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

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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. In addition, this issue examines in detail issues of price transparency in healthcare along with a review of the Massachusetts healthcare reform initiative that focuses on access to healthcare services. Finally, the reader is provided a review of Michael E. Porter and Elizabeth O. Teisberg's latest book titled, "Redefining Health Care."

COSTS

Review of Healthcare Costs of Individuals that are Covered by an Employer-Sponsored PPO Program

Milliman Inc. has completed its second study of the total annual medical costs for the "Typical American Family of Four." [The Milliman Medical Index \(MMI\)](#) measures the average spending for such a family if covered by an employer-sponsored PPO program. It provides a benchmark by annually assessing the changes in those costs over a five-year period. The MMI also examines the key drivers and the components of actual medical spending. The MMI breaks out and measures the rate of consumer (employee) spending and the rate of total spending for health care services in a given year. (Milliman)

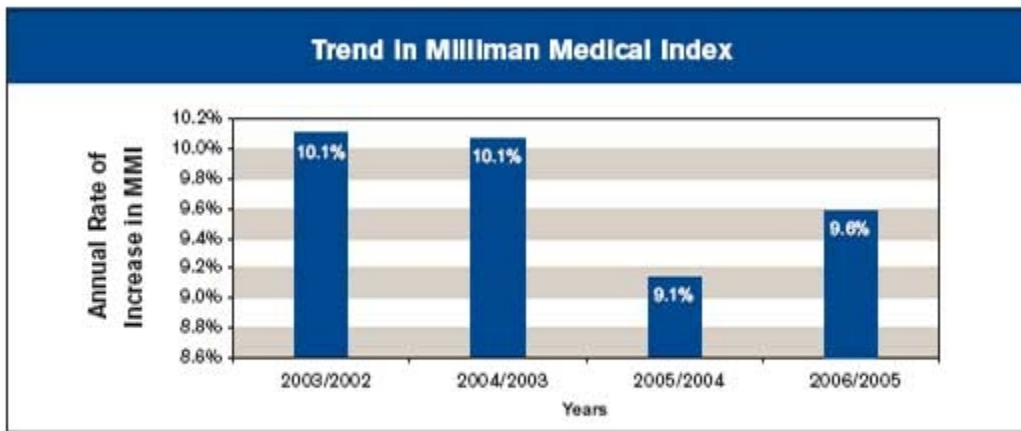
The average annual medical cost for a family of four in 2006 is \$13,382 (See Figure 1) Note: Costs include the amounts paid by both the employee's health plan, if applicable, and the employee's out of pocket expense. (Milliman)

FIGURE 1



The average annual medical cost for a family of four will increase by 9.6% from 2005 to 2006. The annualized rate of increase for the four-year period 2002-2006 was 9.7% (See Figure 2.)

FIGURE 2



In 2006, inpatient and outpatient hospital services represent 46% of the total annual medical costs, physician services represent about 36%, prescription drugs about 14%, and other miscellaneous services represent 4%. For 2005 to 2006, the MMI shows a hospital inpatient trend of 9.3%, a hospital outpatient trend of 12.6%, and a physician trend of 5.9%, and a pharmacy trend of 8.3%.

For inpatient hospital services, trends are due to some or all of the following:

- New technologies, often requiring larger expenditures by the hospital
- An increased ability by hospitals to negotiate more successfully with health plans (as a result of merged hospital systems, etc)
- Cost-shifting to private payers based on increases in hospital charity care and lower reimbursement from government programs (Medicare and Medicaid)

Hospital outpatient services have been affected by an increase in outpatient technology that allows for a continuing shift of surgeries from inpatient to outpatient, moderating an otherwise higher inpatient trend. Hospital outpatient services are often paid on a percent of charge basis, and hospitals have continued to increase their charge level. Private payers are increasingly switching to a fixed outpatient payment methodology from that of a percent of charge, which should moderate future increases in outpatient costs.

Health plans have been fairly successful in maintaining relatively moderate trends of reimbursement for physician services, but there have been increases in office visits, surgeries, and radiology costs. (Milliman)

The Impact of Consumer Driven Health Plans on Cost Trends.

