinguished faculty who are scholarly, yet grounded in real-world experience.

*Baldwin-Wallace College
Practical. Principled. Powerful.*

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 provides the reader with a wide spectrum of articles under the heading of cost, quality and access to care. Health care costs continue to take their toll on both employer and employee budgets. As employers and their employees struggle to survive in a difficult marketplace, there appears to be no end in sight to health care cost increases.

This issue of the Quarterly Health Care Report will primarily focus on two areas that significantly contribute to our health care costs. Under the

broad titles of clinical effectiveness and life-style accountability we will delve further into the root causes of the cost problem as well as discuss potential solutions. Finally, we will continue our series on state initiatives that are attempting to address their uninsured population. As part of that review we will focus on one such proposal for the state of Ohio.

COSTS

Total Medical Costs for Families Increase Eight Percent in 2007

The [Milliman Medical Index 2007](#) (MMI), measures average medical spending for a typical American family of four by an employer-sponsored Preferred Provider Organization (PPO) program. The MMI examines the total cost to deliver healthcare and how this cost is allocated between employer and employee.

Key MMI findings include:

- The total 2007 medical cost for a typical family of four is \$14,500.
- The average annual medical cost for a family of four increased by 8.4% from 2006 to 2007. This is lower than the average annualized rate of increase of 9.3% for the period from 2003 to 2007.
- The cost of healthcare varies significantly by metropolitan area, which may have implications for national healthcare reform proposals that utilize a standard nationwide tax deduction.
- For 2007, pharmacy trends decreased for the second consecutive year, although specialty drugs are likely to drive pharmacy costs higher in the coming years (Also see [April/May QHCR](#), "Prescription Drug Spending Growth Rate is Expected to Increase in 2008 and 2009").
- This year's double-digit increase in employee contributions will affect all plan participants, not just those utilizing healthcare services.

The MMI estimates total annual medical costs for a typical American family of four at \$14,500. This is an increase of 8.4% over the 2006 Milliman Medical Index. The 2007 increase is 1.2 points lower than the 2006 trend of 9.6% (See Figure 1 and Figure 2). Milliman does not anticipate further trend reductions in the near future.

Figure 1: Milliman Medical Index (MMI)

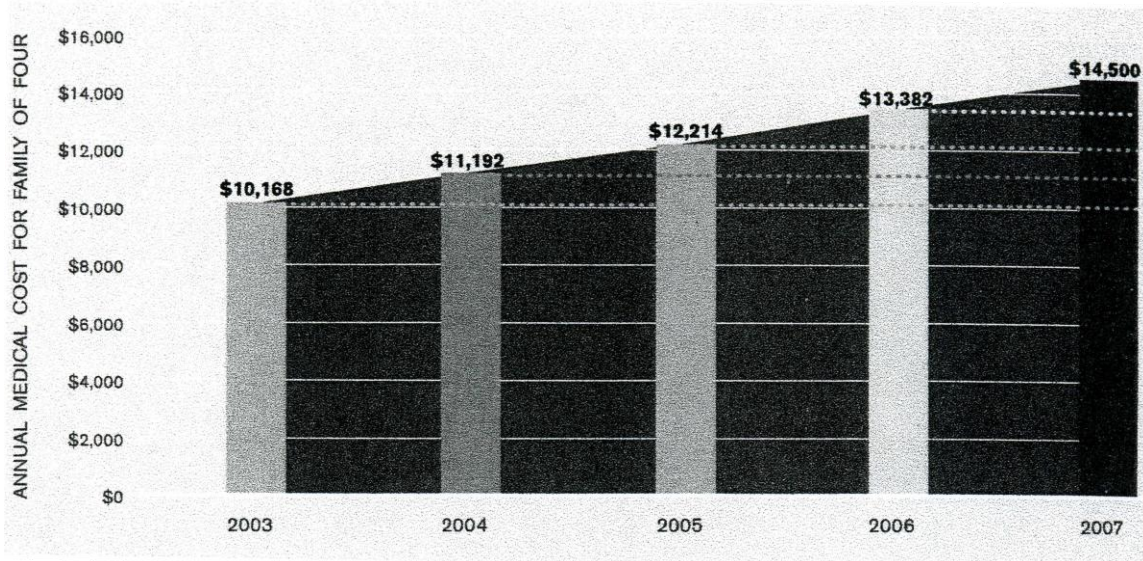
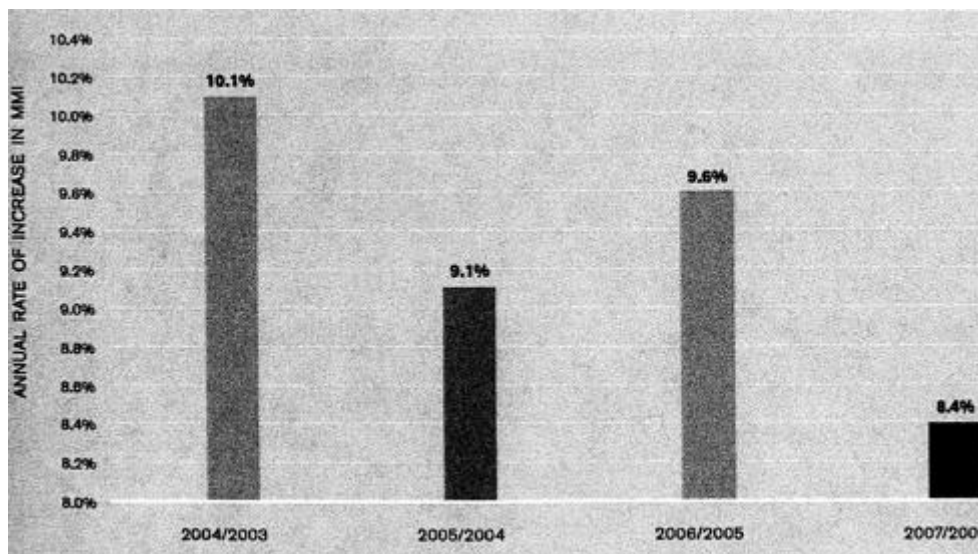


