2010
A POLICY PRESCRIPTION FOR

date

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On the web

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Mission: To empower communities through the provision of timely and insightful analysis of the current and future landscape of the policy and politics of health care

A Health Reform Odyssey

Many would say that the election of Barack Obama as the 44th President of the United States was predicated on one major factor - the faltering American economy. Accounting for one-sixth of this massive economy (roughly $2.2 trillion), the health care sector is both vast and personal. Health care reform, or more accurately, health insurance reform was one of the President's most prominent campaign issues and over the span of the past year probably his most passionate concern. Several positive steps have been taken over the last 12 months: expansion of the Children's Health Insurance Plan, investments in comparative effectiveness research and health information technology, and a commitment to universal access to health care for all Americans. In this new year, we outline a set of principles upon which policy makers should base their decisions for health reform.

Five Prescriptions for Health Reform

Since the turn of the 20th century, American Presidents and presidential hopefuls have advocated for changes to the way in which the United States delivers health care. Theodore Roosevelt and the Progressive party were among the first to advocate for national health care coverage. Roosevelt was thwarted and the struggle to make health care in the United States a universal phenomenon has continued into the present. Truman, Carter, and Clinton all attempted to provide health care to all Americans. But success arrived in limited fashion when Lyndon Johnson signed the Medicare law in 1965 creating universal health care for seniors. Our nation's current passion for universal coverage has been championed by the President and his dear friend, the late Senator Ted Kennedy. We too, at Policy Prescriptions, believe that "what we face is above all a moral issue" and that health care ought to be universal in America. The following are our five prescriptions for health reform.

Create a Multi-payer Universal Health Care System

There are as many health care systems as there are nations in this world; each one a consequence of the unique cultural phenomena taking place within each country. Health care systems vary dramatically from ones where coverage is guaranteed by a government for all its citizens, others where government requires that citizens be responsible for ensuring their own coverage, and yet others where health care is a voluntary endeavor. Other than for senior citizens, health coverage in America is largely voluntary and as a result falls far short of achieving universality.

Nations such as Great Britain and Canada provide health care as a right to all their citizens. Germany puts responsibility on individuals to enroll in one of many available sickness funds which are associated with employers. Nations such as Switzerland and the Netherlands require their citizens to purchase health coverage in a well regulated (and therefore more equitable and less imperfect) health insurance marketplace.

To each nation, a uniquely tailored system. However, many would argue that in the United States, we possess a non-system. In order to craft a rational health care system from what currently exists, the United States does not require radical deviation from the status quo but only tighter regulation of a fractured health insurance marketplace and a re-alignment of incentives.

The main goal of health reform should be universality. A rational health care system should seek to provide continuous care to patients, regardless of health status, and strive for quality care that is affordable for both individuals and society. A multi-payer system with robust patient protections (such as guaranteed issue, guaranteed renewal, and modified community rating) coupled with a citizenry responsible enough that all individuals will obtain their own health coverage can achieve such goals.

Focus on Health Care Quality

We deliver intensive care; we deliver life saving and life changing care. However, our health care system must focus on providing quality care. Quality care is defined as that which is safe, timely, effective, efficient, equitable, and patient-centered. These are the keys to improving the health and well-being of America. Strategies to align incentives and improve the quality of care such as pay-for-performance should continue. The risks and rewards of pay-for-performance, however, need to be magnified in order for it to serve as an effective stimulus for quality.

Additional tools such as comparative effectiveness research will permit clinicians to make critical health decisions in a more rational manner. Health information technology will ultimately, though not immediately, improve efficiencies in health care, minimize variations in practice, and reduce the risk of serious medical error.

However, when patients fail to receive health care that is safe and whenever injury occurs, a mechanism to provide compensation for bad outcomes without focusing blame on health care providers must be established. We need malpractice reform to prevent abuses and prevent defensive medicine; but we also need to focus on patient safety and patient outcomes whether or not a patient's injuries are a consequence of negligence.

Even more importantly, we need a universal medical record accessible by all clinicians, with the authorization of each patient, in order to reduce the redundancy and inefficiency in the health care system. Americans already trust the security of their financial information; the health care industry needs to develop a trustworthy parallel and a reliable mechanism to allow authorized clinicians access to the personal health information of any patient, any where, at any time.

Foster a Diverse, Well-Distributed Health Care Workforce Focused on Primary Care

The health care workforce needs to expand to cover the increasing needs of our aging society. However, we cannot go about expanding the workforce in the same way as has happened in past generations. Selecting medical school entrants from the privileged sections of society does little to reduce the impact of health disparities or the maldistribution of clinicians in underrepresented urban and rural communities. Medical schools must find ways to attract and retain students from America's minority, impoverished, and middle-class populations.

Additionally, medical education in the 21st century must encourage a focus on primary care and community involvement - two aspects of medicine that are rapidly vanishing. Otherwise, the decline of endangered medical specialties - internal medicine, pediatrics, family medicine, and general surgery - will only continue. Physicians must become more than just clinicians; they must become effective managers of midlevel practitioners and passionate advocates for their patients.

Engage in a Discussion about the Purpose of Health Insurance Benefits

As we expand care to those currently without it, American society must finally engage in a frank discussion about the purpose and extent of health insurance. Much like how we have made a distinction that oil changes and rotating tires is not something for which car insurance was intended, we must agree upon which health care services should and should not be covered by basic health insurance. Health insurance serves as financial protection against rare and unpredictable events. Sometimes insurance includes the pre-payment for necessary services such as annual physicals and preventive screenings. Yet, certainly we can agree that not every medical service requires the pooling of risk. Society must decide which of these health care services should be paid for by individual patients as the need arises.

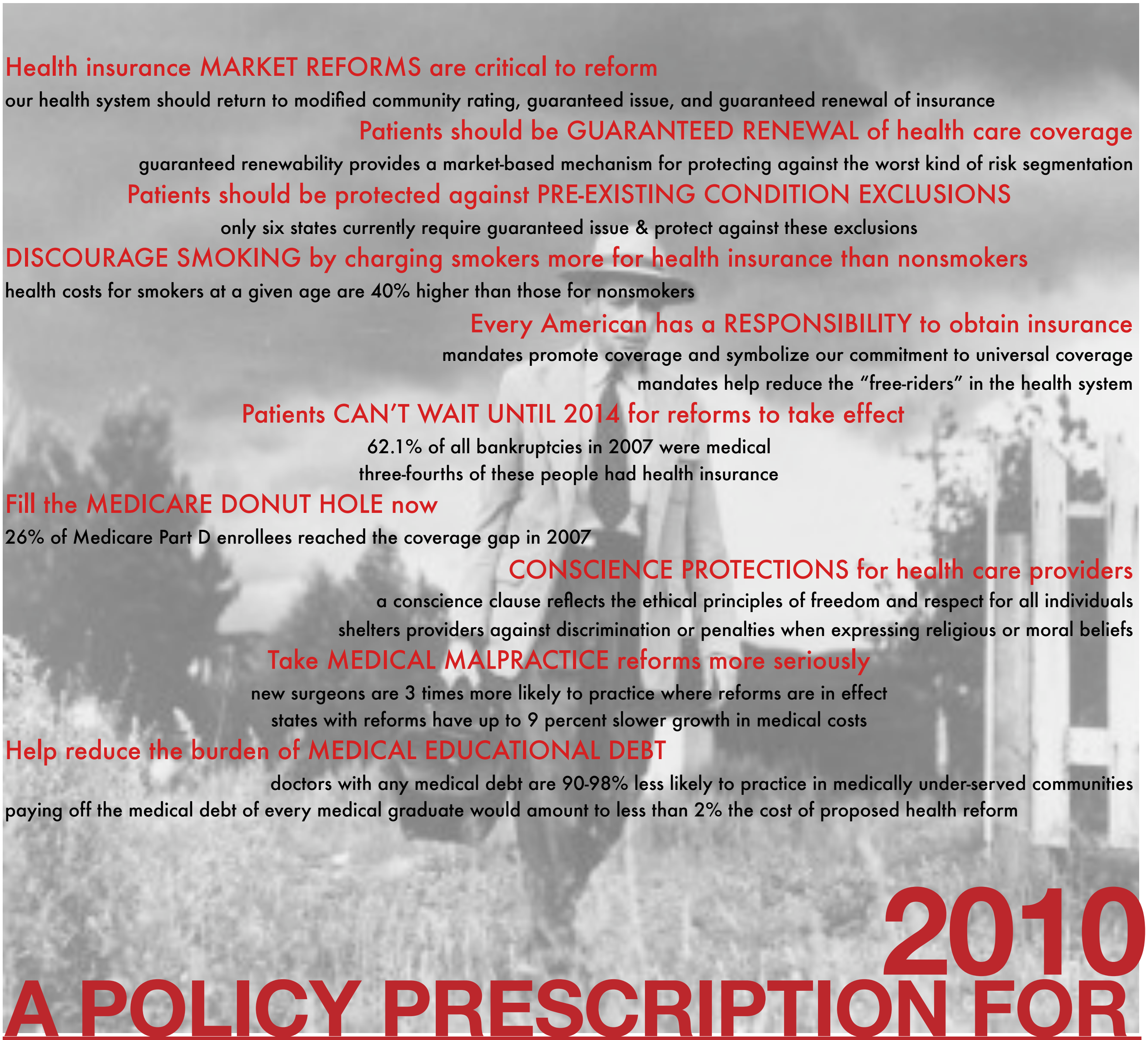
Determine an Equitable Financing Scheme for Health Care

