

Baldwin-Wallace College

HEALTH CARE REPORT

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

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

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 Health Care Report's website.

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

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INTRODUCTION

Tom's Take on Health News of Note

This issue of the Health Care Report takes on themes of **accountability, leadership and consumer empowerment**. Together, the integration of these themes could dramatically improve healthcare costs and quality in the U.S.

Specifically, can Congress show true **leadership**, by taking on real Medicare reform? The essence of that reform evolves around the immediate transformation of Medicare's payment methodologies to one that fosters provider **financial accountability** for delivering cost effective quality healthcare services.

Can we as a society attack unhealthy lifestyles by holding individuals **financially accountable** for their lifestyle choices? Are we ready to advance the role of the **empowered consumer**, in order foster true competition between providers and innovation both from a cost and quality perspective?

Dealing with these issues will be socially and politically tricky, but the results will be worth the effort.

Quarterly Rave

Some Managed Care Organizations are publishing real provider cost information for their members:

"One giant step for the consumer!"

Some managed care organizations have started providing user-friendly cost and quality hospital and physician data to their customers (individual members and employers). Historically, hospitals, physicians and some

MCOs have resisted the distribution of such data to MCO customers (members and employers). In fact, in many hospital contracts the distribution of such information was prohibited. Given the healthcare cost pressures that both members and employers are facing, the tide is now turning.

In many ways the nail in the coffin of such prohibitions is coming from the federal government which is now viewing such prohibitions of distribution of cost and quality information as anti-competitive. The new ACO rules, in fact, expressly prohibit ACOs from contractually limiting such distribution.

This data would include actual total costs (not charges) for the healthcare services being provided. For example, consumers and employers should be able to compare the cost of a medial meniscus tear (torn knee cartilage) between providers. This cost would include all services provided (e.g. facility and physician, etc.). While the numbers of procedures that can be compared are limited at this time, it is a start.

As noted by economist, James W. Henderson, PhD, "Decisions must be made by well-informed, cost-conscious consumers. Motivated by self-interest, and adequately informed about treatment alternatives, cost-conscious consumers will economize because they will personally benefit from such behavior. The patient/buyer must be an active participant in the decision-making process if cost-containment is to be achieved." (*Health Economics and Policy, Fifth Edition, James W. Henderson, South-Western Cengage Learning, Page 90*)

This information will foster true competition between providers and innovation both from a cost and quality perspective. That competition will result in both winners and losers from a provider perspective. Those providers that can meet the value demands of the marketplace in the form of better quality and cost will survive and prosper. Those providers that cannot meet the needs of the marketplace will either rise to the challenge, find a market niche in which they can compete, or not survive. Ultimately, though, this is a victory to consumers, payers (employers/government) and value driven providers.

Quarterly Rant

Unhealthy lifestyles that cause either directly or indirectly chronic diseases

"We can no longer afford to enable poor lifestyles"

As we all know, growth in healthcare spending outpaces growth in the rest of the economy. “In the past 20 years health care spending has grown at an annual compound rate of 6.6% compared to the GDP (less health care) that grew at only 4.5% per year. Every year health care spending growth on average exceeds GDP growth by 2.1 percentage points. If the trend continues for the next two decades, the health care sector will absorb almost 25% of GDP by 2030.” (Health Economics and Policy, Fifth Edition, James W. Henderson, South-Western Cengage Learning, Page 5)

On the surface this growth in healthcare spending (including the percentage of the GDP) may not seem to be a real problem, until one focuses on the negative impact health care costs have on our national debt (Medicare), state budgetary priorities (Medicaid) and overall job creation outside of the healthcare sector.

What can be done? As we have discussed in prior issues of the Health Care Report, escalating health care cost is a function of a number of factors. One particular cost driver is the subject of this “Rant,” that is, unhealthy lifestyles that cause, directly or indirectly, chronic diseases. The following excerpt from the McKinsey Quarterly highlights the problem.

“In recent decades, the nature of medical risk in the United States has shifted dramatically. About two-thirds of all deaths in the United States now result from chronic diseases most often induced by behavior and lifestyle—for instance, obesity and related chronic conditions, type 2 diabetes and related conditions, smoking-related cancers, and alcohol-related liver disease. By contrast, before the 1940s or thereabouts, medical risk had largely been concentrated in random, infrequent, and catastrophic events such as injuries, congenital conditions, or contagious diseases. Health insurance was designed, at its inception, to address these kinds of events.

The increasing prevalence of chronic disease has significant implications for managing health care costs. For one thing, advances in medical technology and treatments mean that people with such conditions can now live much longer, though at a substantially higher financial cost.

Obesity—a widespread chronic condition linked to others, such as diabetes, heart and circulatory maladies, orthopedic problems, and certain cancers—provides a telling example. The incidence of clinically defined obesity in the US adult population has more than doubled, to 34 percent, since 1980. The average annual cost of health care claims associated with morbidly obese patients (the fastest-growing category of

obesity) is more than \$7,500 a year, nearly twice the average for adults who are not obese. To put these figures in perspective, we estimate that the medical costs associated with clinically obese patients represent about 10 percent of the sum spent on health care premiums and that reducing obesity to the 1980 level would generate \$60 billion a year in net savings." ("Three imperatives for improving US health care," Paul D. Mango and Vivian E. Riefberg, McKinsey Quarterly, December 2008) https://www.mckinseyquarterly.com/Three_imperatives_for_improving_US_health_care_2274

As noted above, given the impact of escalating healthcare costs on jobs and the debt burden of future generations of Americans it is imperative that we proactively address escalating health care costs. Per the Center for Disease Control, lifestyle disease directly or indirectly impacts 50 – 70% of our health care costs. Now more than ever we need to develop a health care system that does not enable poor lifestyle choices.

Fortunately, the tide appears to be turning, and more attention is being focused on lifestyle issues and personal accountability. "As Aon Hewitt notes, "Workers who choose not to participate in employee wellness programs or make unhealthy choices are being hit with higher health insurance premiums, deductibles and out-of-pocket expenses, said Dr. Paul Berger, chief medical officer at Aon Hewitt, a human resources and benefits consulting company.

Meanwhile workers who participate in wellness programs are being rewarded with incentives, such as gift cards and contributions to health reimbursement accounts.

Such initiatives and penalties are expected to expand because of continuing increases in healthcare costs and changes under the federal health-care reform law. Employers can provide discounts or penalties of up to 20 percent on employees' health insurance premiums for participation in wellness programs, including programs requiring them to quit smoking and lower their blood pressure and body fat, or face higher premiums. Under the health-care law, that maximum will rise to 30 percent in 2014, according to Aon Hewitt.