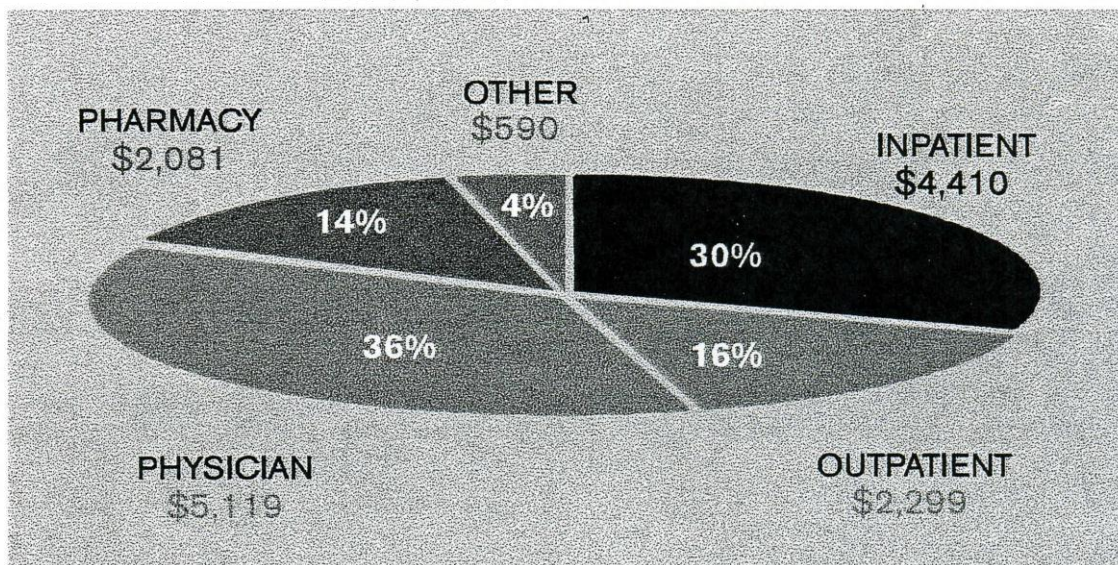
Figure 2: Trend in Milliman Medical Index



Milliman also categorizes costs and trends into the following major categories: inpatient hospital services, outpatient hospital services, physician services, prescription drugs and other services including ambulance, durable medical equipment, private duty nursing, and home health.

Figure 3 shows the distribution of total medical costs paid for and on behalf of the typical American family of four. It includes both the portion of the costs borne by an employer's benefit plan and the portion paid by the family in the form of out-of-pocket cost sharing.

Figure 3: 2007 MMI Components of Spending



The 2007 distribution of costs by category is stable as compared to 2006.

Figure 4 shows the annual rate of increase by component of medical care. As you will note, the rate of increase did not vary significantly by major component. The 2006 to 2007 estimated hospital cost trend rate decreased just slightly this year from 9.3% to 9.0%, while hospital outpatient trend rate dropped substantially from 12.6% to 9.8%. The physician trend rate is up somewhat from 5.9% to 6.8% but, is still the lowest of the major components.

For the second year in a row, pharmacy trend rates dropped to 7.7%. The primary driver of the lower trend is a continued shift to generic drugs. On the horizon Milliman sees the potential for higher pharmacy trends as the use of specialty drugs increases. (Also see [April/May QHCR](#), "Prescription Drug Spending Growth Rate is Expected to Increase in 2008 and 2009").