Milliman Inc. notes that according to a report of the United States Government Accounting Office, participation in CDHPs increased from about 3 million in 2005 to more than 5 million in 2006. While the percentage increase is impressive, it is important to note that it still represents only about 3% of the 177 million Americans with private health insurance coverage.

Milliman Inc. further states that a key assumption for proponents of CDHP's is that consumers with a greater economic stake in their healthcare decisions will take a more active role and be more prudent purchasers. Per Milliman Inc., to date, few statistically valid studies have successfully separated the behavioral effects as a result of consumer education and plan design from utilization differences that are due solely to the selection of consumers who tend to elect coverage through a CDHP plan.

Tom's Comments:

Milliman Inc.'s comment above relates to the fact that the majority of people to date that have selected CDHPs are young, healthy or wealthy. The young and/or healthy would have little utilization under any benefit plan scenario. The wealthy use CDHPs (specifically HSAs) more as tax shelters, similar to an IRA, rather than as a health benefit plan.

Multi-Prong Strategy Critical to Control Health Costs

Employers achieving the most success at reigning in health benefit cost increases are those using an array of 15 to 20 data-driven programs that encourage employees to utilize high-quality providers, guide them in management of their own health issues, and motivate them to use medical services appropriately, per Lale Iskarpatyoti of [Watson Wyatt Worldwide](#).

Per Watson Wyatt's survey report, entitled "[Delivering on Health Care Consumerism: Strategies for Employer Success](#)," some of the proactive programs include:

- Making available to workers information on provider quality and performance
 - Giving workers tools for comparing provider quality
 - Offering tiered networks based on provider quality
 - Providing workers information on their specific health issues
 - Offering premium differentials based on clinical condition or participation in health management programs
 - Implementing an obesity-reduction program
 - Basing health plan decisions on claims analysis
 - Offering health-risk appraisals or a nurse help line
 - Setting up disease-management programs
- (Managing Benefits Plans, June 2006)

Tom's Comments:

There are multiple factors that impact an employer's healthcare costs and consequently as noted above, any proactive solutions need to be multi-prong. The key is to link the various programs into an overall strategy that is data driven based on the profile of the specific employer. Employers that are self-insured (usually greater than 300 employees) will

have the most flexibility in designing strategies that would best meet their specific needs.

Medicare Spending Seen Rising Rapidly, Despite Cut in Estimated Cost of Drug Benefit

Medicare spending continues to rise rapidly, despite falling cost projections for the new prescription drug benefit, necessitating reforms such as paying hospitals, physicians, and other providers for delivering quality care more efficiently, [Centers for Medicare & Medicaid Services](#) Administrator, Mark B. McClellan said on July 11, 2006.

The Bush administration in its mid-session budget review for fiscal 2007 said spending on Part D drug benefit would be \$34 billion less from fiscal 2006 to fiscal 2010 than estimated in the 2007 budget, in part due to competition among drug plans for enrollees.

However, that decrease was offset by a \$17 billion increase in Part A (hospital) spending and a \$30 billion increase in Part B (physician) spending over the five-year period, due to increased utilization and medical intensity of services, as well as more physician office visits, use of physician-administered prescription drugs, and minor office procedures.

McClellan said the increase in Medicare Part A (hospital) and Part B (physician) spending argues for changes in how the program pays for services delivered to beneficiaries. "We just can't keep pumping more money into a payment system that is not sustainable," he said of the Medicare physician payment system. "We've got to move away from a system that simply pays more for more services...to a system that promotes quality."

Bush in his fiscal year 2007 budget proposal asked Congress to implement legislative changes to produce \$35.9 billion in Medicare savings over five years and expressed support for physician payment reforms such as differential updates initially for physicians who report on quality measures and later for doctors who achieve efficient and quality care. (BNA's Health Care Daily Report) (July 12, 2006)

Tom's Comments:

There needs to be major reforms in the Medicare and Medicaid programs. They must evolve from being payers of claims to being true "health plans." Currently Medicare and Medicaid balance its budget by "underpaying providers of care." These same providers then "cost-shift" to the private payers in order to balance their budgets. A recent study by Premera Blue Cross in Seattle, Washington highlighted these phenomena. The study found that in 2004, hospitals in Washington State charged an additional \$738 million—or 14.3% of their revenue—to private payers to make up for Medicare and Medicaid underpayments. Similarly, doctors shifted \$620 million, or 12%, said John Pickering, an actuary of Milliman Inc. a consulting and actuarial firm that conducted the study. (["Low Payments by U.S. Raise Medical Billions a Year,"](#) The New York Times, June 1, 2006, Milt Freudenheim)