Such penalties are legal and governed by federal and state laws, including genetic anti-discrimination laws, the Americans with Disabilities Act and the Health Insurance Portability and Accountability Act, according to J.D. Piro, national practice leader for Aon Hewitt's health-care legal consulting group.

But he noted that workers have to be offered alternatives when there are penalties. If a worker's cholesterol level is too high and there's a requirement to lower it or face a higher premium, and that's unreasonably difficult for a worker, that worker must be offered an alternative such as taking cholesterol medication, he said." ("Bosses to employees: Shape up or pay up," Francine Knowles, Business Reporter, Suntimes.com, August 14, 2011)

<http://www.suntimes.com/news/metro/6859055-418/bosses-to-employees-shape-up-or-pay-up.html?print=true>

Cover Story

Real Medicare Reform

"True Leadership is Needed"

Background

"Medicare was established in 1965 as a federal social insurance program to provide what the private insurance market did not: adequate, affordable health insurance for America's elderly population. Prior to Medicare's enactment, only about a half of the elderly population in America had health insurance, and they paid close to three times as much as younger people while having half as much income.

Serving 19.1 million in 1966, Medicare enrollment reached 46.3 million American in 2009; over 15 percent of the total population (Source: 2010 Annual Reports of the Board of Trustees of the HI and SMI Trust Funds). This figure included over 38 million senior citizens and approximately 8 million permanently disabled, including over 300,000 suffering from end-stage kidney failure. Although 75 % of the beneficiaries of Medicare are between the ages 65 and 84, the disabled and those over 85 are the fastest growing segments. In 1966, the first complete year of the program, total Medicare spending was \$1.6 billion. Medicare spending reached \$509 billion in 2009 and is expected to grow to \$895 billion by 2019 (2010 Medicare Trustees Report).

Each year, the Trustees Report projects the year that the HI Trust Fund will become insolvent. The HI Trust Fund began running deficits in 2008 and according to the 2011 report; reserves are projected to be depleted by

2024. At that point, if no changes are made, scheduled HI income will cover 90 percent of estimated expenditures.

Put another way, when HI Trust Fund reserves are depleted in 2024, payments to doctors and hospitals can still be made, but only from current payroll tax contributions; these tax contributions will only be sufficient to cover 90 cents on the dollar. Congress could make up this gap through direct appropriations."

("Medicare Finances: Findings of the 2011 Trustees Report"), Sabiha Zainulbhai and Lee Goldberg, Health Policy Brief, National Academy of Social Insurance)

http://www.nasi.org/sites/default/files/research/Medicare_Finances_Findings_of_the_2011_Trustees_Report.pdf

Can we have an honest debate on real Medicare reform

Like most Americans, I did not like the political wrangling in Washington relating to the national debt and the failure of the "supercommittee." ("Panel Fails to Reach Deal on Plan for Deficit Reduction," Jennifer Steinhauer, Helene Cooper and Robert Pear, The New York Times, November 21, 2011)

(<http://www.nytimes.com/2011/11/22/us/politics/death-of-deficit-deal-opens-up-new-campaign-of-blame.html>) There was one positive that came out of this "political tug-of-war": increased public awareness as it related to our national debt and the impact that Medicare has on it. The public needs to recognize that we do not have unlimited resources to meet all of our societal needs. As a result of this scarcity of resources, we need to make choices, and those choices can be very difficult.

Ultimately those difficult choices will focus on the entitlement programs, specifically Medicare and Medicaid. Medicare, especially, has always been the "untouchable" federal program, especially given the politically powerful senior population.

I believe, historically, that seniors have been used as a political pawn by both parties when it comes to Medicare reform. Each party accuses the other of attempting to derail Medicare at the expense of seniors' health, welfare and security. There has never really been an honest and forthright discussion of both the challenges that Medicare faces and the alternatives to address the problems.

As discussed in a prior issue of the BW Health Care Report (**April/May 2010**) http://www.bw.edu/academics/bus/programs/hcmba/nl/archives/QUARTERLY_HEALTH_CARE_REPORT_April.pdf, Congress has known about the problems facing Medicare since the 1970s, and they have not been able to muster the political courage to address them.

I am also very disappointed, but not surprised, by the failure of AARP to truly represent current and future seniors in a responsible manner. Instead of attempting to stifle national debate on Medicare reform, AARP needs to recognize the importance of such discussions and debate in order to foster a new era of openness, which would benefit not only seniors, both past and present, but society in general.

Recently, for example, I had an opportunity to teach a class on healthcare policy in the Institute for Learning in Retirement program at Baldwin-Wallace College. The attendees of the class were all seniors (approximately 30) and the class discussion focused on health policy related issues, including Medicare reform. The discussion was rich and insightful, and it gave me an appreciation of the experience and energy that seniors can bring to a national dialogue on real healthcare reform.

While this group of seniors had a strong interest in cost, quality and access issues relating to their own generation, they were also very open to meaningful discussion relating to end-of-life issues, personal accountability, etc. In fact, the seniors were most passionate about making sure that we are building an affordable quality based healthcare system for their children and grandchildren.

Who are the High Spenders?

“Medicare spending is highly concentrated among a small group of people who have significant medical needs. Ten percent of beneficiaries accounted for 60% of spending, while 22% of beneficiaries incurred less than \$1,000 each in Medicare costs (accounting for only 1% of program spending), and 12 percent incurred no costs at all (Kaiser, 2010).”

(“Medicare Finances: Findings of the 2011 Trustees Report”), Sabiha Zainulbhai and Lee Goldberg, Health Policy Brief, National Academy of Social Insurance)

http://www.nasi.org/sites/default/files/research/Medicare_Finances_Findings_of_the_2011_Trustees_Report.pdf

In order to address Medicare reform we must focus on the real cost drivers: chronic diseases and end-of-life care

Chronic Diseases

“While the highly skewed distribution of spending has been markedly persistent over time, the proportion of expenditures accounted for by the highest spending groups has actually declined somewhat over the past two decades as high medical spending has spread to a broader swath of the population. For example, spending by the top 5 percent of spenders

declined from 56 percent in 1987 to 48 percent in 2008. This flattening of the spending distribution is consistent with the well-documented increase in population risk factors – most notably, obesity – and a concomitant increase in treated disease prevalence for chronic conditions that are clinically linked to these risk factors, such as hypertension, diabetes and hyperlipidemia.

People with at least one chronic health condition were two to four times more likely than the general population to have spending in the top 5 percent, with the risk increasing as the number of chronic conditions rose. The link with obesity-related conditions was also evident in this work. Nearly half of all people in the top 5 percent of spending reported having hypertension, one third had lipid disorders (high cholesterol), and more than one quarter had diabetes.