Figure 4: MMI Annual Rate of Increase in Cost by Component of Medical Care

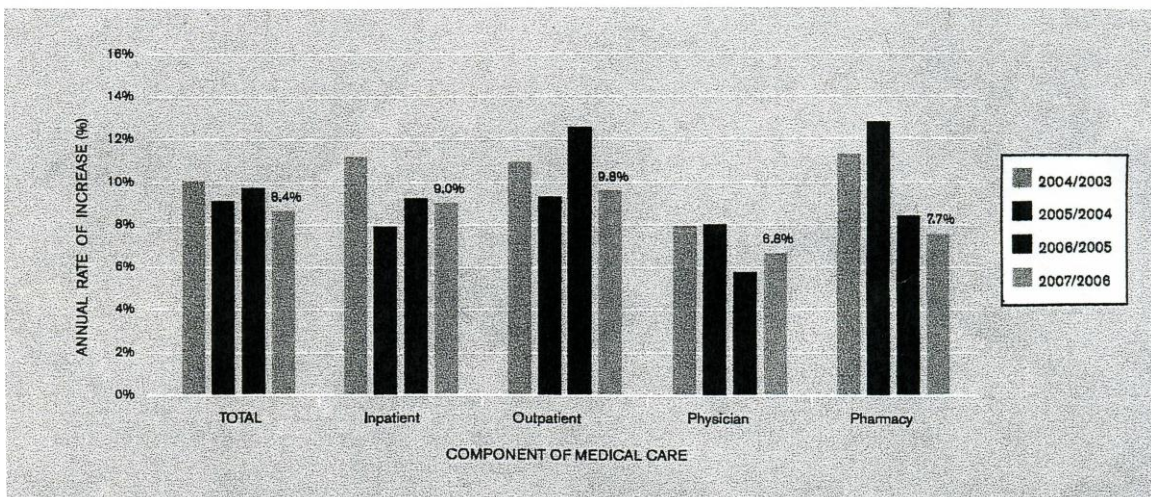
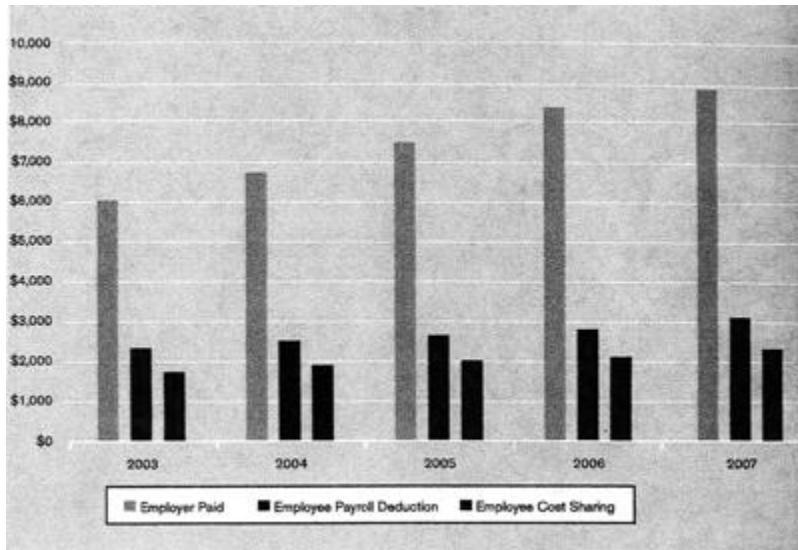


Figure 5 shows that of the \$14,500 total medical cost for a family of four under a PPO, the employer pays about \$8,909 (62%), and the employee pays about \$5,591 (38%) -- \$3,171 of the employee share is in payroll deductions and \$2,420 in cost sharing.

Figure 5: Medical Cost by Source of Payment



(“Milliman Medical Index 2007,” Milliman Consultants and Actuaries, May 2007)

Tom's Comments:

Milliman Consultants and Actuaries are a respected organization in health care. Both the integrity of their data and their analysis has proven to be insightful over the years.

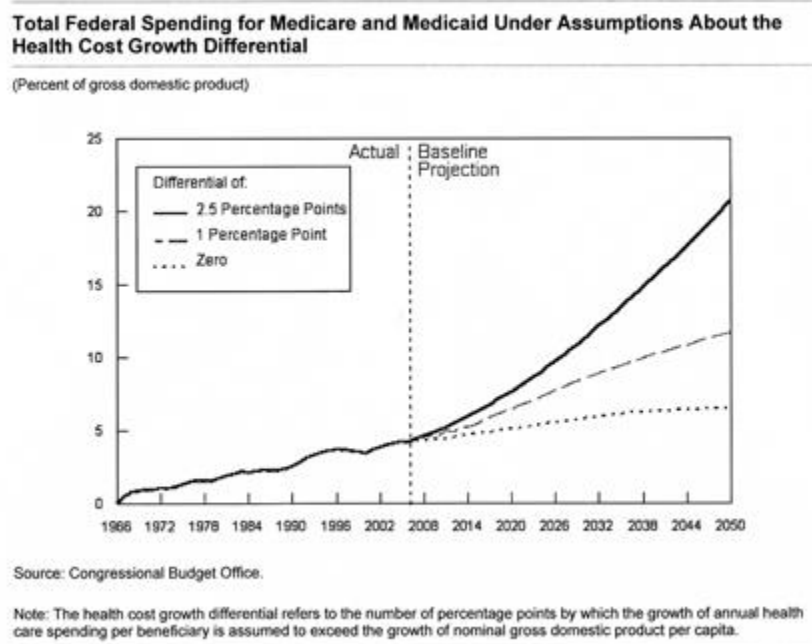
Research on Comparative Effectiveness of Medical Treatments: Options for an Expanded Federal Role

The following are excerpts from the testimony of Peter R. Orszag, Director of the Congressional Budget Office (CBO) to the Subcommittee on Health Committee on Ways and Means, U.S. House of Representatives. Over the past four decades, Medicare's and Medicaid's costs per beneficiary have

increased about 2.5% faster per year than has the per capita gross domestic product (GDP). If those costs continue growing at the same rate over the next four decades, federal spending on those two programs alone would rise from 4.5% of GDP today to roughly 20% by 2050 (See Figure 1).

Figure 1.

Total Federal Spending for Medicare and Medicaid under Assumptions about the Health Cost Differential



A variety of evidence suggests opportunities to constrain health care costs both in public programs and in the rest of the health system without adverse health consequences. Perhaps the most compelling evidence of those opportunities involves the substantial geographic differences in spending on health care – both among countries and within the United States – which do not translate into higher life expectancy or measured improvements in other health statistics in the higher-spending regions.

Furthermore, hard evidence is often unavailable about which treatments work best for which patients or whether added benefits or more effective but more expensive services are sufficient to warrant the added costs.

Together those findings suggest that better information could eventually yield lower health care spending without having adverse effects on

health – and that the potential reduction in spending below projected levels would be substantial. Ultimately, more information about comparative effectiveness could yield better health outcomes from the resources devoted to health care.

Because any private-sector entity (such as a health plan) has only a limited incentive to produce information that could benefit many entities, an argument can be made to coordinate comparative effectiveness research in a more systematic way than is currently being done. In addition, because federal health insurance programs play a large role in financing medical care and represent a significant expenditure, the federal government itself has an interest in evaluations of the effectiveness of different health care approaches.