A similar Milliman study in California for 2004 said that health plans and consumers paid an additional \$4.5 billion for hospital care in that state to compensate for Medicaid and Medicare constraints (Note: This study did not focus on the physician side of the issue). (New York Times, June 1, 2006)

Medicare and Medicaid currently have a number of initiatives (egg. pay for performance, EMR, disease management, etc.) on their plates to better address their budgetary issues. Medicare and Medicaid cannot continue to operate as "business as usual." The ripple effect, as noted above, of Medicare and Medicaid's provider payment policies is creating financial havoc to both employers and consumers of healthcare services.

What is Price Transparency?

Tom's Comments:

The cry for "price transparency" of hospital and physician services is increasing in all sectors of the U.S. economy. The introduction of Consumer Driven Health Care Plans have definitely added to this disclosure movement, but the need for information goes beyond the individual consumer to the major purchasers of care (government and employers).

As Richard Clarke, President and CEO of the [Healthcare Financial Management Association \(HFMA\)](#) stated, "in the non-healthcare sectors of our economy, price information for most products and services is fairly easy to communicate. Consumers can then make value assessment (that is, the relationship of price to quality) using readily available information.

In health care, per Mr. Clarke, the model breaks down because understandable, comparable quality information is not readily available.” (April 2006 HFMA, page 170)

The majority of Americans pay for their healthcare services through a private health insurance plan or through a government program (egg. Medicare), and consequently hospital and physician charge information would have no value to the consumer.

Consumers would also not benefit from a laundry list of prices for individual hospital and physician services even if the data represents actual negotiated pricing of the managed care organization or the government. While individual unit pricing has relevance to overall healthcare costs, utilization of all services during an “episode of care” in many ways is the major cost driver. Examples of the bundled services in an “episode of care” would include the hospital and/or physician costs, and if applicable lab tests, anesthesia, radiology, rehab, etc.

The ultimate source for most Americans of “episode of care” actual data would come from the payer side of healthcare. Managed Care Organizations and Government payers (Medicare and Medicaid) have the data available to construct a user-friendly “episode of care” comparison between providers.

Even though the managed care industry has begun in earnest to address this issue, the federal government is in the best position to take a lead on this initiative from a number of perspectives. First, Medicare represents a significant portion of most hospital and physician revenues, and the disclosure of user-friendly “episode of care” cost and quality information would have a major ripple effect to all sectors of the healthcare industry. Second, the government can play a facilitation role with employers and the managed care industry to attempt to disseminate user-friendly comparable data to their employees/members. An example of such an effort is noted below in the article that quotes HHS Secretary Michael O. Leavitt.

HHS Secretary Michael O. Leavitt Unveiled a new ‘Payer Power’ Plan that will Lower Costs, Boost Quality

HHS Secretary [Michael O. Leavitt](#) announced that government analysts will examine claims data from Medicare, Medicaid, Defense Department, and Federal Employee Health Benefits program so that price and quality data will be available for each hospital and doctor. The initiative calls for the listing of the total costs of particular procedures, even though insured patients pay only a small fraction of those costs themselves.

“Take hip replacement surgery, for example,” Leavitt said. “It would change the health care world if people could know, before their operation, what the overall package price is going to be, including lab tests, anesthesia, rehab costs, as well as specific information on quality, such as complication rates and patient satisfaction. We will start with a few of the most common procedures and expand as quickly as possible.”

In another phase of the program, HHS said it will analyze six metropolitan markets around the country in coming weeks. Leavitt said he will travel to those markets, and ask that their largest employers formally declare that they will join with the federal government in a program to pressure providers to measure quality, list prices, and adopt health information technology.

As a condition of business with the employers, any providers and insurers would have to agree to disclose quality of their care for 20 of the most frequently used medical procedures. Similarly, prices would have to be listed for the most common medical procedures.