Chronic conditions are also a likely reason why some people have high spending over an extended period, particularly when multiple chronic conditions are present. A recent analysis of MEPS data by Cohen and Yu provides evidence of the degree of persistence from one year to the next in spending patterns for a given individual (Figure 6).⁴ They found that 18 percent of people who were in the top 1 percent spending category in 2007 remained in the top spending category in 2008. For the top 5 percent and top 10 percent spending categories, the comparable retention figures were 31 and 43 percent, increasing to nearly two thirds retention from year to year among those in the top 30 percent of spending.

End-of-Life Care

“Between 27.2 and 30.6 percent of Medicare expenditures in a given year were for the 5.0 percent of beneficiaries who died during the year, and this share of Medicare spending has been quite constant over a couple of decades. About half of spending in the last month was for hospital care, and one in five patients die in an intensive care unit (ICU). Of those who die in an ICU, their average stay was about 13 days.” (Containing the Growth of Spending in the U.S. Health System,” Urban Institute, Health Policy Center, October 2011)

<http://www.urban.org/UploadedPDF/412419-Containing-the-Growth-of-Spending-in-the-US-Health-System.pdf>

How can we effectively address chronic diseases and end-of-life care?

“The systems approach”

In order to effectively address chronic diseases and end-of-life care, we must have a “systems approach” to problem solving by looking at these cost drivers from a holistic perspective.

Systems thinking has been defined as an approach to problem solving, by viewing "problems" as parts of an overall system, rather than reacting to specific part, outcomes or events, as in this case, “chronic diseases” and “end-of-life care.”

Chronic Diseases

Let us first look at chronic diseases. As stated above, we know that chronic diseases are a major cost driver in healthcare and especially in Medicare. Let us start by addressing the following questions:

- Why are chronic diseases more of a cost driver in the U.S. vs. other countries?
- What are the major contributors to chronic diseases?
- Are there fundamental issues relating to our society in general as well as the U.S. healthcare system that are the root cause of our chronic disease epidemic?
- From a “systems” perspective, what fundamental changes can we make in our healthcare system to create an environment that minimizes the negative impact of chronic diseases?

Why are chronic diseases more of a cost driver in the U.S. vs. other countries? What are the major contributors to chronic diseases?

The combination of poor societal lifestyles and a lack of a comprehensive and coordinated approach to preventing and managing chronic diseases are the major reasons why the U.S. is plagued by higher healthcare costs related to chronic diseases vs. other countries.

As noted previously in this issue of the Health Care Report, per the Center for Disease Control, 50-70% of the U.S. healthcare costs are directly or indirectly related to chronic diseases that are lifestyle related (e.g. obesity, poor diet, smoking, alcohol and drug abuse, lack of exercise, etc.). The combination of bad lifestyles, the lack of a true primary care system, and a health care system that is dominated by our medical technology arsenal are the reasons we have such high health costs relating to chronic diseases.

Are there fundamental issues relating to our society in general as well as the U.S. healthcare system that are the root causes of our chronic disease epidemic?

There are many positive aspects to health insurance. Ultimately, it provides access to healthcare services to millions of Americans that otherwise could not afford it. **There is a downside to health insurance, though, in that it insulates the consumer from the true cost of healthcare services.** In economics, we call this “moral hazard.” Moral hazard arises since insurance reduces the net out-of-pocket price of medical services and thus increases the quantity demanded.

Another negative side effect of health insurance is that it can insulate an individual from the financial consequences of bad lifestyle choices. When risk is pooled, as in the case of employer insurance (especially for large size groups), and for the Medicare and Medicaid programs, the healthcare cost risks of poor lifestyles are spread across the many people in a group/program that have healthier lifestyles or overall lower healthcare costs.

Finally, instead of addressing chronic diseases through better life-styles and a strong primary care system, the U.S. uses high-priced technology as the cure all. Both private health insurance and Medicare and Medicaid, as they are structured today, further exacerbate the chronic disease costs related to poor lifestyles. Historically, our public and private insurance programs payment policies did not adequately pay primary care and was the major catalyst for the fragmented technology dominated healthcare system that exists today.

From a “systems” perspective, what fundamental changes can we make in our healthcare system that will create an environment that minimizes the negative impact of chronic diseases?

Given the above, there needs to be a recognition that we need to find a way to link poor lifestyle choices with financial accountability as well as develop a comprehensive and coordinated primary care system.

As it relates to poor lifestyles, if that financial accountability linkage can be made, there would not only be a fairer distribution of healthcare costs among consumers, but there will also be an increased likelihood of improved societal lifestyles. As noted previously in this Health Care Report, employers have started to take a proactive role in this arena by not hiring smokers and charging higher premiums to employees over a certain BMI level.

There also needs to be a recognition that any real societal solution to the lifestyle dilemma cannot just focus on the “stick”, there also needs to be appropriate “carrots” in place. There needs to be available programs, possibly with incentives, that both educate and help facilitate healthy lifestyles (e.g. smoking cessation, nutrition, exercise, etc.).

In addition to addressing the unhealthy lifestyle issue, we need to financially incent the creation of a comprehensive and coordinated primary care system that is focused on prevention and management of chronic diseases. In theory, Accountable Care Organizations and Medical Homes models are potential vehicles to facilitate the prevention and management of chronic diseases. I state in theory, since as discussed previously in this Health Care Report, the key to success of these initiatives will be the rapid evolution of Medicare's current payment methodologies that rewards overutilization, to one that rewards success but also in a financial framework that incents real "accountability" on the part of providers of care.

End-of-life Care

The high cost of end-of-life care is often cited as the major driver of our societal healthcare costs. As noted above, end-of-life care is indeed a major cost driver, but it comes in second to lifestyle related chronic diseases as a major cost driver.

As previously stated using systems thinking as an approach to problem solving, how would this impact our discussion relating to "end-of-life care."

Let us start by addressing the following questions:

- Why is end-of-life care more of a cost driver in the U.S. vs. other countries?
- What are the major contributors to end-of-life care costs?
- Are there fundamental issues relating to our society in general as well as the U.S. healthcare system that are the root cause of our high end-of-life care costs?
- From a "systems" perspective, what fundamental changes can we make in our healthcare system to create an environment that optimizes the high cost of end-of-life care without compromising quality-of-life?

**Why is end-of-life care more of a cost driver in the U.S. vs. other countries?
What is the major contributor to end-of-life care costs?**

The combination of Americans' (or maybe more their families) unwillingness to let go of "life," along with our arsenal of technology, highly trained physician specialists and our nation's "blank check book," feed into our high cost of end-of-life care.