The funding of the American health care system is fractured and inequitable. Ever since the Internal Revenue Service exempted employer-sponsored health insurance from taxable income, there have been distortions in the health insurance marketplace. Not only are employers who purchase health insurance more likely to purchase more than they need; employees, by being shielded from the true cost of insurance, are equally likely to consume more health care services than they otherwise would. All the while, those who obtain health insurance individually are not afforded this same tax benefit and face a peculiar inequality in their access to health care.

The United States Treasury has simultaneously forfeited substantial amounts of tax revenue because of this tax exemption, enough revenue to pay for the current reform proposals discussed by Congress. Removing the tax exemption for employer-sponsored health insurance could pay for health reform and the expansion of coverage to the uninsured. But at a minimum, the tax treatment of health insurance - whether employer-sponsored or individually purchased - should be the same. Which route to choose is a political decision; but, by exempting from taxation health insurance, our nation will encourage better health among its citizens.

Conclusion

In a nation as wealthy as the United States, that a single person goes without necessary health care is an inexcusable offense. Today, America is at the brink of establishing a health care system tailored specifically to our society - one that expects personal responsibility to obtain health insurance and couples it with the promise of hassle-free, rejection-free, affordable coverage from multiple private and public payers. Such a health care system must focus on patients and the quality of care provided by a workforce that is currently in short supply in some areas and poor in diversity in almost all others. Americans must now engage in a legitimate discussion about the role of health insurance and the extent of benefits required of our health insurance carriers. And we must provide for a system that is financially equitable regardless of an individual's employment status or ability to pay. Now it is time for us craft a multi-payer universal health care system which will provide our communities equitable, safe, and better health and well-being.



Health insurance MARKET REFORMS are critical to reform

our health system should return to modified community rating, guaranteed issue, and guaranteed renewal of insurance

Patients should be GUARANTEED RENEWAL of health care coverage

guaranteed renewability provides a market-based mechanism for protecting against the worst kind of risk segmentation

Patients should be protected against PRE-EXISTING CONDITION EXCLUSIONS

only six states currently require guaranteed issue & protect against these exclusions

DISCOURAGE SMOKING by charging smokers more for health insurance than nonsmokers

health costs for smokers at a given age are 40% higher than those for nonsmokers

Every American has a RESPONSIBILITY to obtain insurance

mandates promote coverage and symbolize our commitment to universal coverage

mandates help reduce the “free-riders” in the health system

Patients CAN’T WAIT UNTIL 2014 for reforms to take effect

62.1% of all bankruptcies in 2007 were medical

three-fourths of these people had health insurance

Fill the MEDICARE DONUT HOLE now

26% of Medicare Part D enrollees reached the coverage gap in 2007

CONSCIENCE PROTECTIONS for health care providers

a conscience clause reflects the ethical principles of freedom and respect for all individuals

shelters providers against discrimination or penalties when expressing religious or moral beliefs

Take MEDICAL MALPRACTICE reforms more seriously

new surgeons are 3 times more likely to practice where reforms are in effect

states with reforms have up to 9 percent slower growth in medical costs

Help reduce the burden of MEDICAL EDUCATIONAL DEBT

doctors with any medical debt are 90-98% less likely to practice in medically under-served communities

paying off the medical debt of every medical graduate would amount to less than 2% the cost of proposed health reform

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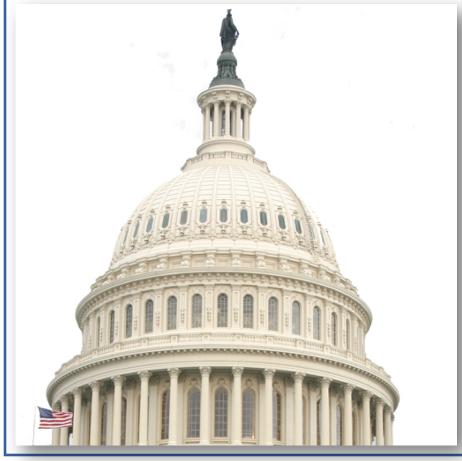
JANUARY 8, 2010

POLICY PRESCRIPTIONS

WHY WE CAN'T WAIT UNTIL 2014

A well-cited study in early 2009 proclaimed that 62.1 percent of all bankruptcies were secondary to medical calamity. A newer study analyzes this same point and provides evidence to support the case that America cannot wait until 2014 for the benefits of health reform to take effect.

This study analyzes data from the RAND Corporation's Health and Retirement Study conducted from years 1992 through 2006. The authors sought to compare their data with the claims of other researchers which estimated that anywhere from between 50-62 percent of bankruptcies are the result of medical illness. In most cases of illness, insurance covers the bulk of medical expenses. However, there often are many out-of-pocket costs such as copays, coinsurance, and deductibles. Even for insured patients, these out-of-pocket costs can prove to be challenging. For a person who happens to be uninsured, medical expenses must be borne one hundred percent. The authors of this study examined several key illnesses including, diabetes, cancer, emphysema, heart disease, stroke, and psychiatric illness. Individuals who suffered illness and were uninsured prior to becoming ill were the cohort of interest. These individuals were compared



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to others matched on the basis of initial (pre-illness) assets, income, home ownership, and the presence of pre-existing medical conditions. Newly ill, uninsured households for which no matches were achievable were excluded from analysis.

Evaluation of the data revealed a total of 304 newly ill, uninsured households and compared them to similar households that were either (1) insured and had a new illness or (2) uninsured and healthy.

The outcome of interest was the net change in assets - including savings and checking accounts, retirement accounts, businesses, stocks and bonds, vehicles, and real estate (excluding the primary residence). Compared to similarly matched households, those households that experienced a new illness and were uninsured had a median net loss of assets of 54 percent or $4,240 (for households with initial assets between $1,000-$200,000). For all newly ill, uninsured households with initial assets up to $300,000, the median loss of assets after illness struck was 33 percent or $3,006. Potential confounding factors included homeownership and college education, both of which had a positive impact on household asset change.

In an attempt to illustrate their findings, the authors suggested that readers think of 4 similarly situated households with initial assets of $20,000. After passage of time, one household that is healthy and uninsured and another that is newly ill and insured would still have roughly the same amount of assets. By comparison, the newly ill, uninsured household would only have $15,600 in assets remaining. Thus, the authors conclude that the consequences of illness for an uninsured household are potentially devastating from a financial standpoint.

Key Points

- Uninsured households lose 33-54% assets when illness strikes
- Health insurance offers financial protection from illness

HSR. 2009; Article online before print.