Finally, the public listing of prices – on www.Medicare.gov will help the uninsured find lower prices for care, according to Leavitt. Seeing the lower prices Medicare pays for care will give them leverage to bargain with hospitals to charge less than the full price, Leavitt suggested. (The Commonwealth Fund, March 20, 2006, “Washington Health Policy Week in Review”)(HFMA, July 2006, “Eye on Washington,” Jeanne Schulte Scott)

Tom's Comments:

The above programs are examples of some proactive ways that the government can maximize the benefits from healthcare dollars. Ultimately the government should use this data to develop and promote value oriented (cost-effective/quality) healthcare services for its members.

QUALITY

Medication Errors Harming Millions, Report Says

At least 1.5 million Americans are sickened, injured or killed each year by errors in prescribing, dispensing and taking medications, the influential [Institute of Medicine](#) concluded in a major report released on July 20, 2006.

Mistakes in giving drugs are so prevalent in hospitals that, on average, a patient will be subjected to a medication error each day he or she occupies a hospital bed, per the Institute of Medicine report. Following up on its influential 2000 report on medical errors of all kinds, the institute, a branch of the National Academies, undertook the most extensive study ever of medication errors in response to a request made by Congress in 2003 when it passed the Medicare Modernization Act.

The report found errors to be not only harmful and widespread, but very costly as well. The extra expense of treating drug-related injuries occurring in hospitals alone was estimated conservatively to be \$3.5 billion a year. Many of these medication errors could be avoided if doctors adopted electronic prescribing, if hospitals had a standardized bar-code system for checking and dispensing drugs, and if patients made more of an effort to know about risks of the drugs they take, the report said. Per the report, at least a quarter of the injuries caused by drug errors are clearly preventable.

Common errors include doctors writing prescriptions that could interact dangerously with other drugs a patient is taking, nurses putting the wrong medication—or the wrong dose—in an intravenous drip and pharmacists dispensing 100-milligram pills rather than the prescribed 50-milligram dose.

The report's most striking findings concerned hospitals and long-term care facilities, which it said generally do not report errors to patients or family members unless they result in injury or death. The panel said all health-care organizations should report medication errors to patients, whether or not they cause harm. ([Washington Post](#), July 21, 2006, Marc Kaufman)

Tom's Comments:

The Institute of Medicine has an excellent reputation in producing objective, timely and accurate reports that are critical to our overall healthcare policy formation.

Diabetes: 73 Million in U.S. have it or at Risk

Nearly a third of Americans, more than 73 million adults, have diabetes or higher-than-normal blood sugar levels that results in a high risk of acquiring it, a new study shows. The lead author of the report is Catherine Cowie of the [National Institute of Diabetes and Digestive and Kidney Diseases](#).

The prevalence of diagnosed diabetes rose from 5.1% of the population in 1988-94 to 6.5% in 1999-2002, based on analysis of data from the National Health and Nutrition Examination Survey. Per the report another 2.8% of Americans have the disease but don't know it.

"Another 26% of adults had impaired fasting glucose" blood sugar levels above normal but not high enough to be diagnosed as diabetes, Cowie says. So "we're talking about a third of the population who have diabetes or at risk of getting it."

Research has shown that people with impaired fasting glucose, a form of pre-diabetes, are at increased risk of developing heart disease and diabetes, yet with moderate weight loss and exercise, they can reduce this risk measurably.

Type 1 diabetes is caused by the loss of insulin-producing cells and is usually diagnosed in children or young adults. Type 2, which accounts for 95% of diabetes, is caused by the inability to produce enough insulin or to use it efficiently. It is associated with obesity and usually begins in middle age, but is increasingly being found in teens. ("[Study: 73M have diabetes or at risk in U.S.](#)," USA Today, May 5, 2006, Anita Manning)

Another study by the Veterans Affairs Inpatient Evaluation Center in Cincinnati, Ohio found that high blood glucose levels, even just 1 point above normal, raise death risk in ICU patients. In stroke patients with the highest sugar levels, deaths were 15 times higher than what would be expected. The risk was greatest in patients who had had heart attacks and stroke. (["What are your odds of developing diabetes?"](#) U.S.A. Today, June 12, 2006, Anita Manning)

Tom's Comments:

We are at a cross-roads in regard to diabetes (specifically Type 2 diabetes). As noted above, the diabetes epidemic is increasing. It impacts both our young and old. It has a major negative impact on our quality of life and our healthcare costs. It also is preventable, if not at least manageable. There needs to be a comprehensive strategy to address this deadly disease. All of the stakeholders (employers, providers, managed care organizations, government, pharmaceutical companies and most of all the consumers) have a vested interest in addressing this disease. A solution needs to involve all of the above stakeholders, not in isolation but in a coordinated strategy. Employers should be working with managed care organization which in turn should be working with providers and members to create an environment for success. Diabetes programs need to focus on education, exercise, diet, etc., along with regular interaction with healthcare providers. Employee health benefit designs and incentives need to be evaluated so as to maximize the likelihood for success.

Employers Focus on Chronic Ailments

Hoping to slow rising healthcare costs, a small but growing number of employers are reducing or eliminating drug co-payments for workers with chronic ailments, offering medical screening at work, and helping employees with catastrophic diseases access clinical trials.

With employers' health insurance premiums expected to increase by 9.9 percent this year, companies say their goal is to encourage workers to take medications and get regular checkups to reduce the likelihood of expensive hospital admissions and disability payments. In all, 38 percent of employers have instituted targeted incentives or say they plan to, up from 20 percent in 2001, according to Camille Haltorn, national practice leader for managed health at Hewitt Associates, a benefits consulting firm.

An estimated 4 percent of insured employees with serious health conditions account for almost half of their employers' annual healthcare spending, according to [Watson Wyatt](#) report release last week

Concerned about escalating health insurance premiums, Marriott International Inc. began eliminating co-payments on generic drugs for workers with chronic conditions such as asthma, diabetes, and heart disease last year. Marriott also reduced its co-payment for brand name drugs related to the above chronic diseases by 50 percent.

Dr. Mark Fendrick, Director of [University of Michigan's Center for Value Based Insurance Design](#), said incentives are more effective than higher deductible plans. "Right now, this country's number-one approach to the high cost of healthcare is to make employees pay more," said Frederick. "But cost sharing is a blunt instrument and the evidence actually shows that if you make people with chronic illnesses pay more, they stop buying the lifesaving things they need and companies wind up paying more." (Boston Globe, May 4, 2006, Diane E. Lewis)

[Tom's Comments:](#)

[Dr. Mark Fendrick's comments are right on point.](#)

ACCESS TO CARE

Gaps in Health Insurance: An All-American Problem

Gaps in health insurance coverage—a problem that has long afflicted lower-income U.S. families—is increasingly becoming an all-American problem. Findings from the Commonwealth Fund Biennial Health Insurance Survey show that, while lack of insurance continues to be highest among families with incomes under \$20,000, uninsured rates for moderate- and middle-income earners and their families are rising, putting their health and financial security at risk.

The survey finds that most of these individuals reside in working families: Of the estimated 48 million American adults who spent any time uninsured in

the past year, 67% were in families where at least one person was working full time.

In addition, survey respondents were asked about problems managing chronic conditions; utilization of routine preventive care, like mammograms and colonoscopies; and coordination of efficiency of care. ([“Gaps in Health Insurance: An All-American Problem,”](#) The Commonwealth Fund, April 2006, Sara R. Collins, Karen Davis, Michelle M. Doty, Jennifer L. Kriss, and Alyssa L. Holmgren)

Tom's Comments:

Access to adequate healthcare services has always been a challenge for the “have-nots,” but recently this issue has become more politically charged since it is starting to impact the “haves.”

Healthcare Reform: A Review of Michael E. Porter and Elizabeth O. Teisberg's Latest Book “Redefining Health Care”

The following is a summary of “Redefining Healthcare” as described by the Harvard Business School Working Knowledge Press:

In their new book [Redefining Health Care: Creating Value-Based Competition on Results](#), Michael E. Porter and Elizabeth Olmsted Teisberg take a systematic approach to healthcare reform. Today's system is dysfunctional, they argue, rewarding participants who redirect costs and restrict services rather than those who create value for the consumer. The system needs to be redesigned so that each participant is motivated to increase value, measured by health outcomes per dollar expended.

Porter and Teisberg further state patient value in health care delivery... can only be understood at the level of medical conditions. Overwhelmingly, value is determined by how well a provider delivers care in each medical condition, not its overall breadth of services. The value delivered in a medical condition arises from the full set of activities and specialties involved. It is not the individual roles, skills, or functions that matter, but the overall result.