What is comparative effectiveness? As applied in the health care sector, an 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. Such studies may compare similar treatments, such as competing drugs, or they may analyze very different approaches, such as surgery and drug therapy. The analysis may focus only on the relative medical benefits and risks of each option, or it may go on to weigh both the costs and the benefits of those options. In some cases, a given treatment may be found more effective for all types of patients, but more commonly a key issue is determining which specific types would benefit most from it.

Other developed countries also face challenges financing health care costs and have taken various steps to assess the comparative effectiveness of treatments. Many of those countries establish overall budgets for their national health systems and use comparative effectiveness analysis to help determine which treatments and procedures will be covered or how they will be reimbursed. Perhaps the best known example is the National Institute for Health and Clinical Excellence (NICE), which was established in 1999 as part of the United Kingdom's national health services.

Another question is whether assessments would be limited to procedures and treatments or would also seek to evaluate the performance of individual doctors. In particular, the data from medical records that are used to compare the effectiveness of different treatments for a given type of patient could also be used to analyze the quality with which doctors provided each treatment. The potential gains from such analysis

include identifying doctors who deliver high-quality care and encouraging those who are not performing well to improve, and doing both on the basis of objective medicine.

Expanded research on comparative effectiveness, if linked to changes in incentives for providers and patients, offers a promising mechanism for reducing health care costs to a significant degree over the long-term while maintaining or improving the health of Americans. ([“Research on the Comparative Effectiveness of Medical Treatments: Options for an Expanded Federal Role,”](#) Peter R. Orszag, Director of the Congressional Budget Office (CBO), June 12, 2007)

Blue Cross & Blue Shield Association (BCBSA) Supports Creation of a Private Institute Focused on Clinical Effectiveness

Too much of the health care delivered today lacks a basis in evidence. Researchers and policymakers agree that there often is not enough information regarding which medical treatments work best. One study estimates up to 30% of healthcare spending pays for ineffective, inappropriate, or redundant care. Another study estimates that only 54% of acute care and 56% of chronic care provided by physicians conforms to medical literature.

To address this gap in understanding, BSBSA has called for the creation of a new independent, private institute that would offer consumers and providers with much needed information on the effectiveness of new and existing medical procedures, drugs, devices and biologics.

BCBSA has identified four key principles to guide the institute's development and future success. They are:

- Funding for the institute would be ensured by asking all healthcare payers to contribute;
- The institute would support a broad range of research, especially clinical trials;

- Significant education and incentives are needed to ensure new research improves clinical practice;
- The new institute should be chartered as an independent, private entity.

(“Statement on Ways and Means Hearing to Examine Comparative Effectiveness Research,” Scott P. Serota, President and CEO, BCBSA, June 12, 2007)

Reflections on Science, Judgment, and Value in Evidence-Based Decision Making

Evidence-based Medicine (EBM) has increasingly influenced decision-making in health policy and patient care. Appropriate use of EBM in decision making requires a clear understanding of the distinct “anatomical” components of all decisions: (1) scientific evidence and (2) judgments applied to that evidence by individuals or organizations. The link below will provide you access to Sean Tunis’s (founder and director of the Center for Medical Technology Policy) discussion with David Eddy (founder and director of Archimedes, Inc.) The focus of this discussion is the application of Evidence-based Medicine principles to health policy decision making at the Office of Technology Assessment, the Centers for Medicare and Medicaid Services, and the Center for Medical Technology Policy. (**“Reflections on Science, Judgment, and Value in Evidence-Based Decision Making: A Conversation with David Eddy,” Sean R. Tunis, Health Affairs, June 19, 2007)**)

Tom’s Comments:

The above three articles relating to clinical effectiveness send a strong message. The lack of compliance to Evidence-based Medicine is a major contributor to our health care costs in the U.S. The statements by the Director of CBO are especially powerful. If the federal government in partnership with the private sector takes a lead role in clinical effectiveness research it could have a major impact on both health care costs and quality. That impact becomes even more powerful if the government integrates clinical effectiveness research into the Medicare and Medicaid programs. The private sector health plans also closely

follow Medicare policy, and the more aggressively Medicare incorporates clinical effectiveness into their payment policies, the greater the likelihood the private insurers would follow.

As a side note, "Health Affairs" is a great source of current and relevant data and analysis relating to a variety of health care topics. I would strongly recommend that the reader investigate subscribing to this publication.

Fast Facts:

- An interesting source of data and analysis relating to healthcare costs and reform ideas is Peter R. Orszag (Director of the Congressional Budget Office) testimony (**See link**) to Congress on June 21, 2007. (**["Health Care and the Budget: Issues and Challenges for Reform,"](#) Director Peter R. Orszag, June 21, 2007**)
- Blue Cross & Blue Shield of South Carolina launches subsidiary to facilitate medical tourism. The subsidiary, Companion Global Healthcare is organized to help U.S. patients plan trips to Thailand for lower-cost medical procedures. The link below will provide the reader access to their website. The jury is still out with regards to whether "Medical Tourism" is a fad or a trend. (**<http://www.companionglobalhealthcare.com>**)

QUALITY

Employers Look for Ways to Put More Muscle into their Wellness Programs

Scotts LawnService hired Scott Rodrigues to treat Sagamore Beach, Mass., lawns with chemicals in the summer of 2006 on the condition he pass drug- and nicotine-screening tests. About six months earlier, the company had banned employees from smoking cigarettes anytime or anywhere. Scotts fired Rodrigues when his test came back positive for nicotine, even though he never smoked at work.