Commentary

The purpose of insurance is to anticipate and protect against catastrophic financial loss. In the case of health insurance, the purpose is to protect a family's financial well-being in the event an expensive illness arises. This study clearly demonstrates that families that are uninsured expose themselves to significant financial risk. When compared to similar households, those that are uninsured and suffer illness stand to lose approximately one-third to one-half of their accumulated assets. With over 45 million Americans without health insurance, a heart attack or a major car crash could spell financial ruin to millions of American families. Although this study is flawed because comparisons to uninsured households require selecting similarly situated matches - low income, minority, and often non-citizen households, it does suggest that expanding health insurance coverage will protect the financial well-being of many Americans, reduce bankruptcies, and contribute to the revival of the economy. Unfortunately, many benefits of the health reform bills in Congress do not take effect immediately. Many American families cannot wait until 2014 for Medicaid expansions, premium subsidies, limits on deductibles, guaranteed issue, and prohibitions on pre-existing conditions to take effect.

JANUARY 4, 2010

POLICY
PRESCRIPTIONS

MAMMOGRAPHY, BUT AT WHAT AGE?

Recent recommendations by the USPSTF suggest that women can safely postpone mammography until age 50. However, such rational use of evidence to inform policy may be seen by some others as arbitrary health care rationing.

In November, major news networks, ethicists, medical professionals, and the public alike were buzzing with surprise in response to newly released recommendations by the United States Preventive Services Task Force (USPSTF) regarding screening mammography for the prevention of breast cancer. The most debated aspect of the recommendation, which differed from the previous recommendations of 2002, specified that women should start getting mammography at the age of 50 instead of 40. It further recommended that women younger than 50 years of age decide individually whether or not to get screening mammography, taking "patient context into account, including the patient's values regarding specific benefits and harms."

The 2002 recommendations had concluded that although their meta-analysis showed that the benefit of mammography in the ages of 40-49 was not as large as for women 50 years of age and older (relative risk of death from breast cancer 0.85 versus 0.78, respectively), screening mammography was still recommended starting at age 40. The USPSTF Committee members pointed out that the most important question is what rate of false positives, leading to unnecessary stress, needle biopsies, and cost, are women willing to undergo for the chance of preventing one death from breast cancer? Interestingly, they calculated that for every one prevented death, 400 women would have false-positive results from screening mammography and 100 women would undergo biopsy or fine-needle aspiration. A survey from 2000 suggested that society was willing to accept these risks, with most women surveyed responding that they would accept 500 false positives in mammography to prevent one death.

Since those previous recommendations in 2002, a new trial specifically looking at screening mammography in over 160,000 women aged 40-49 has published data, which has now been added to the data from before 2002. The new calculated relative risk of death from breast cancer using screening mammography remains the same. However, using this new 2009

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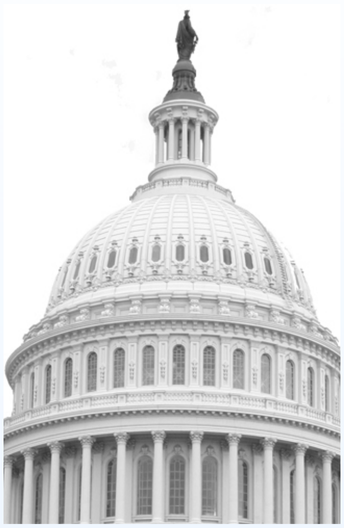


We are always looking for new writers to help scour the volumes of journals and primary literature detailing the pros and cons of health care reform proposals. If you are interested, please email us at cedric@policyprescriptions.org and include a resume & writing sample (no more than 1 page please). Successful candidates will have an advanced degree in medicine, law, public health, or public policy.

summed data set, the actual risk of breast cancer, and therefore the absolute risk reduction, in the younger age group of women is less than previously thought. This is best demonstrated with the number of women needed to screen to prevent one death as calculated with all data up to 2009: 1904 women aged 40-49 and 1339 women aged 50-59 years. This can be compared to the 2002 calculated numbers of 1792 and 838 for women 40-49 and 50-59, respectively.

The Mikulski Amendment

- Mandates first dollar coverage for:
- USPSTF A & B rated items
- Health Services and Research Administration's guidelines
- Recommendations of CDC's Advisory Committee on Immunization Practices

In light of the new controversial recommendations, an amendment was adopted to the Senate's health care reform bill as proposed by Senator Mikulski of Maryland, which mandated insurance plans to cover (without cost-sharing) women's preventive services as recommended by the Health Resources and Services Administration in addition to those recommended by the USPSTF. Specifically, this would include mammography starting at the age of 40, consistent with the old USPSTF recommendations.

Bjurstam N, et al. The Gothenburg Breast Screening Trial. Cancer 2003; 97: 2387-96.

Nelson HD, et al. Screening for breast cancer: an update for the U.S. Preventive Services Task Force. Ann Intern Med 2009; 151: 727-37.

Schwartz LM, et al. U.S. women's attitudes to false positive mammography results and detection of ductal carcinoma in situ: cross sectional survey. BMJ 2000; 320(7250): 1635-40.

U.S. Preventive Services Task Force. Screening for breast cancer: recommendations and rationale. Ann Intern Med 2002; 137: 344-6.

Moss SM, et al. Trial Management Group. Effect of mammographic screening from age 40 years on breast cancer mortality at 10 years' follow-up: a randomised controlled trial. Lancet 2006; 368: 2053-60.

Commentary

The new data taken into consideration in the recent USPSTF recommendations does show that screening mammography for women ages 40-49 is not as effective as previously believed, although marginally so. Third-party payers may have used the new USPSTF recommendations to deny coverage for screening mammography for women under the age of 50. However, as in 2002, it is debatable how much proven benefit is necessary to outweigh the measurable and immeasurable adverse effects of such screening. No matter your opinion of mammography, the Mikulski amendment leaves the decision on when to begin regular screening mammography in the hands of the physician and patient and ensures third-party payer coverage for those who wish to begin at 40 years of age.

JANUARY 19, 2010

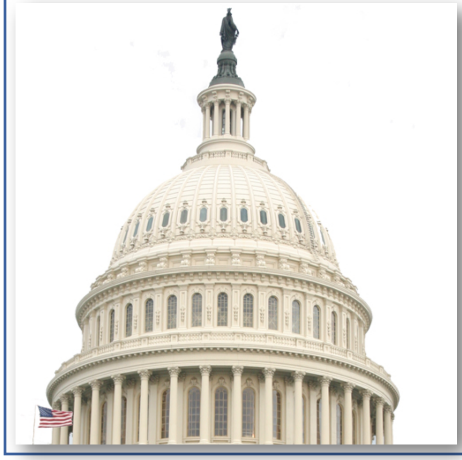
POLICY
PRESCRIPTIONS

DON'T TAX MY 'LAC

Lawmakers are considering the controversial revenue stream that would come from taxing employer-sponsored health insurance. Many liberal groups and labor unions oppose such a tax on the premise that it will affect many union members and middle class Americans.

Health economists have long argued that the tax exclusion of employer-sponsored health insurance (ESHI) benefits skews an already imperfect health insurance market. Such tax free benefits encourage the maximization of expenditures on health insurance coverage in exchange for lower take home pay. For instance, a worker in the 33 percent tax bracket could get an additional $1 of health insurance coverage versus 67 cents of extra take home pay. In addition to distorting incentives to purchase insurance coverage as opposed to higher pay, the tax exclusion poses two major inequalities: (1) self-employed individuals cannot enjoy such benefits and (2) greater benefits accrue to wealthier individuals, that is, those in higher tax brackets.

The authors of this study estimated effects of the tax exclusion for ESHI based on a standard deduction for health insurance up to $7,500 for individuals and $15,000 for families (based on a proposal by the Bush administration in 2007). Analysis was based on the 2007 Kaiser Family Foundation/Health Research and Educational Trust (KFF/HRET) Employer Benefits



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Survey. The currently debated 40 percent tax on "Cadillac health plans" differs from the Bush administration plan and would impact individuals plans costing above $8,500 and family plans above $23,000. Therefore, a direct analysis relevant to today's policy debate is unavailable.

When looking at plan characteristics, those plans above the cutoff had statistically significant increased premium cost compared to plans below the tax cutoff (($16,266 versus $9,874). The actuarial value of plans above the proposed tax cutoff were statistically richer than those below the cutoff, but only marginally so (81 percent versus 79 percent). When investigating plan types, only high deductible plans were unevenly distributed across the taxation threshold; high deductible plans such as Health Savings Accounts and Health Reimbursement Accounts comprised 1 percent of the expensive plans and 6 percent of the less costly plans. In that same vein, the average deductible for plans above the tax threshold was $319 versus $473 for plans below the threshold.