Are there fundamental issues relating to our society in general as well as the U.S. healthcare system that are the root cause of our high end-of-life care costs?

It is often said, that in other countries, people recognize that death is a natural part of life, but in the U.S. we have a fascination with immortality. While this may be true, we cannot realistically change the views of death that are deeply imbedded in different countries' cultures, including our own.

In the U.S. we have always had a difficult time discussing end-of-life issues. While it may be difficult within families, it is even more of a taboo on a political basis, and even in the physician office. As we recently rediscovered in the healthcare reform debate, even rational discussion about facilitating the education of Medicare members and their families regarding their end-of-life options has turned into "death panels."

Ultimately, there needs to be societal recognition of the 1,000 pound gorilla in the room; the escalating cost of end-of-life care cannot be sustained. As part of this recognition, there needs to be a debate on how best to address this issue that would make sense in the U.S. culture.

Finally, as with chronic diseases, both private health insurance and Medicare and Medicaid, as they are structured today, further exacerbate the costs relating to end-of-life care. Our public and private insurance programs (especially Medicare) payment policies finance the high costs of end-of-life care. Medicare pays for end-of-life care without regards to appropriateness and clinical effectiveness which financially incepts overutilization of high-cost technology, and many times has a negative impact on the quality of life of the dying.

Also as previously discussed in this Health Care Report, as a result of lack of financial responsibility on the part of the consumers and their families (moral hazard), there is an overutilization of high cost healthcare services at the end-of-life.

From a "systems" perspective, what fundamental changes can we make in our healthcare system to create an environment that optimizes the high-cost of end-of-life care without compromising quality of life?

As we have stated repeatedly in the Health Care Report, every society, including the U.S., has a scarcity of resources. As a result of this scarcity choices have to be made, and sometimes those choices can be very difficult.

On a personal basis, I don't believe that "rationing" of healthcare services would work in the U.S. culture. I do believe that we can have a rational approach to end-of-life care in the U.S. that includes education, alternative approaches to end-of-life care (e.g. hospice), and some form of increased financial accountability.

The following are potential approaches to addressing the high cost of end-of-life care:

- Medicare should pay for periodic individual and family counseling relating to end-of-life issues for all Medicare recipients (THIS IS NOT A DEATH PANEL);
- As part of the overall education of Medicare members there needs to be a focused strategy for increasing awareness of hospice programs and services (including site visits);
- Medicare payment policies need to facilitate the collaboration of acute and hospice services; and
- While highly controversial, there needs to be some form of financial accountability for the consumer linked into end-of-life care that discourages overutilization of unnecessary services

What road should we take to reform Medicare?

As noted above, any road that is taken to truly impact the high cost of Medicare must address chronic diseases and end-of-life care. Some potential roads include the following:

- Free market approach to Medicare reform
- A rationalizing approach to Medicare reform
- A coordinated hybrid approach to Medicare reform

The case for the free market approach to Medicare reform

Recently, Congressman Paul Ryan proposed a free market approach to Medicare reform. Under the broad title of the Health Care Security Act, the proposed legislation states the following:

“For future Medicare beneficiaries who are now under 55 or younger (those who first become eligible on or after 1 January 2021), the proposal creates a standard Medicare payment to be used for the purchase of private health coverage. Currently enrolled Medicare beneficiaries and those becoming eligible in the next 10 years (i.e. turning 65 by 1 January 2021) will see no changes in the current structure of their Medicare benefits. The payment will be made directly to the health plan designated by the beneficiary (similar to the administration of the refundable health care tax credit), with the beneficiary receiving any leftover amount as a payment from the health plan, or assuming financial responsibility for any difference in the payment and the total cost of the

premium. This allows the Medicare beneficiary to invest the leftover amount in a Medical Savings Account [MSA] to pay for other medical expenses, or to purchase long-term care insurance.

Each Medicare beneficiary becomes eligible for the payment by enrolling in a health insurance plan. Medicare will publish an annual list of plans that are “Medicare certified.” Medicare enrollees are able to use their payment to pay for one of the Medicare certified plans, or any other plan, such as those offered by former employers or available from the private market.”

<http://www.roadmap.republicans.budget.house.gov/plan/#Healthsecurity>

The free market approach to Medicare reform has a number of inherent advantages including its reliance on competition between managed care plans and the financially engaged consumer that would facilitate competition between providers of care to provide cost effective quality services to Medicare members. Using private sector examples, competition along with financially engaged consumers fosters the following:

- Competition between suppliers of services to meet the demands of the purchasers will foster innovation, efficiency and value
- Competition takes production out of the hands of the less efficient and places it in the hands of the more efficient – constantly promoting more efficient methods of production
- Private sector examples (computers, cars)

The challenge with the free market approach to Medicare Reform, even though it may promote the most efficient allocation of resources is that it has the real potential of creating equity issues in the market place. While there could be programs in place to address these equity issues (tax credits, etc.), ultimately there will be some disparities.

Is it rationing or a rational approach to Medicare reform?

“Even though U.S. spending on medical care exceeds that of any other country using virtually any metric imaginable, there is not enough money or resources to provide everybody with the medical care they desire. In a world characterized by scarcity, how do we determine who gets care and who does not? If we are unwilling to let the market price ration resources, we must come up with another mechanism. The dilemma we

face today stems from our unwillingness to establish a formal rationing mechanism. Other countries, particularly in Europe, have established formal guidelines that determine who receives a particular medication or treatment and under what circumstances they receive it. A drug treatment that is appropriate for a young and otherwise healthy patient may be considered inappropriate for an elderly patient with a history of heart disease or stroke. The younger patient would receive the treatment and probably recover, but the older patient would be provided an alternative treatment and possibly die.

Is it ethical to withhold treatment from critically ill patients? Clearly most medical providers consider it unethical to withhold treatment if the primary reason is financial. However, most providers do not consider it unethical when patients and treatments are prioritized according to comparative evidence. The problem most providers have with the current ad hoc system of rationing is that the decision is usually made under conditions of medical urgency.