Moreover, for each aspect of care, value is determined by how well the needed set of skills and functions come together. In surgery, for example, value depends on not only the surgeon but also the anesthesiologist, the nurses, the radiologist, the skilled technicians, and others, all performing well. Yet no matter how skilled the surgical team, the overall care cycle is crucial.

Unless the patient's problem is accurately diagnosed, the patient is properly prepared, and recovery and rehabilitation are managed well, patient results will suffer. Indeed the impact of the cycle of care is even broader. Value may be enhanced by not performing the surgery at all, and treating it in a different way. Value may be still greater if preventive care and advice is provided over time so that little or no treatment is needed at all.

The relevant business in health care delivery, then, is a medical condition seen over the full cycle of care. The business is congestive heart failure, for example, not heart surgery, cardiology, angiography, or anesthesiology. The medical condition is not orthopedic care, but several conditions, including spine disorders, hip disorders, and so forth. Indeed medical conditions are patient centric, not provider centric.

Providers must choose the set of medical conditions in which they can achieve true excellence in terms of patient value, given their particular patient mix, skills, and other circumstances. In each medical condition, providers must decide what roles they will play in the care cycle, and what services to offer to ensure good overall patient results. The choices will be different for each provider. Academic centers will make different choices than community or rural hospitals.

Part of the strategic choice of service lines is to match the complexity and acuity of the conditions diagnosed and treated with the skill, technology, facilities, and cost base of the institution. Routine or simple services should not be offered by institutions that cannot deliver them at a competitive cost. Conversely, complex or unusual services should not be offered by institutions that lack the experience, scale, and capabilities to provide excellent results.

In value-based competition, most hospitals and physician groups will retain an array of service lines but will stop trying to offer everything. In healthcare, the need for strategic choice of services has been avoided because of the lack of information and the lack of accountability for

results. (["Using Competition to Reform Healthcare,"](#) Harvard Business School Working Knowledge, June 2, 2006)

Tom's Comments:

The above over-view of "Redefining Health Care" by the Harvard Business School Working Knowledge publication focuses on the primary premise of the book, that is, value-based competition that is patient centric. The book also focuses on the laundry list of problems and issues that we have in healthcare that fall under cost, quality and access to care. The authors attempt to identify a potential solution of each of the identified problems, all of which would be under the umbrella of value-based competition.

The book further explores the current roles of key healthcare stakeholders (hospitals, physicians, managed care organizations, employers, suppliers, consumers, and the government, etc.). Porter and Teisberg recommend fundamental changes in focus for each of the above stakeholders that would not only ultimately create a better overall healthcare system in the U.S., but enhances their own likelihood for success in a value-based competition environment. Of note, the authors extensively cite the Cleveland Clinic as an example of a hospital system that is organizing around medical conditions to best serve the needs of the patient.

Finally, Porter and Teisberg support universal healthcare coverage for all Americans. They state, "That there is no way to truly reform healthcare without moving to a system in which everyone is covered by health insurance. In health care, where an individual can impose costs on society, the need for mandatory insurance is common sense. Everyone who wants to drive an automobile, for example, is required to have insurance so that they will not inflict cost on other citizens if they have an accident. The only fair way to provide access for all is to make health coverage mandatory for everyone, with subsidies for those who need them so that everyone becomes a paying customer and contributes what they can to costs of the system."

Porter and Teisberg suggest, "There are a variety of ways to provide subsidies. The best solution would be vouchers based on income that enables individuals to buy into a plan. An alternative approach proposed by some experts is to enroll automatically everyone without another health plan in a state Medicaid program with premiums adjusted for income."

I enjoyed reading this book and I found their identification of healthcare issues that plague us to be right on point. Overall, I also thought their proposed solutions to each of the identified problems to be intellectually

appealing. Some of their proposed solutions, while appealing, had a number of very practical limitations, especially in their discussion of rural healthcare providers. Specifically, as they attempt to limit the role of rural hospitals to emergency care, diagnosis, treatment of relatively common conditions, follow-up care, and disease management for chronic conditions.