The authors then sought to determine what explains such variability between premiums. Actuarial value explained only about 4 percent of the variability. When firm type, market characteristics, and plan type were factored into the equation, only 16 percent of premium variation could be explained. Thus, 84 percent of the variability in health plan expense remains largely unexplained and requires additional research.

Key Points

- Actuarial value only explains 4% of health plan cost
- High deductible plans are more likely to be under the tax penalty.

Health Affairs, 2010; 29 (1): 174-181.

Commentary

Senate Democrats have proposed a 40 percent tax on health plans whose cost exceeds the $8,500 threshold for individuals and $23,000 for families. In this analysis and others by the Commonwealth Fund, analysts perceive the taxation of "Cadillac health plans" as a crude and likely ineffective way to reduce health care costs. While it remains true that the current tax exemption for ESHI serves as lost revenue to the government and skews employees' incentives to maximize health coverage at the expense of additional wages, the neglected issue is one of equity. Individuals who obtain their health insurance in any other fashion besides through their employer must do so with after-tax dollars instead of pre-tax funds. As we have mentioned before, health is something to incentivize and not penalize. Therefore, as negotiations proceed between the House and Senate, priority should be given to equalizing the treatment of health insurance benefits in the tax code. Secondarily, efforts should be made to encourage the purchase of health insurance - likely by exempting both ESHI and individually purchased insurance plans. A crude cap on tax free benefits may encourage a reduction in over-insurance, but only if employees truly understand the actual cost of the health plans. Therefore, Congress should require employers to report the cost of ESHI on an individual's W-2 form, just as it does for wage income.

JANUARY 25, 2010

POLICY

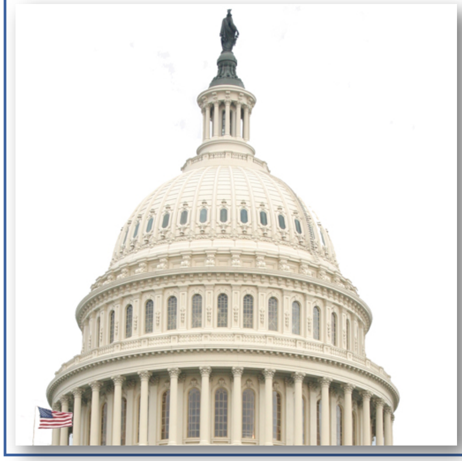
PRESCRIPTIONS

JAPAN'S TRAGEDY OF THE COMMONS

The Japanese tout one of the world's best multipayer, universal health care systems in terms of long life expectancy, copious technology, and low cost. Still, areas for improvement persist and lessons for the US abound.

Of the myriad healthcare systems in the world, the Japanese system resembles one towards which the American system was metamorphosing. That was, until last week's events threatened to stall or kill the movement for health reform in the United States. Regardless, in our zeal to promote a universal healthcare system structured around multiple payers, we find it instructive to examine international systems resembling that ideal. This post represents the first in a series of comparative national and international health systems.

The Japanese have guaranteed health insurance coverage to its citizens since 1958. Presently the life expectancy in Japan is the longest in the world, the infant mortality is among the lowest, and the per capita number of physicians, MRIs, and CT scanners is among the highest around the globe. Health costs in Japan amount to approximately 8 percent of GDP. Although this figure is growing, it remains far less than the 16 percent of GDP the United States spends on health care. The Japanese system divides patients into one of the three segments - (1) employer based insurance, (2) the elderly (Roken), and (3) everyone else (Kokohu). Further fragmenting the employer-based health insurance system, Japan's government manages



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insurance for small and mid-sized companies (Seikan) as well as government employees and teachers (Kyosai). Larger private firms are serviced by over a thousand separate private insurance (Kenpo) plans. Cross subsidization is paramount in the Japanese system and is vastly more explicit than in the American system.

When examined from this perspective, the Japanese system appears quite similar to the American one, except that the Kokohu plans which includes the self-employed and retired, also provider coverage for individuals without another qualified insurance plan. In this sense, the Kokohu could appear similar to a large national insurance exchange open to America's currently uninsured.

Despite the positive aspects of the Japanese systems, scholars have identified several areas for reform:

(1) over prescription by physicians - doctors earn income by writing prescriptions and therefore it is no surprise that Japanese doctors write more prescriptions than are likely necessary. Drug costs amount to nearly one-quarter of total health costs in Japan (compared to only 10 percent in the US).

(2) resistance to cross-subsidization - large employer-sponsored plans cross-subsidize smaller plans within the employer based system as well as the elderly. As financial pressures worsen for Kenpo plans, many are losing the social solidarity supportive of cross-subsidization schemes.

(3) mixed private and insurance payments are prohibited - resistance to allowing a two-tiered system is strong among Japanese physicians. However, because of the comprehensiveness of benefits, there is little incentive to minimize marginally effective health care services on the part of patients.

(4) Fee-for-service - the Japanese equivalent of American DRG system for hospitalizations was implemented in 2003. No value based systems yet exist.

(5) Evidence-based medicine - over the past decade, the Japanese government has met resistance from the medical community over protocolized EBM as a threat to professional autonomy.

"International Health Systems Primer" by the American Medical Student Association.

"Sick Around the World" A PBS special on health systems around the globe.

BMJ. 2005; 331: 648-9.

Commentary

To each nation, a uniquely tailored health system. As the United States continues to move towards universal health care, comparisons to other multipayer, universal systems are instructive. Many of the problems we face are still present in Japan. How the Japanese work to resolve the issues surrounding cross-subsidization of health care and the resistance to evidence-based medicine will help inform US lawmakers about how to tackle two critical issues: (1) explicit cross-subsidization in order to cover the uninsured and (2) the adoption of comparative effectiveness research as the next leap forward in evidence-based medicine.

A key point from Japan, however, is that there has been a commitment on the part of the people to provide care to all Japanese, not just those of financial means.

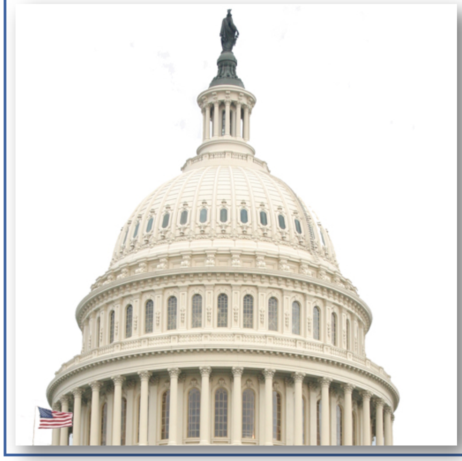
February 1, 2010

POLICY PRESCRIPTIONS

THE MOST DIFFICULT DECISION

As the healthcare debate appears to have stalled in Congress, perhaps we should take note that health care is a limited resource. How to best divide this resource, in terms of how to define what is covered and what is not, has yet to be adequately debated.

A clever Perspective in the New England Journal of Medicine last month verbalized one of the most neglected issues in our current health care debate. How can America reconcile the conflict between covering more people versus covering more health services given a fixed amount of resources devoted to the health sector? The authors provide a simple comparison of the costs of insuring more Americans based on the cost of health insurance premiums. They looked at the cost of premiums ranging from 10th percentile ($2,800)), median ($4,200), and 90th percentile ($6,000) and calculated that to insure an additional 50 million Americans the nation would need to spend an additional $140, $210, or $300 billion annually, respectively.



Looking at the problem from another angle, the authors provide estimates on the average number of quality-adjusted life-years (QALYs) gained from certain medical interventions. Given the same fixed budget of $180 billion, the United States could provide left-ventricular assist devices for heart failure patients and thereby gain fewer than 360,000 QALYs.

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Alternatively, the nation could provide HIV medications and receive over 1.8 million QALYs. Currently, our society chooses among these choices based on financial factors. If you can afford it, you can purchase whatever health care technology will pay for. If you can't, even inexpensive technology is out of a patient's reach.