Rodrigues sued Scotts in January 2007 seeking compensatory and punitive damages for alleged violations of his privacy and civil rights and a permanent injunction barring Scotts from terminating employees for smoking outside of working hours. The pending suit pits employees' rights to engage in off-the-job conduct that is legal but carries health risks against employers' business interest in a healthy workforce.

Companies like Scotts, which also charges employees more for health insurance if they decline to participate in an extensive health assessment and coaching program are putting muscle into their wellness programs in a last ditch effort to rein in skyrocketing health care costs.

So while few companies have gone as far as Scotts in forcing employees to change their lifestyles, many are luring employees with substantial incentives as they move in the direction of making wellness mandatory. At the same time, federal and state anti-discrimination and privacy laws (HIPAA, American with Disabilities Act, Age Discrimination in Employment Act, various state laws, etc.) limit how far an employer can go. In the absence of court rulings and regulatory guidance, employers venturing into mandatory programs run the risk of violating law. ([“Employers Challenge Legal Restrictions on Wellness Programs,”](#) **Inside Counsel, Mary Swanton, July 15, 2007**)

Employer to Fine Unhealthy Workers

While many employers have been using financial incentives to encourage participation in wellness programs, one company will begin charging employees more for their health insurance in 2009 if they allow health risks such as tobacco use, obesity or high cholesterol to go unchecked.

Although this punitive approach by Indianapolis-based Clarian Health is a departure from the methods used by most employers, per Clarian it is permitted under the final rules the federal government issued in December 2006 to ensure wellness programs with the nondiscrimination provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The rules become effective July 1, 2007.

Per Clarian's legal review, the program's total possible assessment of \$25 per paycheck for an employee who fails to meet their standards is less than 20% of the cost of coverage limitation by HIPAA rules. In addition, if employees have a

medical condition that prevents them from meeting certain standards, they can obtain an exemption by providing a doctor's note.

"This kind of plan is not at unusual as it would have been five years ago. I've heard of employers considering getting more aggressive," says Sharon Cohen, group and health care benefits counsel at Watson Wyatt Worldwide in Washington. "I think more and more employers, now that the HIPAA final rules are in place, want to take the next step. If they're not implementing this type of arrangement, it's on the table and they're discussing it." (["Employer to Fine Unhealthy Workers," Joanne Wojcik, Workforce Management, July 24, 2007](#))

Tom's Comments:

We all talk about the importance of personal accountability. I believe it was inevitable that issues of accountability would become more of a focal point in health care. Wellness publications cite as a fact that 70% of our health care costs are associated with life-style diseases. Even if that is somewhat of an overstatement, it is widely accepted that life-style choices have a major impact on both our societal health care costs as well as our own quality of life.

We are all aware of the division between the "haves" and the "have-nots." Sadly we are also coming to a point where there indeed may be a division between the "healthy" and those people that choose that "unhealthy" status as a result of life-style choices. A common statistic that is often cited is that 1% of the utilizers of a large pool of people usually result in 30% of the health care costs and 10% of the utilizers result in 70% of the health care costs. While the top utilizers may change on an annual basis (egg. an acute case individual may die), many of the high utilizers fall into the chronic disease category. Many of these chronic diseases as well as acute cases either have their root in life-style decisions (egg. smoking) or are made more critical as a result of poor life-style choices (egg. diet/lack of exercise).

Obviously all of these issues are very sensitive. Many people with diseases, etc. are genetically disposed to them and attempt to manage them effectively. Wellness and disease management programs are also becoming more sophisticated, and the programs that are currently or will be in place can go a long way in both having a positive impact on costs as well as improving the quality-of-life of the recipient of services.

As noted in the above articles, employers have a vested interest in developing wellness and disease management programs in partnership with experts in those fields. The challenge for relating to these programs has always been employee compliance. As health care costs continue to increase and employee cost-shifting increases (as well as loss of coverage) there will be added pressure to address the causes of higher health care costs, including those causes that are tied to personal accountability.

Finally, employers that are considering implementing wellness or disease management programs that are linked to sanctions, etc., should meet with their legal counsel, since this area of law is not only complicated, but is still evolving.

Hospitals Asked to Account for Errors on Their Watch

Hospitals are under increasing financial and legal pressure to eliminate egregious medical errors. States, consumer organizations, and now the federal government are pushing hard to create accountability. They believe that withholding payment to hospitals for the extra care that results from provider errors will help to forge that accountability.

The newest development is a recently announced proposed Centers for Medicare & Medicaid (CMS) rule change: The federal government may stop paying hospitals for care associated with six specific preventable medical errors. CMS calls those errors “hospital-acquired conditions.”

Three of the conditions are what are known as “never events,” highly preventable medical errors delineated by the National Quality Forum, such as an object left in a patient during surgery. The second is hospital-acquired infections, and the third is pressure ulcers.

Private insurers are also looking to deny payments for extra care that result from provider error. “Having a financial incentive will increase hospitals’ awareness of the need to make the systematic changes necessary to avoid these errors, which no hospital wants to ever see happen,” say Charles Cutler, MD, Aetna’s Chief Medical Director of National Accounts. “We are considering making non-payment for “never events” a standard part of our contracts.”

In a separate initiative pushed hard by the Leapfrog Group, the CMS Office of Inspector General is conducting a study on whether CMS should ever pay for any “never event.”

The proposed CMS rule change is more limited in scope. If adopted, it will take effect on October 1, 2008, and “will mean that hospitals will not benefit from higher reimbursement for specific conditions that were not present at the patient’s admission,” says CMS spokeswoman Ellen Griffith-Cohen.