The U.S. health care systems ration medical resources, a statement that is also true for every government-run system throughout the world. The difference is that most of our foreign neighbors are more open about the rationing mechanism they use, and as a result, rationing has been subjected to a national debate. At some point, we are going to be forced to admit that rationing occurs in the United States. Only then will we be able to move beyond the arbitrary guidelines of demand management to establish national norms based on medical evidence." (H – pg. 107-108). ("Who Gets Health Care? Rationing in an Age of Rising Costs," Geeta Anand, Wall Street Journal, Four Part Series, September 12 – 23, 2003)

"In the U.S. health care system, and in those of many other countries, the care of dying patients is generally not performed well, with pain and other distress frequently undertreated and patients' preferences not respected. Most of 2.5 million deaths each year in the United States occur in institutional settings (45% in hospitals and 22% in nursing homes) and over 25 percent of Medicare expenditures go to beneficiaries' final year of life. Moreover, researchers have found that the pain and other kinds of distress that commonly occur among dying patients are frequently undertreated in the U.S. Medicare's hospice benefit, though intended to facilitate palliative care (relief or prevention of pain and suffering at the end of life is limited to patients who forgo other treatment for their terminal illness; the benefit is used by fewer than 40 percent of dying patients, often only in the last few days of life.

England's evidence based End of Life Care Strategy could prove instructive. This issue brief discusses the origins, content, and implementation of the strategy, as well as its potential impact. Both England and the United States struggle with similar challenges, including looking beyond the province of hospice and palliative care specialists and initiating palliative services before the patient's final days. Aspects of the English approach that may be useful in the United States include strategies to help physicians recognize when patients are entering a trajectory that may end in death, the use of "death at home" as a metric for measuring progress, improving the skills of clinical and care giving personnel through Web based training, and developing a national improvement pathway." ("England's Approach to Improving End-of-Life Care: A Strategy for Honoring Patients' Choices," Bradford H. Gray, Ph.D. http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/Jul/1527_Gray_Englands_approach_endoflife_care_intl_brief_v2.pdf

Will this rationalizing approach to Medicare reform work in the U.S.? It may be questionable, although given the current out of control cost trends for Medicare, it may be inevitable.

A coordinated hybrid approach to Medicare reform

Is there an alternative to the two extreme approaches to Medicare reform that are noted above (Free market and Rationalizing services) that would not just represent a compromise, but a real value added? Per our prior "systems approach" discussion relating to chronic diseases and end-of-life care, as well as the topics covered earlier in this Health Care Report, any such "Coordinated Hybrid Approach" to Medicare reform must address the following:

- Lifestyle accountability
- Financial engagement on the part of the consumer of healthcare services
- Real provider cost (and hopefully quality) information that will foster true competition between providers and innovation both from a cost and quality perspective.
- The establishment of a comprehensive primary care system that both helps prevent and manages chronic diseases
- Payment for periodic individual and family counseling relating to end-of-life issues for all Medicare recipients
- Focused strategy for increasing awareness of hospice programs and services (including site visits)

- Payment policies that would facilitate the collaboration of acute and hospice services
- Some form of financial accountability for the consumer linked into end-of-life care that discourages overutilization of unnecessary services
- An aggressive timeline for the implementation of payment methodologies that would lay the foundation for a true “health system” vs. the costly “sick system” that exists today. The common denominator in all of provider payment methodologies should be a risk component that rewards success and promotes financial and quality accountability.

Each of the bullet points, noted above, could be addressed by means of a free market or a governmental approach to Medicare Reform. It also would make sense for the government to facilitate alternative approaches to Medicare Reform that could be delivered through private sector Medicare Advantage programs.

Conclusion

Ultimately there is no silver bullet to addressing Medicare Reform, but coordinated strategies can be implemented to make a real difference from a cost and quality perspective. Any of the three approaches noted above (free market, rationalizing, and hybrid) could potentially effectively address the high cost of chronic diseases and end-of-life care over a short and long-term basis. What is certain is that Medicare, as it exists today, not only will not effectively address the high cost of chronic diseases and end-of-life care, it will actually make it worse.

Finally, as noted earlier in this Health Care Report, Medicare, by far, is the biggest payer of health services and, as a result of this financial leverage, is the major influence on our current healthcare system. If real Medicare reform takes place it will have a ripple effect on private sector managed care organizations (MCOs) that focus on the under 65 population. These private sector MCOs will follow Medicare’s lead, particularly regarding reimbursement methodologies, since they lack the financial leverage to effectively influence provider behavior on their own.

INTERNATIONAL

The following are interesting websites relating to international healthcare systems. As we look to ways to reform Medicare, we may be able to get additional insights from other countries:

- <http://www.kaiseredu.org/Issue-Modules/International-Health-Systems/Overview.aspx>
- <http://healthcare-economist.com/category/international-health-care-systems/>
- http://www.medscape.com/viewarticle/703712_sidebar1

NATIONAL

Managed Care Organizations' Response to Health Care Reform

As noted in the September/October 2010 issue of the Health Care Report (http://www.bw.edu/academics/bus/programs/hcmba/nl/archives/QHC_R_Sept_2010.pdf) the passage of The Affordable Care Act (ACA) will impact the future role of MCOs in a number of ways. Specific parts of the law that will have the most impact on MCOs include the following: limitation relating to medical loss ratio; health insurance exchanges and regulations relating to health risk underwriting.

The world of the MCO is also changing from a number of other perspectives. Large integrated healthcare systems are becoming more of the norm in communities throughout the country. These integrated systems will gain even more market power as a result of passage of Accountable Care Organizations. Some of these integrated systems will, over time, also market directly to employers (mostly large self-insured employers) or large purchasing coalitions as direct providers of healthcare services, and as a result minimize or eliminate the need for MCOs in those cases.

Some MCOs, especially in large metropolitan areas, will enter into exclusive contracts with Accountable Care Organizations using some form of risk arrangements as the primary form of payment (bundled payments, global fees, episode payments, capitation, etc.). These new products would mirror the HMO products of the 1990s that in most cases were only successful on the West Coast and part of New England.

Some MCOs will also look to enter into the provider side of healthcare. MCOs have the resources, technology and expertise to have an impact in selected geographic areas as well as medical services niches to be successful.

This would not be the first time that for-profits or insurance companies attempted to enter the provider world. During the 1990s, for-profit corporations such as Columbia HCA, HealthSouth and MedPartners shook up the provider world by aggressively acquiring hospitals, outpatient clinics and physician practices throughout the country. The arrival of Columbia HCA in many local marketplaces was a key catalyst of many of the non-profit hospital mergers that occurred throughout the country (including in Northeast, Ohio).

Blue Cross & Blue Shield of Ohio (the predecessor to Medical Mutual of Ohio), made headlines by acquiring hospitals in Toledo as well as northeast Ohio. Blue Cross & Blue Shield of Ohio was to become the health insurance arm of Columbia HCA, which would have evolved to a Kaiser like model. All of this never resulted because of legal issues at both Blue Cross & Blue Shield of Ohio and Columbia HCA. Ironically, HealthSouth also ran into legal issues with Medicare that also derailed their plans on becoming a major player in the outpatient clinic arena. Fast forward to 2011, "Recently, Pittsburgh insurer Highmark Inc. (part of the Blue Cross & Blue Shield family), struck a deal to acquire the second largest hospital chain in its region, an ambitious, controversial step that would further blur the lines between those who pay for medical care and those who provide it.