The authors go on to remind us of the Oregon Health Plan, where a commission of patients and doctors sought precisely to determine the relative value of various health care interventions. The goal was to change the implicit rationing our current health care system provides via the patient's financial situation with that of explicit rationing via cost effectiveness and participatory democracy. However, the Oregon Health Plan has not been very successful at rationing care or saving costs. This is largely a factor of politicians being unwilling to implement deep cuts in services to their constituents.

Key Points

- Health resources are finite
- More benefits covered means fewer people covered
- Oregon Health Plan saved only 2% of anticipate costs

NEJM. 2010. 362; 2: 95-97.

Commentary

Our current health care debate has focused on expanding coverage to the uninsured, providing subsidies to help the uninsured purchase insurance, and fixing business practices which allow health insurers to avoid risky patients and abandon sick ones. What the health reform debate has missed has been a genuine discussion about the scope of health insurance, that is, what services should and should not be covered. Other than abortion services, which are only mentioned because of the ideological fervor separating the political parties over that issue, and mammography, which only became an issue when the USPSTF altered their recommendations, minimal energy has been devoted to determining which health care services our society values over others. This article reminds us that the most difficult decision is adjudicating the battle for health care resources between the uninsured and the overinsured. Our political process makes it possible for specific interest groups to politically guarantee access to certain treatments or therapies. By requiring certain benefits be covered, the cost of insurance for everyone goes up. The more services required, the costlier it becomes.

The health reform bills under debate defer the definition of "minimal credible coverage" to administrators within the Department of Health and Human Services. First, our society must come to grips with the inevitable truth that health care is a limited resource and decisions must be made regarding how much, to whom, and by what means to distribute this resource. We cannot realistically cover all things for all people. We should not cover all things for some people. The first priority of our healthcare system is universality. With that as a goal, difficult decisions about where to draw the line on benefits coverage must be made in such a meaningful way that funds allocated for health can cover some things for all people.

February 8, 2010

POLICY
PRESCRIPTIONS

ABORTION: CONTROVERSY AND COMPROMISE

A brief from the Department of Health Policy at George Washington University posits that the proposed limitation on coverage of medically indicated abortions within health care reform legislation will have industry-wide effects.

Current federal law prohibits any use of federal funds for abortion, with the exception of the case where a pregnancy is a result of an act of rape or incest, or where "a woman suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed." Similar to Medicaid restrictions, federal employees also are subjected to limitations of coverage, unless "the life of the mother would be endangered if the fetus were carried to term, or the pregnancy is the result of an act of rape or incest." Within Medicaid, states are preserved the right to fund additional abortion services using only state and local monies, with 23 states currently paying for some abortion services beyond that permitted under the federal law. Private employers also have no mandatory exclusion of payment for certain types of medically appropriate abortions. In fact, 87 percent

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of employer-based insurance plans cover medically indicated abortions and 46 percent of workers have coverage that includes some level of abortion services.

The Stupak-Pitts Amendment seeks to continue the prohibition of federal funding for abortion in Medicaid and the proposed national health insurance exchange. The Amendment would:

- prohibit the use of funds either to directly pay for abortion or to buy an exchange product that coverages abortions other than a narrow range of services (i.e., a case of life-endangering physical condition)

- prohibit companies from offering supplemental coverage or plans that cover abortions unless they also offer an exchange plan that is identical in every respect except that no prohibited abortion coverage is provided.

- prohibit use of federal funds for that supplemental coverage, with administrative costs and all services offered through such supplemental coverage or plan to be funded only by premiums collected for such coverage.

The authors make the point that the health benefit services industry depends on standardization and norms, with a preference for products that can be offered in all markets. The new large market as created through a health exchange program is expected to include 30 million people within the first six years of implementation, taking into account that small employers are expected to migrate into the exchange system. As in other industries, with the exclusion of certain types of products from large markets, the market itself will shift over time as the insurers accommodate their products through redesign. Under this Stupak-Pitts Amendment, the default coverage will become a product that excludes all but a limited number of abortion procedures, as the industry will seek to meet the lowest common denominator.

In addition, the development of supplemental plans that cover abortion services will be limited due to the extensive difficulty of plan administration. Costs of supplemental coverage will be high as the supplemental premiums must alone cover all administration and the risk of cost for certain abortions that are connected with serious health conditions cannot be shared in the larger risk pool. Individual coverage determinations will differ for women based on their procedures, severity of health conditions and medical evidence in the case. Complex decisions will be difficult as the abortion might not always be the immediate subject of the claim, i.e. part of a broader treatment for a serious health condition. Coverage determinations and grievance and appeals procedures will have to be separately administered to respond to different coverage rules. The legal risks involved will also be high as the commingling of plan administration duties between the prohibited and non-prohibited plans is difficult to avoid. Indeed this reasoning accounts for the lack of availability of such supplemental products currently in states that enforce the same sort of limitations on abortion coverage.

Key Points

- Stupak-Pitts Amendment prohibits used of federal funds for most abortions
- Insurers may seek to standardize products
- 87% of ESHI plans pay for abortion services

An Analysis of the Implications of the Stupak/Pitts Amendment for Coverage of Medically Indicated Abortions

The authors also describe a potential for spillover effects from the administration of an exclusion that imposes a life-threatening coverage standard that will eventually consume the entire industry. Plan administrators will have difficulties with the complex decisions about whether a certain condition is life-threatening.

They will be more likely to deny treatment altogether, rather than face the prospect of legal violation for paying for excluded abortions.

Commentary

Indeed, there will be significant standardization of insurance products as the health insurance exchange will include a large portion of our citizenry. As insurance companies join the exchange, incentives must be created to maintain their competitive nature through differing services. At the same time, the conversation must also turn towards the regulation of all insurance companies and their ability to apply unfettered subjectivity within their claims approval process. There are currently no sanctions for improper claims denials - the consumer has no recourse or apology after a long appeals process and the insurer has no incentive to prevent such action in the future. There must be a forum within the determination process that will force insurers to be subjected to a level of standardization that is appropriately reactive to medical evidence and that applies priority to fairness as opposed to the insurer's profit margin. Among other results, such a forum might mitigate the spillover effects of excluded treatments in order to allow for the intent of the proposed Amendment to be realized.

February 16, 2010

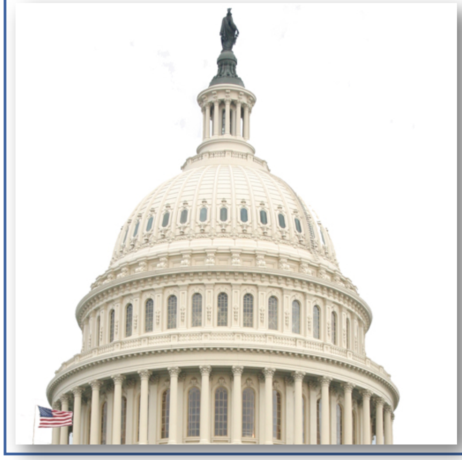
POLICY PRESCRIPTIONS

THE FRENCH CONNECTION

The French health care system is viewed by some as the best in the world; multiple payers combine to provide universal care for all of France's legal residents under the principle of social solidarity.

At the turn of the millennium, the French health care system was touted the best performer in the world according to the World Health Organization. Its universal, multi-payer health care system provides service to all legal residents of France based on a culture rich in social solidarity. It remains the envy of many other nations across the globe.

The French system is delivered through several sickness insurance funds based on an individual's occupation and geographic location within the country. Additionally, up to 90 percent of the French population has voluntary supplemental insurance on top of the compulsory insurance offered through the sickness funds. The French healthcare system is financed via specifically earmarked taxes (on income, pharmaceutical companies, and tobacco/alcohol) and payroll deductions (up to about 13 percent). Physicians practice in one of two sectors. Sector I physicians follow a national fee schedule; physicians participating in this program are entitled to certain government benefits including health insurance. Sector II physicians can charge rates above the national fee schedule but do not receive government benefits. Patients traditionally have had a free choice of doctors - both generalists and specialists. However



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lately, the French have tried to restrict this open access model of care. The goals of such restrictions were to reduce the utilization of services, specifically specialist care.