“There are no reporting requirements at this time for hospital-acquired conditions, including infections,” says Griffith-Cohen. “A purpose of the proposed rule is to attempt to address that. The initiative was mandated by Congress in order to prevent Medicare from bearing the cost when a patient incurs a hospital-acquired condition that could have been prevented with proper care and evidence-based guidelines.” ([Hospitals Asked to Account for Errors on Their Watch](#),” **Martin Sipkoff, Managed Care Magazine, July 27, 2007**)

Tom's Comments:

The above article is another of the series of articles discussed in this report relating to hospital-acquired conditions. (See the last two issues of the QHCR report.

- [April/May 2007](#)
- [January/February 2007](#)

Fast Facts:

- Researchers at Harvard University recently completed a study that confirms many of our own observations, namely that there has been a fourfold increase in childhood obesity in the past three decades and twice the asthma rates since the 1980s.

About 18% of children in the U.S. are obese, up from 5% in 1974, the study said. Obesity accounts for about 10% of the US health costs. An estimated 9% of children have asthma, twice the rate it was in the 1980s. The breathing disorder persists into adulthood in about a quarter of children.

Genes may play a role in obesity and asthma, but environmental and social changes are behind the surge, researchers said. Modern life has brought fast-food, increase time spent indoors watching television or playing on the computer. ([“Chronic Illnesses on Rise](#),” **The Boston Globe, Angela Zimm, June 27, 2007**)

- If people keep gaining weight at the current rate, fat will be the norm by 2015, with 75% of U.S. adults overweight and 41% obese, U.S. researchers predicted. For their analysis, a team at Johns

Hopkins University in Baltimore examined 20 studies published in journals and looked at national surveys of weight and behavior published in the Journal of Epidemiologic Reviews.

They defined adult overweight and obesity using a standard medical definition call Body Mass Index (BMI). People with a BMI of 25 or above are considered overweight, while those with BMI of 30 or above are obese and at serious risk of heart disease, diabetes and some cancers. Finally, the report states, that obesity is likely to continue to increase and, if nothing is done, it will soon become the leading preventable cause of death in the United States. ([“Study Predicts 75% Overweight in U.S. by 2015,” Reuters, July 18, 2007](#))

Tom's Comments:

The above items under “Fast Facts” are additional examples of life-style issues that are discussed above.

ACCESS TO CARE

Fast Facts:

- The U.S. has a mixed public-private system of health insurance. It is comprised of the following:
 1. Federal Medicare programs, covering people aged 65 and over and those who have been disabled for two years or more (12% of population);
 2. State Medicaid programs, covering children from low income families and in some states their parents, as well as providing long-term care and cost sharing for acute care for Medicare beneficiaries with low incomes (13% of population);
 3. Voluntary employer-based private insurance, covering many working families (54% of the population);
 4. Individual insurance (5% of the population); and
 5. Uninsured (16% of the population).([Commonwealth Fund, 2007](#))

State Health Care Initiatives

Massachusetts' Universal Health Care Law – Is This a Template for Other States?

- I. The Massachusetts' Universal Health Care Law
 - A. A requirement that all individuals maintain creditable health insurance coverage
 1. The law defines creditable coverage very broadly to include most forms of individual and group health insurance.
 2. Residents must report their insurance coverage status as of December 31st of the previous year on the state tax forms.
 3. Residents who lack both coverage and a waiver will lose their personal exemption for their state taxes. They also will be fined one-half of the monthly premiums of the most affordable health plan.
 4. Law passed in April 2006, and enrollment began in May 2007. Effective July 1, 2007. Most health insurance offered will be considered minimal creditable coverage until January 1, 2009.
 - B. The creation of the Commonwealth Health Insurance Connector, which acts as a clearinghouse for insurance plans and payments.
 1. Commonwealth Care connects eligible citizens with approved health insurance plans and helps pay for them. Commonwealth Care is for uninsured people whose incomes fall within certain guidelines and who meet other qualifications.
 2. Commonwealth Choice offers new health insurance options to individuals and small employers that do not qualify for Commonwealth Care. The Connector works with major insurers to offer new, comprehensive plans.
 3. The state makes health insurance plans available to a resident who meets one of the following conditions:
 - a. Is unemployed
 - b. Is employed by a small business (with fewer than 50 employees) that offers health insurance through the Connector
 - c. Is not offered employer-subsidized health insurance through an employer with 50 or more employees
 - d. Is self-employed, working part-time or working for multiple employers

4. The Connector establishes premium subsidy levels for Commonwealth Care and affordability limits for individuals.
 5. The Connector makes health insurance portable by allowing employees to keep the same plan even if they leave an employer.
- C. The employer fair-share contribution
1. Massachusetts requires employers to make a fair-share contribution to their employees' health care plan. The law applies to all employers with 11 or more full-time employees (FTEs) (35 hours per week) in Massachusetts.
 2. To determine whether an employer's contribution is fair and reasonable, the employer must meet one of two tests for the period from October 1 to September 30:
 - a. Enroll at least 25% of FTEs in a group health plan and contribute to the plan
 - b. Offer to pay at least 33% of the premium cost of any group health plan offered to all FTEs who are employed more than 90 days
 - c. Employers that fail both tests will be assessed up to \$295 per FTE.
- D. A requirement that employers maintain section 125 cafeteria plans
1. Employers with 11 or more full-time employees that do not pay the full monthly cost of medical coverage for all employees must maintain a section 125 cafeteria plan that meets both IRS rules and Connector regulations.
 2. Enrollment not required until September 1, 2007
 3. The Cafeteria Plan must allow employees to pay for some or all of their health care coverage on a pretax basis.
- E. The free-rider surcharge on employers that do not maintain section 125 cafeteria plans and whose employees use at least \$50,000 of uncompensated medical care.
1. An employer's surcharge amount will depend on (1) the number of its employees, (2) the number of admissions and visits for each applicable employee, (3) the total state-funded health services provided to the applicable employees and (4) the percentage of employees for whom the employer provides health insurance.
 2. The charges range from 20% to 100% of the state's costs for the health services, depending on the state-funded costs and the size of the company.
- F. A requirement for employers to submit annual "Health Insurance Responsibility Disclosure" (HIRD) form to the Division of Unemployment Assistance.
- G. A requirement for health plans to extend coverage for young adults who lose dependent status.