Under the tentative plan, nonprofit Highmark will pump as much as \$475 million into the five hospitals West Penn Allegheny Health System, which has been operating in the red for the past five years."

http://online.wsj.com/article_email/SB10001424052702303627104576413580875856442-1MyQjAxMTAxMDAwMzEwNDMyWj.html#printMode

One acquisition does not make a trend, but in various forms we are already seeing MCOs starting to enter into the provider market. In some cases it is niche markets, such as base-line primary care services that focus on wellness and prevention.

Another new entrant in the primary care market is Wal-Mart. <http://www.kaiserhealthnews.org/Stories/2011/November/09/walmart-primary-care-medical-services.aspx?p=1> Wal-Mart recently announced that it is their strategic goal to be the largest provider of primary care services in the country. As a side note, nurse practitioners and physician assistants are playing a greater role in these models.

Integrated non-profit hospitals will still be the norm in most metropolitan areas, but the combination of independent minded physicians, physician groups, advances in technology on the outpatient side, cost quality transparency that can incite competition, and the increasing cost of healthcare both from the consumer and employer perspective, could indeed lead to a more creative model of ownership on the provider side of the equation.

Finally, as the financial stakes increase in healthcare it may also lead to the reemergence of the for-profits on the provider side of healthcare.

Accountable Care Organizations (ACOs)

The ACO model (<https://www.cms.gov/ACO/>) is one of the centerpieces of the Accountable Care Act. Ideally, ACOs are seen as the vehicle to reduce the rate of increase in health care costs over time, while also improving the coordination and quality of care of the patients. But, in reality, ACOs are not the “Field of Dreams.” “If you build them, cost savings and better quality may not come.”

ACOs, no matter how effectively developed, will not be able to have a real impact on healthcare cost trends if the current Medicare payment methodologies are the dominant form of provider reimbursement. Key to long-term success of Accountable Care Organizations (ACOs) will be the rapid evolution of Medicare’s current payment methodologies. Medicare’s current payment methodologies reward overutilization, and does not incentivize cost-effective quality care on the part of providers.

Organizational inertia and resistance to change will be a major challenge for ACOs. Inadequate physician leadership, which plays a critical role in the success of ACOs, could also be a major barrier to success. In order to truly break down these historical barriers to cost effective quality care there needs to be real financial incentives in place that both significantly reward success but also hold providers financially accountable. This financial accountability can only be achieved by integrating a “strong risk component” into payment methodologies of all ACOs.

Finally, over the last few months, I have had the opportunity to speak to various groups who are involved in creating ACOs within their own organizations. While most of these people support the theory behind ACOs, a clear majority did not believe that they will be successful in achieving real cost savings. As one executive noted, as long as the majority of revenue to a hospital flows through a “fee for service

environment," there would be no real incentive to change the business model that feeds into it. See the next section on payment reform for additional observations and recommendations on this issue.

Medicare Payment Reform

As discussed in a prior issue of the BW Health Care Report (**April/May 2010**) http://www.bw.edu/academics/bus/programs/hcmba/nl/archives/QUARTERLY_HEALTH_CARE_REPORT_April.pdf there needs to be an aggressive timeline for the implementation of payment methodologies that would lay the foundation for a true "health system" vs. the costly "sick system" that exists today. While there may be different types of payment methodologies that would incent such a transition, the common denominator in all of them should be a risk component that rewards success and promotes financial and quality accountability.

Payment methodologies that could accomplish both objectives would be the following: global/bundled payments that include all services for an episode of care (e.g. hospital, physician, pre and post care, etc.), capitation, percentage of premium, etc. These risk/reward payment methodologies would focus on both inpatient and outpatient settings as well as for management of Medicare members with chronic diseases.

Payment reform in the hospital setting (e.g. global fees/bundled payments) should be fast tracked for all hospitals since it can build off the current Diagnostically Related Groups (DRG) system. An aggressive timeline may seem too radical for some, but it probably is no less radical than the short timeline that was used to transition hospitals from cost reimbursement in the 1980s to DRGs.

The next evolution of global fees/bundled payments should be some form of capitation. Probably the best approach to implement capitation or a percentage or premium for ACOs or integrated provider networks would be to partner with Managed Care Organizations (MCOs) through Medicare Advantage. Obviously, capitation may not be appropriate for all ACOs or integrated networks of providers, but when appropriate, the partnership between the ACO and the Managed Care Organization could further facilitate the evolution of our "sick system" to a real "health system."

Finally, as noted in the prior issues of the BW Health Care Report, our healthcare system is shaped by how we pay for services and what we pay for. The government, on the federal and state levels, is already responsible for almost 50 percent of U.S. healthcare related expenditures.

Medicare is by far the biggest payer of health services and, as a result of this financial leverage is the major influence on our current healthcare system. In fact, the individual private sector managed care organizations (MCOs) have mostly followed Medicare's lead, particularly regarding reimbursement methodologies, since they lack the financial leverage to effectively influence provider behavior on their own.

Federal Guidelines on Coverage for Preventive Care

In a perfect world, there'd be no limit to necessary preventive care. But, given our scarce resources, and our competing societal priorities, the definition of "necessary" grows fuzzy. As a result of this dilemma, we need to be willing to take on tough, politically unpopular issues.

I do believe there is merit in evaluating recommendations from the Institute of Medicine (IOM) concerning factors HHS should consider in drawing up the minimum benefit package as it relates to preventive care.

Given our scarce resources, we need to be willing to take on tough politically unpopular issues. Based upon a clinical cost-benefit perspective, some preventive medicine mandates may make financial and clinical sense only for a certain targeted group of patients. These will not be easy decisions as illustrated by the following recent well-publicized event.

"In November 2009, the U.S. Preventive Service Task Force published new guidelines for breast cancer screening (USPSTF, 2009). The new recommendations turned the preventive screening world upside down. Reviewing several screening modalities, the task force recommended against routine mammography screening for women between the ages of 40 and 49 years. Regular biennial screening should commence at age 50 and continue until age 74.