Since 2006, the French have initiated a form of gate-keeping (known as the "preferred doctor scheme") which requires patients to initiate interactions with the medical system by visiting a pre-defined primary physician. Implementation of the preferred doctor scheme provided incentive payments for physicians and penalized patients if they went directly to specialists without referrals form their primary care doctor.

However, political scientists note that the preferred doctor scheme established in France was largely a political move and not one based on empirical evidence or thought. The need for a greater role of primary care in the French system was doubtful; up to 90 percent of patients within the French system could already identify a primary care physician even before implementation of the preferred doctor scheme. Upon implementation of the scheme, 81 percent of French patients choose to participate. In fact, when compared to patients that did not agree to join the preferred doctor scheme, those that did agree to participate in the gate keeping process were over 5 times more likely to already have a primary care doctor. Age greater than 65, having complimentary insurance, and poor health status were other factors correlating with an increased likelihood of participation in the preferred doctor scheme.

Following implementation of the preferred doctor scheme, no appreciable reduction in health costs were produced. Similarly, no changes in health care quality were noted.

Key Points

- France has the best health system in the world (WHO, 2000)
- 90 percent of patients can identify a primary care doctor

Health Policy. 2010; 94: 129–134.

Commentary

France implemented reforms in 2006 that made good political sense but likely were unnecessary if the government had conducted a thorough needs assessment. While the basis for any health care system should rest on a firm foundation of primary care - doctors who can coordinate care among different specialists - the French system already celebrated a heavy investment in primary care. Therefore, a formalized system of "gate keepers" or "preferred doctors" was unnecessary in the French system where at least 90 percent of patients already had primary care physicians.

The French experience does suggest that while the united States should attempt to reinforce primary care, costs may not be reduced and quality may not be improved once a minimal level of attainment has been reached. What that percentage is however, remains unknown.

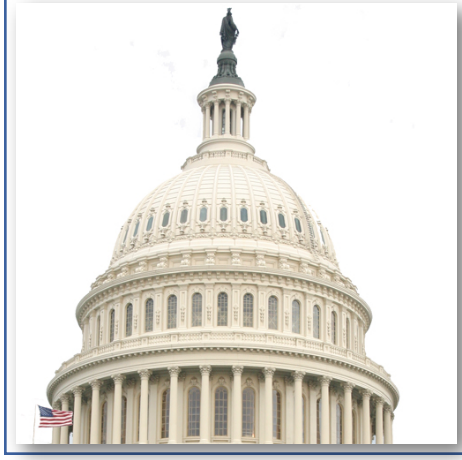
February 22, 2010

POLICY PRESCRIPTIONS

EMBRACING THE ELECTRONIC ERA

Medicine lags behind many other industries in the transition to the electronic era. While high-tech advances like CAT scans and MRI machines take advantage of computerization, many physicians still rely on paper and pen to document patient conditions and treatment plans.

The American Recovery and Reinvestment Act has provided ample stimulus for doctors and hospitals to initiate the used of electronic health records. Prior surveys have demonstrated poor uptake of EHR among physician offices. Those most likely to use EHR systems are those in larger practices, those affiliated with residents or medical students, or those affiliated with hospital systems. Of those with electronic systems, most physicians (greater than 80 percent) are able to view lab results or document patient visits but less than half can order laboratory tests of transmit prescriptions to pharmacies electronically. A national survey of physicians conducted two years ago described far worse rates of EHR adoption among private practice doctors. In that survey, only 13 percent of physicians had a EHR; only 4 percent could claim to possess a "fully functional" electronic records system.



The current report in the NEJM describes efforts of a New York hospital system to entice local physicians to purchase and implement an electronic health record. Funds from the ARRA would allow for $44,000 in

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incentives from the federal government for physicians who have "meaningful use" of EHR. In addition to this, one hospital system in New York is offering up to an additional $40,000 for physicians who install an EHR which communicates with the hospital (50 percent match). If the EHR system allows for the sharing of quality data, the hospital will pay an 85 percent share of the cost.

The electronic incentives are specifically excluded from Stark Rules that otherwise prohibit hospitals from enticing physicians for referring patients to them. Historically, physicians have viewed the costs of installing and maintaining an EHR to be steep and often an unworthy investment. However, larger entities such as hospitals may find a broader information network as a means to expand their capture area and improve not only market share but also quality of care. The sharing of clinical information may reduce duplicative testing and will likely enable community physicians to be able to keep recently hospitalized patients from requiring readmission to the hospital.

NEJM. 2010. 362 (3):192-195.

Commentary

Currently, patient information is scattered haphazardly in a mixture of illegibly-written paper notes and charts in millions of physicians offices. A small fraction of physicians have ready access to electronic health systems which permit rapid sharing of clinical information. Many of these clinicians are in academic institutions or large multi-specialty groups. The solo-practitioner and those practicing in small (less than 6 physician) groups are extremely unlikely to have access to electronic health records.

As financial incentives begin to appear in order to spur the adoption of electron health records, an emphasis must remain on interoperability and "meaningful use." However, regulators must be cautioned that to define "meaningful use" one must have an intimate view of the practice of medicine. The current push for electronic health records is not simply the digitization of doctors' notes but rather a streamlined process for all medical interactions and decision-making. From initial patient intake and medical record-keeping, EHRs must possess that capacity to allow for laboratory orders and data exchange, medication prescription, clinical decision support, and the transfer of patient specific data to other clinicians. On top of all this, electronic systems should promote the gathering of a robust, de-identified research data base to determine quality of care and a means by which to fairly compensate physicians delivering the "best" patient care.

Another important consideration is choice versus uniformity. We must not allow the typical American zeal for competition and choice trump the need for uniformity and interoperability; having practiced in an environment where several electronic systems reside in separate silos, the information might as well be locked in a vault.

Ultimately, we need a universal patient record that is accessible to authorized clinicians in order to ensure efficient, safe, and effective patient care.

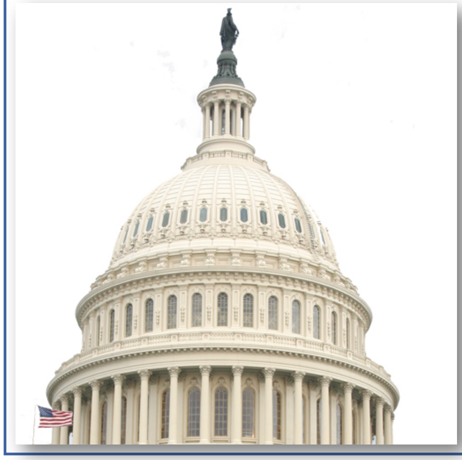
MARCH 1, 2010

POLICY
PRESCRIPTIONS

REFLECTIONS FROM HAITI: CHAOS TO CAMARADERIE

Doctor Stanley Frencher recounts recent experiences of working in a field hospital in the earthquake-ravaged nation of Haiti. But in the end, he ponders is the health care system of Haiti all that different from his home of inner-city Detroit?

Amazing. Beautiful. Picturesque. Inspiring. Not words one would associate with the earthquake-ravaged disaster occurring in Haiti. In contemplating the idea of going there, I certainly faced questions of why now, what can you really do, shouldn't trained professionals only go, and is it safe? While all of these questions were important, the main one I kept in mind was who better to go? I've been working with a local grassroots organization that has grown to national prominence on a message of working with existing infrastructures and providing culturally appropriate health messages to African American men in barbershops. Through that work, we have developed a myriad of partnerships that enabled us to garner needed supplies ($30,000 worth), travel to Santo Domingo, Dominican Republic and then work with a local NGO to arrive at the Dominican/Haitian border. There, Pastor Prophet and Dean, a family medicine doctor from Oregon, recruited us from Good Samaritan Hospital in Jimani to a Haitian Christian Mission just a few miles across the border. Upon arriving there, we were immediately inundated with surgical patients and limited facilities to treat them. Fortunately, a local field hospital had recently been established a few miles



Stanley Frencher, Jr., MD, MPH

is a co-founder of Policy Prescriptions. He graduated from the University of Michigan with a bachelor's degree in Biology/Sociology. He specialized in Health and Aging, as well as in Social, Inequality: Race, Class, Gender. Dr. Frencher earned his medical degree from Albert Einstein College of Medicine and obtained a master's in Public Health at Columbia University. He is in the midst of a General Surgery residency training while currently engaged as a Robert Wood Johnson Clinical Scholar.

away and a nurse at the Mission helped us coordinate transfer of several surgical patients to that new facility. The Love-a-Child Field Hospital, as it was called, was phenomenal. It sat at top a hillside with amazing panoramic views of Haiti. There could not have been a more tranquil place for victims of a disaster to recover both physically and emotionally. The Field Hospital was well-organized by emergency department trained staff with disaster preparedness expertise. We managed over 300 patients, most of whom required surgery. Operation Smile provided surgical oversight and supplies. The Field Hospital received daily shipments from various donors including 1,000 tents, a satellite dish for high-speed internet, and negative pressure tents that could be used to replace the classroom-style operatories where surgical procedures are performed. We still lacked basic things like sufficient food, trash bags, biohazard containers, and enough crutches for the dozens of amputees and patients with fractures. Nonetheless, the camp was nothing like any clinic I've ever experienced. I had only planned to stay a short time and return after gathering actionable information for our partner organizations, but had decided I was going to stay when I lost my passport. After some wrangling I was able to board a C-130 military plane and traveled home with dozens of Haitian evacuees.