1. Fully insured health plans that provide family coverage must cover young adults until the earlier of age 26 or two years after they lose dependent status.
 2. Effective July 2007, the Connector offers reduced-benefit plans for young adults up to age 26 without access to employer-based coverage.
- H. The Massachusetts law may face an ERISA challenge.
1. Under ERISA, states may not enforce legislation that “relate(s) to ERISA employee benefit plans.
 2. At particular high risk of ERISA preemption are
 - a. The employer mandate requiring covered employers to “offer” medical coverage to their employees
 - b. The fair-share contribution requirement and
 - c. The individual mandate requiring Massachusetts residents to have individual or group medical coverage that constitutes “minimum creditable coverage.”
- I. Insurance market reform
1. Merger of the small group and non-group insurance markets to pool the health care risks of approximately 750,000 people in the small-group market (1 – 50 workers), and 50,000 people in the non-group, or individual market.
 2. Premiums for both the small-group and non-group markets are based on a modified community rating – meaning that premiums are based on the average cost of health services for people in the combined pool but vary for people by certain demographic characteristics. In Massachusetts, premiums can vary by age, geography and family size (single, couple or family), but not by health status and gender.
- [“Massachusetts Universal Health Care Goes Live,”](#) Watson Wyatt, August 4, 2007)**

Ohio Health Insurance Plan Proposed

Recently, State Representative Armond Budish drafted a proposal that would make available to all Ohioans health insurance coverage. The plan would address the 1.3 million Ohioans without health insurance by:

- Requiring insurance companies to allow young adults through the age of 29 to remain on their parents’ insurance, which would cover 100,000 people.
- Changing the Medicaid eligibility rules to cover 400,000 more low-income adults by increasing children’s coverage to 300% of the poverty level and adults without children to 100% of the poverty level.

- Allowing (not mandating) 800,000 Ohioans to buy a private health-care plan negotiated through the Ohio Department of Insurance (state and federal money would subsidize monthly premiums for some).

The plan would cost \$4.1 billion to \$4.4 billion a year but does not call for a tax increase. State Representative Budish, with the assistance from the nonpartisan Health Policy Institute of Ohio, said the annual costs would be covered by:

- \$200 million in new health care fees paid by people joining the state negotiated plan
 - \$1.1 billion of federal Medicaid money. The federal government would need to grant a waiver to their Medicare regulations to allow Ohio to cover adults without children
 - \$2 billion in premiums
 - \$100 million in new tax revenue generated by the increase in insurance business
 - \$680 million as a result of an assessment on hospitals for what they now spend on care for the uninsured patients
 - \$320 million as a result of redirecting dollars the state currently reimburses hospitals for indigent care.
- (“[Ohio Health Insurance Plan Proposed](#)”, Naymik, Mark, The Cleveland Plain Dealer, July 27, 2007)

Tom's Comments:

In evaluating any universal health care coverage initiative you must first focus on the following key questions:

- Who is covered?
- What is covered?
- Who pays for it?

The ideal template to evaluate reform initiatives should include the following:

- How does it impact cost, access and quality?
- Does it promote innovation and efficiencies in our health care system?
- Is there a greater likelihood of better “value”, in the form of the optimum cost and quality as a result of the initiative?
- Does the initiative promote and enhance the effectiveness of wellness and disease management programs?
- Does the initiative promote personal health accountability?
- Are the resources identified to finance universal access sufficient and sustainable to ensure the long-term success of the initiative?

The primary focus of all of the state initiatives, proposed or instituted to-date, is to provide access to care for all of their citizens. The key challenge to the sustainability of such initiatives is their lack of focus on the cost of health care. Much of the sources of funding for these initiatives are the result of cost-shifting between the various stakeholders (egg., redirecting government dollars from hospitals; assessing employers and managed care organizations, individual insurance mandates, increasing costs of family coverage to cover dependents, etc.) or pooling of risks. While these approaches may address the immediate problems of access to health care services, it only represents a band-aid approach.

The sustainability of financing through cost-shifting is further jeopardized by the following:

- Reductions in federal assistance as a result of competing priorities
- Changes in guidelines relating to use of federal funds to finance such initiatives
- Employers' ability to pay for escalating health care costs, as they attempt to compete in a local, regional, national and now international marketplace
- Individuals' ability to pay for escalating health care costs as they attempt to financially survive in a difficult economic environment
- As discussed above, the potential impact of carving-out ERISA employers (larger self-insured companies) would have a major negative cost and access impact on the proposed state initiatives.

Achieving universal health insurance coverage would have a positive impact on cost of care, quality of care and access to care. Currently most of our uninsured receive care too late and in our most costly settings (egg. emergency rooms). If everyone in the state had health insurance they would potentially have access to preventive medicine and proactive disease management programs, both of which would have a positive impact on costs and quality.

There are many similarities between the various state initiatives. These initiatives also include a number of creative concepts that potentially could address some of the flaws at the state level that adversely impact cost and access to health care services.