The authors do state that for lower volume service lines, rural providers should establish medical relationships with centers that have the experience and facilities to achieve results. The above approach for rural providers does make sense in many ways, but access to “big city” care due to travel constraints, for rural residents, especially the poor, may be very challenging to achieve

I believe that the central theme of Porter and Teisberg's recommendation relating to “value competition by medical conditions” will face an uphill battle, specifically the status quo. While you will hear grumbling from the various healthcare stakeholders about the status quo, they are ultimately all surviving financially, and many quite attractively in this fragmented system of ours. Value-based competition will also have winners and losers, and many of the key stakeholders do not want to jeopardize their current position.

The major question then becomes, what will be the major catalyst/s that ignites the competitive force that leads to better value in healthcare? I believe that catalyst needs to be on the payer side since, as I noted previously, the fragmented status quo system does not provide sufficient incentives for such radical change. Ultimately, the key payers are employers and the government. Employers would be the ideal catalyst, and some of their current initiatives, as noted in Porter and Teisberg's book, show promise. The problem with employers is that they are disjointed and truly do not have the focus and understanding to take a lead on this issue.

The managed care industry as an agent of the employer could potentially play a leadership role on this issue, but it will face many obstacles including resistance from some segments of the provider community.

The government has the potential to be such a leader, not by use of control but as a catalyst for positive change. The authors have identified a number of roles for the government in their book. Most of those roles I agree with, but I do not think that they place enough emphasis on the power that the government possess. Approximately 60% to 65% of a hospital's revenue is from Medicare and Medicaid. History has shown that

the provider community will respond accordingly based upon Medicare initiatives that are tied to funding. Also many of the key changes in the managed care industry were either developed by or fostered by the government (e.g. DRGs, Outpatient Ambulatory Patient Categories, RBRVS, global fees, medical policy, etc.). The managed care industry to this day continues to monitor and follow developments initiated by Medicare.

Porter and Teisberg did state that Medicare and Medicaid should act as health plans rather than payers, and I agree with this conclusion wholeheartedly. If these programs implemented a value-based competition model, using a five year lead time for full implementation, it would create a positive ripple effect throughout the healthcare industry.

Finally, I agree with Porter and Teisberg's call for universal healthcare coverage, for all of the reasons that they identified. Our current system (or lack there-of) not only does a poor job of addressing the healthcare needs of uninsured; it does so in a costly and inefficient manner (egg. emergency room, lack of focus on preventive care, etc.).

My only caution, as was shared by Porter and Teisberg, is that universal access should not be done in isolation. Issues of health care costs and quality that impact all Americans must also be addressed. Porter and Teisberg's value-based competition should be evaluated seriously, especially by the government which must address the multiple needs and issues relating to Medicare and Medicaid.

State Healthcare Update

Massachusetts Health Care Reform Plan

On April 12, 2006, Massachusetts [Governor Mitt Romney](#) signed into law landmark legislation that would provide nearly universal health care coverage to state residents. The bipartisan legislation combines the concept of individual responsibility through an individual mandate on the

purchase of health insurance with government subsidies to ensure affordability.

The prospect of achieving universal coverage in Massachusetts is made easier by the health care market of the state. The state enjoys a strong foundation of employer-sponsored insurance supported by an expansive Medicaid program: 68 percent of non-elderly Massachusetts residents have insurance coverage through their employer compared to just 61 percent nationally. As a result, about 10 percent of the population is uninsured, compared to the national average of 16 percent.

The Massachusetts Health Care Reform Plan requires the participation of both individuals and employers. It mandates everyone in the state to purchase health insurance by July 1, 2007, and would impose financial penalties of up to 50 percent of the cost of a health insurance plan on those who do not via income tax filings. It also includes a requirement that employers with more than 10 employees provide health insurance coverage or pay a "Fair Share" contribution of up to \$295 annually per employee.

The plan creates the Commonwealth Health Insurance Connector to "connect" individuals to insurance by offering affordable, quality insurance products. Small businesses and individuals can purchase insurance through the Connector. The Connector will also offer specifically designed, lower-cost products for 19-26 year-olds.

Employers with more than 10 workers will be required to offer a Section 125 "cafeteria plan" that permits workers to purchase health care with pre-tax dollars. Using these pre-tax dollars, workers not offered insurance will be able to purchase insurance products through the Connector.