As we look to how we are to rebuild and reform our own healthcare system, we rarely look to circumstances and areas of the world such as Haiti for inspiration. Certainly in the short-term, the world will be bringing aid to Haiti. But is there an opportunity for the world and even the United States to learn something from this tragedy. Not simply about how to manage a disaster. And not merely the moral lesson of being a good neighbor. But rather, truly learn substantive lessons about how should a healthcare system be constructed to perform well under normal circumstances and in dire ones.

Our healthcare system is no more ready for a disaster than it is a flu pandemic. The tragic circumstances I observed in Haiti were the result of not only fallen buildings, broken limbs, infected wounds, and lost lives, but also a failed healthcare infrastructure. Haitians, unaffected by the earthquake, flooded makeshift clinics and field hospitals for chronic disease care—hypertension, diabetes, pregnancy, and prostate enlargement. The very same problems of limited access and poor quality that I encountered in Haiti occur here in the US everyday. Ironically, the populations who seem to suffer most in the US resemble that of Haiti—poor and of African descent. Certainly these are not the only populations suffering here, but it further begs that question: why can't we, in a country so prosperous, do better than Haiti? Now, many will argue that we have the best healthcare in the world. And they are right. We have the best care for those who can access it. For those who can't, they might as well be in Haiti.

I began by saying that this experience inspired me. It has. Working in austere conditions with limited resources taught me the value of clinical judgment and the true meaning of care for patients. Seeing the camaraderie of multinational volunteers who worked tirelessly to do whatever it takes to care for patients inspired me. Caring for the wounds of children who underwent amputations, often with limited anesthesia, changed me. I always empathized deeply with my patients, but I find myself even more uncompromising when it comes to the systems within which we physicians work to provide that care. It can no longer be acceptable that some patients can have access to the best care in the world while others settle for whatever is available. That's simply not right. There will undoubtedly be lessons to be learned as Haiti is rebuilt and I am now working with several organizations to undercover and disseminate those strategic lessons. The rebuilding process in Haiti will inform our own redevelopment and the reformation of healthcare in the United States.

March 8, 2010

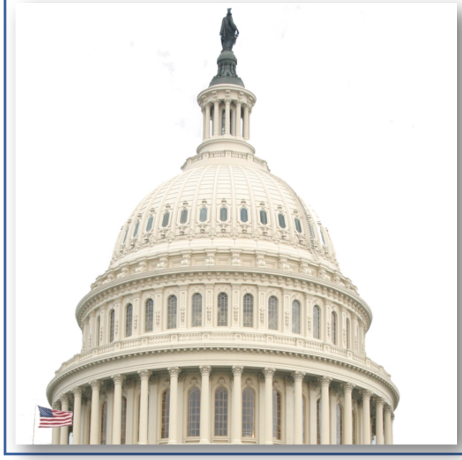
POLICY
PRESCRIPTIONS

A RANDOMIZED TRIAL OF P4P

Pay-for-performance incentive programs are commonplace now among many health care payers. A new study out of California reports on the effect of the frequency of bonus payments on clinician quality improvement.

Pay-for-performance (P4P) initiatives rest on the premise that quality in patient care can be improved by providing incentives to clinicians to improve particular metrics (called process and outcome measures) relevant to patients' health status. Prior research has clearly demonstrated that clinicians can improve tobacco cessation counseling rates and other measures that benefit patients as a result of incentive payments; other studies suggest that current P4P initiatives should put even more risk-reward into the hands of physicians.

The current study is a randomized, unblinded trial comparing the frequency of P4P bonus payments on the change in quality measures. The study investigates physicians practicing in multi-specialty groups in California. Both groups received quality report cards on a quarterly basis; this practice had been in effect prior to initiation of the study. Individual physicians (internists and family practice doctors) were randomized to receive bonus payments (up to $5,000 per year) either on a quarterly or annual basis.



One hundred twenty-four (124) physicians completed the study. Analysis of quality reporting data demonstrated a slow upward trend in composite quality scores in both groups. This trend was not

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statistically significant. Likewise, there was no statistical difference between the annual- and quarterly- bonus groups in terms of overall change in quality scores. The average bonus amount, which was $2,868, did not differ between the two groups.

The authors of this study correctly mention a major limitation; researchers were unable to conduct an additional comparison investigating the effect that the frequency of report cards for the clinicians might have on the change in bonus payments or overall quality scores. The review board approving this study deemed such a comparison unethical. However, quarterly report cards had been sent to these clinicians prior to the initiation of the study and therefore, it should be safe to assume that the observed results are accurate testimony to the ineffectiveness of the *frequency of bonus payments* to promote changes in quality.

Key Points

- Bonuses averaged 1-2% of income
- No difference in quality based on frequency of bonus payments
- Slight tend toward quality improvement

Health Services Research. Does the Frequency of Pay-for-Performance Payment Matter? Experience from a Randomized Trial. Online in advance of print.

Commentary

Reimbursement for medical care is often done based on the amount of service provided regardless of the quality of the service. A recent movement towards quality improvement has led to many pay-for-performance (P4P) initiatives across the United States and the world.

Multiple studies have shown that incentive payments to physicians can encourage doctors to improve of the quality of patient care as measured by various process measures (such as antibiotics before surgery) and outcome measures (such as rates of surgical site infections). This study suggests that quality is not necessarily affected by the frequency of bonus payment. Physicians tend to improve with adequate informational feedback despite waiting until the end of the year for financial feedback.

As the P4P movement continues forward, payers ought to consider these lessons:

- *bonus payments (and penalties) must be significant enough to effect change (some experts suggest upwards of 10% of total compensation)*
- *feedback on quality must be frequent enough to allow clinicians to change practice patterns*
- *payments may be made at any frequency without adversely affecting quality*
- *process and outcome measures must be meaningful and achieve clinician buy-in*
- *quality measures must be added, changed, and retired as necessary to remain meaningful*
- *risk adjustment must be adequate to prevent adverse selection of patients by doctors*

March 15, 2010

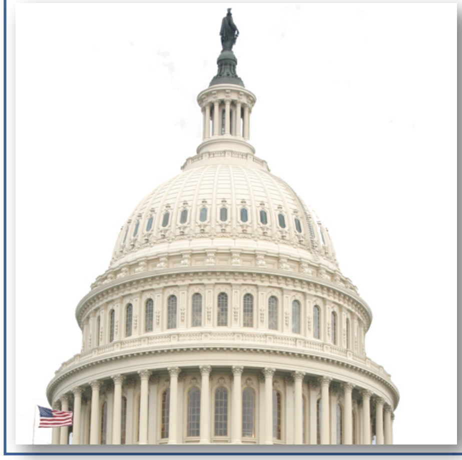
POLICY
PRESCRIPTIONS

A NEW VIEW OF TOBACCO TAXATION

Economic viewpoints on tobacco taxation typically seek to correct for the externailities imposed upon citizens by tobacco smokers. This new analysis seeks to account for these externalities, plus those incurred by family members of smokers, and assumes that smokers do not accurately value their future health.