Even though the recommendations apply to women without a family history of breast cancer and to those without genetic mutations associated with breast cancer, patient advocacy groups including the American Cancer Society and the Society for Breast Imaging were quick to criticize the recommendations

The current American Cancer Society guidelines recommend that women in their 40s should be screened annually. While mammography screening saves lives, how many women must be screened to save one life? The Task Force provides evidence that shows over 1,900 women from 40-49 years old must be screened to save one life. For women between 50 and 59 years old, the number is 1,300. And for women in their 60s, the number drops to 377. Thus a decade of screening will add an average of

5 days to the lifespan of a woman in her 40s. But for the one woman whose cancer is detected with those 1,900 scans, the difference is literally life and death. What strategy makes sense?" (Health Economics and Policy, Fifth Edition, James W. Henderson, South-Western Cengage Learning, Page 133)

Which of the above guidelines makes the most sense (The Task Force or the American Cancer Society (ACS))? In isolation, the ACS guideline that saves lives makes the most sense, but given that we do not have unlimited resources, we cannot make such decisions in isolation. We need to make choices, and sometimes those can be very difficult choices. From a governmental perspective would these incremental dollars be better spent on prenatal care, shelter for the homeless, preschool education, the economy, the fight against terror, etc.? Since these guidelines also impact private sector employers, would these dollars be better spent in reducing employer healthcare costs, decreasing the number of the uninsured, etc.? This is obviously an over simplification of the issue, but it does illustrate the importance of making decisions that are supported by facts, not political persuasion.

Another more recent recommendation has been issued by the United States Preventive Task Force, *"Healthy men should no longer receive a P.S.A. blood test to screen for prostate cancer because the test does not save lives overall and often leads to more tests and treatments that needlessly cause pain, impotence and incontinence in many. This recommendation is based on the results of five well-controlled clinical trials and could substantially change the care given to men 50 and older. There are 44 million such men in the U.S., and 33 million of them have already had a P.S.A. test – sometimes without their knowledge – during routine physicals.*

As the P.S.A. test has grown in popularity, the devastating consequences of the biopsies and treatments that often flow from the test have become increasingly apparent. From 1986 through 2005, one million men received surgery, radiation therapy or both who would not have been treated without a P.S.A. test, according to the task force. Among them, at least 5,000 died soon after surgery and 10,000 to 70,000 suffered serious complications. Half had persistent blood in their semen, and 200,000 to 300,000 suffered impotence, incontinence or both. As a result of these complications, the man who developed the test, Dr. Richard J Ablin, has called its widespread use a "public health disaster."

Of the trials conducted to assess the value of P.S.A. testing, the two largest were conducted in Europe and the United States. Both

“demonstrate that if any benefit does exist, it is very small after 10 years,” according to the task force’s draft recommendation statement.

The European trial had 182,000 men from seven countries that either got P.S.A. testing or did not. When measured across all of the men in the study, P.S.A. testing did not cut death rates in nine years of follow-up. But in men ages 55 to 69, there was a very slight improvement in mortality. The American trial, with 76,693 men, found that P.S.A. testing did not cut death rates after 10 years.” (U.S. Panel Says No To Prostate Test for Healthy Men,” Gradiner Harris, The New York Times, October 7, 2011)

While there is opposition to this recommendation from the Task Force from advocacy groups and some drug makers and doctors, it is hard to refute such findings from this impartial task force recommendation that is based on controlled and large studies. The issues relating to coverage for preventive services will not be easy. Lives are indeed at stake, but there also needs to be recognition that our resources are not unlimited and there indeed may be a “better” use of our societal funds (e.g. education, jobs, food banks, etc.).

The following is a link to a Congressional Budget Office Report on the cost-effectiveness of preventive medicine and wellness programs:

- “Congressional Budget Office Report on the Cost-effectiveness of Preventive Medicine and Wellness Programs,”
http://www.cbo.gov/ftpdocs/104xx/doc10492/08-07-Prevention_PSally.1.1.htm

Health Insurance Exchanges

“Should states play an “active” or a “passive” purchasing role in regards to Health Insurance Exchanges?”

The following are my comments from the last issue of the Quarterly relating to States role in Health Insurance Exchanges (http://en.wikipedia.org/wiki/Health_insurance_exchange). This is an important issue that bears repeating:

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

- Cost savings for consumers and small business would be limited to any incremental reductions of administrative costs on the part of the MCOs due to economies of scale. Remember, MCOs' administrative costs, on an overall basis, have already been addressed by means of the medical-loss ratio caps that are part of the new healthcare law.
- If the financial tension is limited to the MCO administrative expenses, not only will the premium impact be limited, it would create no incentive for providers to enter into innovative/collaborative relations with MCOs that translate to lower healthcare costs.
- **Alternatively**, if the exchanges take more of an **active purchaser role**, it can become a mechanism to foster aggressive competition between the MCOs which would, in turn, lead to lower costs (or at least trends) and better quality in our healthcare system. If exchanges take an **active purchasing role** and limit the number of MCOs to a select group that meet cost, quality and access benchmarks, it will create the necessary tension to impact the provider side of the healthcare cost equation.
- By limiting the number of MCOs that are made available on the exchange, it will increase the carriers' leverage with providers to incent more innovative and cost-effective collaborations. These MCOs could then build off the innovative financial arrangements with providers that are being fostered by Medicare (global payments, risk arrangements, ACOs, medical homes, etc.), to truly reinvent our health care system.
- Over time, as exchanges increase their penetration in the small and mid-size employer market, it could also foster MCOs creating limited provider networks that could replicate ACOs or integrated networks. These limited provider networks (which would have some of the same characteristics of the HMOs of the 1990s) would further foster "the right type" of competition between providers.
- These limited networks could, for example, contract with MCOs by means of a percentage of premium arrangement. The better the provider network can address cost issues, the more competitive the MCO health insurance premium becomes that is available on the exchange. The more competitive the MCO health insurance premium, the likelihood of individuals and small employers selecting

that product on the exchange increases, which, in turn, increases the number of “customers” for the limited provider network.

- In order to foster additional levels of positive provider tension, all MCOs that are selected on the exchange need to make available to their customers user-friendly cost and quality data that will enable consumers to become more prudent purchasers of healthcare services. For example, a consumer needing knee surgery, should be able to go on his MCO website and compare the total price of that knee surgery (physician/facility charge, etc) among the various provider locations (e.g. tertiary, hospital, free-standing facility, etc.) in the network.
- In order to further incent consumers to be prudent purchasers of healthcare services, there should be sufficient levels of deductibles and co-pays in all benefit designs. Individuals would be entitled, based on need, to some form of governmental assistance that would fully or partially offset the deductibles, but not totally offset the co-pay.
- Finally, as we discussed in previous issues of the Quarterly, per the Center for Disease Control, 50% to 70% of healthcare costs are directly or indirectly related to lifestyle diseases. Some form of financial incentives related to member compliance with wellness and disease management programs needs to be built into all insurance products.