Insurance market reforms are also an important component of the plan. In particular, the plan will merge the individual and small-group insurance markets by July 2007, which is expected to reduce premium costs for individuals by 24 percent.

A central part of the plan is the provision of government-funded subsidies to low-income individuals to assist with the purchase of health insurance. The Commonwealth Care Health Insurance Program will provide sliding-scale subsidies to individuals with incomes up to 300 percent of the federal poverty level (or \$49,800 for a family of three) for the purchase of health insurance. Individuals with incomes less than 100 percent of the federal poverty level (\$9,800 for an individual) will not be required to pay any premiums.

Plans offered through Commonwealth Care will not have deductibles, and will be offered by managed care organizations that participate in the Medicaid program. Commonwealth Care is expected to subsidize coverage for 207,500 residents.

Medicaid will also be expanded for children up to 300 percent of the federal poverty level. Enrollment caps on existing Medicaid programs for adults will also be raised.

The plan is expected to cost \$1.2 billion over three years and relies on redistribution of existing funding, including federal Medicaid payments previously paid to safety-net providers and funds from the Free Care Pool (which historically reimbursed providers for uncompensated care). New funding will come from the employer contributions and General Fund revenues (\$308 million over three years). The state anticipates that no additional funding will be needed beyond three years. (["Massachusetts Health Care Reform Plan," Kaiser Commission on Key Facts, April 2006](#))

Tom's Comments:

It will be called the "Massachusetts experiment." One might agree or disagree with the end result of the Massachusetts Health Care Reform initiative, yet couldn't argue that the process did bring together numerous stakeholders from across the political, business, healthcare delivery, and policy sector. As Karen Davis of The Commonwealth Fund stated, "The Massachusetts Health Care Reform Plan is grounded in the idea that individuals, employers, and government must share responsibility for health insurance." (["Providing Health Insurance for All: What Massachusetts Can Teach Us," The Commonwealth Fund, May 5, 2006, Karen Davis](#))

A number of states are evaluating similar approaches to universal healthcare. There are pros and cons to such state by state reform efforts, but at least we will have a real, rather than a theoretical opportunity to evaluate the effectiveness of such an effort. I am sure that the reform plan will need to be altered over time but at least it is a start.

NORTHEAST OHIO

Name Change at University Hospitals of Cleveland

As part of a new branding campaign, UH will change the name of University Hospitals of Cleveland to Case Medical Center and now refer to its entire health system only as University Hospitals. The Case Medical Center name also will give UH and Case an enhanced national identity that highlights the 50-year affiliation between the two entities. ("UH's main campus to bear Case name," Crain's Cleveland Business, July 24, 2006, Shannon Mortland)

MBA Open Houses

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

MBA Open House
6 p.m. / August 31, 2006
Strosacker College Union
120 E. Grand St. Berea, OH 44017

Or

MBA Open House
6 p.m. / August 30, 2006
Landmark Center
25700 Science Park Drive #100
Beachwood, OH 44122

Please call for more information 440-826-2392

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

Free Healthcare Consulting Services

Students in the Baldwin-Wallace College Health Care MBA program, as part of their course curriculum, will be offering free consulting services to interested organizations in the healthcare industry. If your organization is interested in receiving free consultative services, please contact Tom Campanella by phone (440-826-3559) or by e-mail (tcamp@bw.edu).

Join Us for the Next B-W Entrepreneur Network Reception

The B-W Entrepreneurs Network consists of alumni and friends of Baldwin-Wallace College who are actively engaged in entrepreneurial ventures in the private, public or non-profit sector, or who are looking to become more entrepreneurial in their professional or personal lives. Through its programs, the B-W Entrepreneurs Network seeks to help its members advance their own professional and personal growth and to provide current B-W students with mentoring, career advancement and experiential learning opportunities.

Visit the Center for Innovation and Growth webpage for more information.
<http://www.bw.edu/academics/bus/mba/entr/events/>

Innovation and Globalization Conference

Save the Date!

The Center for Innovation and Growth will present "Innovation & Globalization". This conference will feature speakers and events at the Berea campus. The public will be invited to hear our keynote speaker on October 4th.

Watch the website for current details:
www.bw.edu/academics/bus/mba/entr/events/