Of particular note, will be the potential impact on cost, quality and access by the "Connector Type" structures within the states. Will these

structures be proactive facilitators or purchasers of healthcare services or will they just perform a “clearinghouse role?” There would be a greater likelihood of a positive impact on cost and quality if the “Connector Type” organizations play more of a proactive facilitator or purchaser role vs. more of a passive clearinghouse role.

As proactive facilitators or purchasers of health care services, the “Connector Type” organizations would have the ability to leverage their market and political power to demand better value in the health care marketplace. They would also be in a better position to facilitate the growth of wellness and disease management initiatives.

In developing a sustainable program, states must address some highly sensitive and political issues, all of which have the potential to have a significant impact on cost and quality of health care in both the short and long-run:

- A thorough and objective analysis of each of the state mandates should occur to ensure there is an appropriate balance between cost, quality and access issues
- A thorough and objective analysis as well as potential reform of the state insurance laws
- Focused initiatives to improve cost and quality of health care services. An example of such an initiative is included in the Pennsylvania Initiative that requires providers to report health care-acquired infections to a central body and to submit annual reports on error trends, all of which would be communicated to the public in a user-friendly format (**“Pennsylvania’s 2007 Health Care Proposal: Prescription for Pennsylvania”**), Families U.S.A., July 2007)
- A thorough and objective analysis of the diversion of government dollars from hospitals to help finance universal health care coverage. The diversion of dollars should not adversely impact inner-city clinics that serve as a cost effective quality vehicle in providing health care services to a population in need
- Medicaid must also enhance its efforts to reward hospitals and physicians for providing quality services. Medicaid must also find innovative ways to incent personal health accountability on the part of the recipients as well as implement proactive wellness and disease management programs. The potential vehicle for such initiatives could be managed care organizations, but it is important that the state plays an active role in monitoring their efforts.

- If the state's purchasing cooperative is only made up of those individuals that can not afford insurance in the marketplace as a result of low incomes or high health risks, there is a danger that this pool of individuals would be very costly and would need to be subsidized to a high degree in some manner.

While I am not an advocate of a one-payer system (egg. Medicare for all), ideally, universal health care coverage should be addressed at the national level. States have many obstacles in achieving a sustainable system (egg. ERISA issues, financing, economies of scale, states balance budget requirements, etc.). If the federal government took ownership of universal access they would be forced to address some of the fundamental problems we have in our health care system, such as federal laws that limit the effectiveness of wellness and disease management programs (See discussion under "Quality" section of this report), a Medicare payment system that does not incent innovation, cost control or better quality and which in turn contributes to the lack of value in our health care system, etc.

Finally, while discussion and debate at the state level is important, it may be best to initially develop a comprehensive vision/plan in regards to universal health care access. Once developed, it may be prudent to first address those facets of the plan that would have a positive and sustainable impact on the cost of health care in Ohio. The other facets of the plan could be delayed as we further analyze and evaluate the results of other states initiatives (egg. learn from their successes and failures). Remember, Ohio is required to have a balanced budget by law. Any shortfalls in dollars needed to finance universal access would have to come from other budgetary areas, such as education.

Ohio Pushes Long-term Care Insurance as Medicaid Reels

On September 1, 2007, Ohio will roll out a new partnership program, under which people who buy qualifying long-term care insurance, which covers a person if he or she needs care in a nursing home, assisted-living center or at home, automatically could qualify for Medicaid if they still should need it to cover their care-related expenses. In addition, long-term care insurance holders would not need to spend down all their assets before qualifying for Medicaid coverage, as they must do now.

For example, if a person buys a \$100,000 long-term care insurance policy and needed more than \$100,000 in care, the dollar-for-dollar partnership program would allow that person to retain \$100,000 of their assets and still qualify for Medicaid. For the 406,000 Ohioans who already have long-term care insurance, the state will allow those people to switch to a plan that is part of the partnership program.

Until now, such programs were limited to California, Connecticut, Indiana and New York. But the federal government last year voted to allow other states to create partnership programs as well.

The idea, said Ohio Department of Insurance Director, Mary Jo Hudson, is to steer more people away from an already-struggling Medicaid program that is destined to come under more pressure as baby boomers age.

In the past as people aged, they sometimes gave away their assets early so they could save their own money and qualify for Medicaid when they needed long-term care, said Marty Puin, of Marty Puin & Associates Inc., a long-term care insurance broker in Lyndhurst, Ohio.

However, that practice has become more difficult with the passage of the 2006 federal Deficit Reduction Act, which tightened eligibility for Medicaid. The government will now look back five years into a person's financial history, instead of only three years, to make sure people aren't hiding assets to qualify for Medicaid, said Mr. Puin, who is also on the board of the American Association of Long-Term Care Insurance in Westlake Village, California. (["States Pushes Long-term Care Insurance as Medicaid Reels," Shannon Mortland, Crain's Cleveland Business, July 16-22, 2007](#)).

Tom's Comments:

It is inevitable that given the budgetary challenges, states can no longer be the dumping ground for creative estate planning devices. The proposed changes will make long-term care insurance more attractive to the purchasers, but there still needs to be some fundamental changes to this insurance product to make it more market attractive. Finally, there is a fear factor by potential purchasers that their long-term care insurance carrier may not be around (egg. bankruptcy, etc.) when it is their time to use the funding.

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 2008 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 28th & October 30th, 2007
Strosacker College Union
120 E. Grand St. Berea, OH 44017**

Or

**MBA Open Houses
6 p.m. / August 15th & November 1, 2007
Landmark Center
25700 Science Park Drive #100
Beachwood, OH 44122**

Please call for more information 440-826-2392