STATE

Tom's Take:

The news article below is a follow-up to the story from the last issue of the Health Care Report (January/February 2011)
(<http://www.bw.edu/academics/bus/programs/hcmba/nl/>)

As I noted in the last issue of the Health Care Report, I believe that the real culprit in all of this is less the retirees, but the politicians at all levels of government who did not have the courage to say “No!” It is only natural for public employees’ unions, etc. to argue for increased pay and retirement benefits for their members. The problem is that government, at all levels, has never had effective check and balances in place that would ensure prudent decisions during these negotiations. It is much

easier to give into these employee demands than to face a strike. It is much easier to allow future administrations, legislators or generations to bear the brunt of these fiscally irresponsible decisions than to address them now.

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

Judge rules City of Cincinnati may alter retirees' health coverage

"A Hamilton County judge ruled Thursday that City Hall has the right to alter retirees' health coverage to require most to absorb a higher share of the cost. The ruling was a major legal and financial victory for the city of Cincinnati's troubled pension system.

If upheld on an almost certain appeal, Common Pleas Judge Norbert Nadel's decision could save Cincinnati's \$2 billion retirement system tens of millions of dollars on city retirees' medical coverage, which this year will cost about \$46 million.

"This is a very big step in helping us to provide equitable health coverage for retirees and that helps with the health of the system as well," said Paula Tilsley, executive director of the Cincinnati Retirement System. The system provides health care to more than 6,000 city retirees, spouses and dependents.

Neither retirees who filed the lawsuit seeking to overturn the health coverage changes nor their lawyer returned phone calls for comment Thursday.

The lawsuit stemmed from City Council's decision in 2009 to switch from a health plan that cost many retirees only negligible amounts such as a \$50 annual deductible and \$5 payments for brand-name prescriptions.

The new program has higher deductibles, co-payments and yearly out-of-pocket limits. Annual deductibles now range from \$200 to \$600 for most families, brand-name prescriptions cost \$15 to \$20, and yearly out-of-

pocket maximums are \$2,000 to \$3,000 for in-network coverage. Retirees drawing pensions of less than \$30,000 a year pay reduced amounts.

Council adopted the health coverage changes after experts warned that, without major adjustments, the city's retirement system could be insolvent within 20 years. Earlier this year, the council made additional charges that will increase retirement ages and service requirements, reduce annual cost-of-living adjustments, curtail death benefits and alter pension formulas in ways that will require many city employees to work more years for a smaller eventual pension. As with the health changes, those alterations were made to help the city rein in a projected \$1 billion long-term deficit in the retirement system.

Those changes are the subject of another lawsuit now pending in federal court that could have an even greater financial impact on the city's pension plan. "If that gets undone, we're back to square one," said City Solicitor John Curp.

At the heart of the case before Nadel was City Hall's argument that while retirees' basic monthly pension benefits are legally protected, health coverage is, at the city's discretion, subject to change or even elimination.

Nadel's decision is likely to draw statewide and national attention because it delves into the thorny legal question of how far – if at all – governments may go to alter benefits for existing retirees.

As in Cincinnati, the medical coverage issue could significantly affect the financial health of countless other local and state public retirement systems across the country. ("Judge rules city may alter retirees' health coverage," Cincinnati.com, September 1, 2011)

<http://news.cincinnati.com/article/20110901/NEWS0108/309010021/Judge-City-may-alter-retirees-health-coverage?odyssey=tab%7Ctopnews%7Ctext%7CFRONTPAGE>

NORTHEAST OHIO

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

Baldwin-Wallace College is excited to announce the expansion of its Health Care programs to our Eastern Campus starting in 2011. Baldwin-

Wallace East is located at the intersection of Richmond Rd. and Science Park Drive in Beachwood.

- **Health Care MBA**

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

- **Undergraduate Health Care Management Major/Minor**

http://www.bw.edu/images/userImages/wgerhard/Page_4432/A2B%20Health%20Care%20Mgmt%20for%20web%20link.pdf

- **The Healthcare Executive Management Certificate**

<http://www.bw.edu/academics/cpd/healthcare/>

Undergraduate Public Health Major/Minor

An overview of Baldwin-Wallace College's Public Health program

One of only a few such programs in Ohio, the newly developed Public Health program at Baldwin-Wallace College (B-W) leading to the Bachelor of Science in Public Health (BSPH) is designed to train a new generation of public health professionals prepared to face the emerging challenges to human health and health care from a population perspective.

The curriculum is designed to train students in multidisciplinary approaches to Public Health practice and research including a comprehensive and rigorous study of epidemiology, biostatistics, social and behavioral sciences, environmental health, health policy and management.

Students enrolled in B-W's Public Health program learn about the public health care system in the U.S. and abroad and emerging public health concerns such as health disparity, pandemic infectious disease and new threats to the environment. The forty six credit hours of coursework is intended to utilize class room activities, service learning and research in order to provide student with the fundamental knowledge and principles, applications, and skills needed to develop a firm appreciation of health and disease prevention at the population level, and the opportunity to use this special knowledge to transform the experience of their major

education into innovative approaches for solving problems in health care and assessment. The current curriculum emphasizes the following concentrations: i) Global Health; ii) Health Promotion and Education; and iii) Health Prevention.

Meet Baldwin-Wallace College's New Director of our Public Health Program

Swagata Banik, PhD
Associate Professor
Director, Public Health Program

Dr. Banik obtained his doctorate degree from Shivaji University, India and post-doctoral training at Cleveland State University. Before joining B-W he taught at the department of Psychology at Cleveland State University. He also taught in the graduate program of Health and Ecology at Shivaji University, India. His research addresses issues surrounding health disparity and practices. His current research explores individual, socio-cultural and structural factors associated with HIV health disparity in the U.S. and in India.

One of his recent research projects that proposes to develop a cognitive-behavioral intervention for HIV prevention has been selected by NIH for funding. He has served as an expert consultant on projects funded by CDC, UNDP, and Indo-Canada Environment Facility. He has published over fifteen research articles, book chapters, and has presented his research in numerous national and international conferences.

MARK YOUR CALENDAR

Baldwin-Wallace College's MBA Open Houses:
Learn about the B-W Health Care MBA Program.

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MBA Open Houses:

6 p.m. /Wednesday, January 4, 2012

Landmark Center

25700 Science Park Drive #100

Beachwood, OH 44122

Please call for more information 440-826-2392

Or

6 p.m. /Thursday, January 5, 2012

Strosacker College Union
120 E. Grand St. Berea, OH 44017

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

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