Previous exonomic studies have deduced that taxes which increase the price of cigarettes by 10 percent ultimately reduce consmption by 1 to 3 percent. Besides generating revenue for local, state, and federal governments, tobacco taxes serve as disincentives to smoke and urge current smokers to quit. The economic theory behind such taxes is that they are designed to correct for the costs inflicted on society caused by smokers. According to economic theory, any personal harm incurred by a smoker upon himself or herself is a private decision which should not face tax implications.

Today, most smokers realize that their habit is unhealthy and poses potential future health problems. However, the decision to smoke a cigarrette is cotingent on the current benefit of smoking outweighing the foreseen costs of smoking-related disease. This principle is apparent in an analogy



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shared by almost all American consumers: using credit cards values cash (purchasing power) now versus a discounted amount of cash in the future (an amount reduced by interest payments). For smokers, the experience of a cigarette now exceeds the value of health costs in the future. The current author feels that smokers tend to discount the cost of smoking much more steeply in the near future compared to the distant future; this so-called hyperbolic discounting is likely a result of the addictive nature of nicotine.

Empirical evidence imforms that smokers tend to have a skewed perception of the value of health costs in the near future. This implied a tendency towards impatience in the near term. Another study which required smokers who were attempting to quit to deposit money into a bank account in stead of spending it on cigarettes demonstrated a 38 percent increased quit rate compared to a similarly situated control group.

Face with such data, the author of this study suggests that tobacco taxes ought to account for some of the private costs of smoking (internalities) and not merely the externalities associated with smoking. While some economists may view this a readical viewpoint, at a minimum most could agree that tobacoo taxes should offet externalities incurred to society.

Based on present assumptions, the cost to society (including medical costs, sick leave, and life insurance costs) over the life of a 24-year old smoker averages out to $2.20 per pack. Expanding these externalities to household members yeilds an additional $5.44.

Data obtained from www.tobaccofreekids.org shows that the average tax rate on a pack of tobacco is only $1.34; this value fails to correct for the externalities on society and does not begin to account for externalities incurred on household members of smokers.

Key Points: Tobacco Taxes

- South Carolina: 7 cents per pack
- New York: $2.75 per pack
- Wyoming: 60 cents per pack
- Federal Tax: $1.01 per pack

AJPH. 2010; 100: 609-615.

Commentary

Tobacco cultivation dates back to pre-Columbian America were it was used ceremonially and sometimes as a trade item. Upon arrival of Europeans in America, tobacco became highly popularized and was a major cash crop of the Americas until the supremeacy of cotton supplanted it. In the modern world, the evils of tobacco as a contibutor to cancer, pulmonary, and cardiac disease has led to significant regulation and taxation. However, tax rates vary dramatically across the United States. This current economic evaluation of tobacco taxes suggests that at a minimum - taxes (federal plus state and local) ought to add up to at least $2.20 per pack. It is conceivable, based on the eivdence presented, that tobacco taxes could be raised to a maximum of $7.64 per pack to account for externalities incurred upon household members and general society by smokers. While an outright ban on tobacco would seem unconsitiutional, lawmakers should continue to financially penalize those who smoke in order to recoup costs to society in lost productivity and death benefits.

MARCH 22, 2010

POLICY

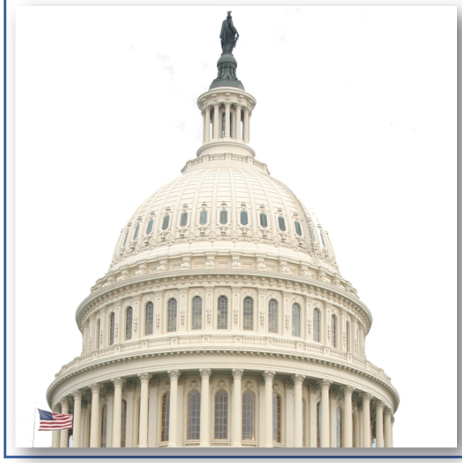
PRESCRIPTIONS

DOES DEFENSIVE MEDICINE EXIST?

Despite the common thought that most physicians perform defensive medicine on a regular basis, the evidence bearing this out has been inconsistent at best.

Ninety-three percent of physicians report practicing defensive medicine; that is, performing tests or therapies that provide little or no value to the patient, or withdrawing care altogether, because of the threat of lawsuit. However, studies looking into the practice habits of high-risk specialist physicians such as obstetricians before and after tort-reform often fail to show change.

One landmark study by Kessler and McClellan in 1996 does, however, suggest that tort reform does reduce the unnecessary testing that exists, defined in that study as reduced intensity of care with consistent measures of quality outcomes. Any such trend in the setting of tort reform, they conclude, implies that the higher level of care formerly performed were extraneous and therefore defensive medicine. Specifically, their study showed that in states that implement tort reform versus states that do not implement such reform, there is a five to nine percent decrease in the Medicare payments for hospital care of patients over 65 years old with ischemic heart disease. However, the rate of repeat admissions and mortality from heart disease stay constant. Of note, this study analyzes the effect of two subcategories of reform: (1) tort that is aimed at directly decreasing the amount of payment awarded per claim, or direct reforms, and (2) tort reform that reduces the pressure tort has on care providers but only indirectly affects award amounts, or indirect reforms. Direct reforms most commonly include caps on damages and allowance of collateral source offset, while indirect reforms include joint-and-several liability reform and limits on plaintiff attorney contingency fees. Both direct and indirect reforms were effective by Kessler and McClellan's measures of reducing defensive medicine.



This current study by Sloan and Shadle used the same data set in patients over 65 years old from 1985 to 2000 to measure effects of tort reform, but attempted to make the analysis more generalizable. In contrast to the 1996 study, they broadened their definition of

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medical care quality as measured by mortality from one disease state to four disease states (acute myocardial infarction, breast cancer, diabetes, and stroke) and measured all Medicare payments (not just hospital payments) in the one year period following diagnosis of the target illnesses. Surprisingly, this analysis showed that while one-year mortality remained constant, there was no significant change in the amount of Medicare payments for any individual disease state for either direct or indirect tort reform. When hospitalizations for all diseases were considered together, there was actually a slight increase in Medicare payments after indirect tort reforms with a concurrent increase in one-year mortality. No such changes were seen for all hospitalizations affected by direct reforms. The authors were unable to interpret the complex data while attempting to single out effects of individual types of tort reform.

Key Points

- Direct torm reforms:
  - caps on damages
  - collateral source offset
- Indirect tort reforms:
  - joint-and-several liability reform
  - limits on plaintiff attorney contingency fees

The Quarterly Journal of Economics. 1996; 111 (2): 353-390.

JAMA. 2005; 293 (21): 2609-2617.

Journal of Health Economics. 2009; 28: 481-491.

Commentary

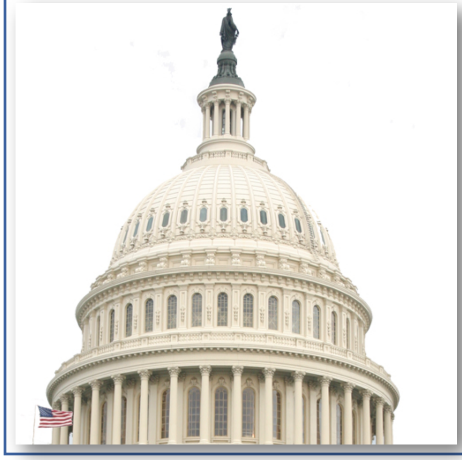
Although almost all physicians report their clinical practice to be affected by the threat of malpractice suits, literature studying changes in malpractice insurance premiums, the frequency of medical malpractice claims, and various types of tort reform yield unreliable effects on physician practice and patient outcomes. This current study, similar to the 1996 study, is measuring the wrong physician activity. It is logical that in a highly litigious environment, physicians would more often tend to order unnecessary tests to diagnose a disease, or rather to not miss a disease, than tend to increase intensity of care once the diagnosis is already made, as was measured in these studies. Moreover, unlike this study, analyses of practice habits and patient outcomes in response to tort reform will not be useful unless policymakers are able to derive which specific reform methods are effective and therefore would translate best to statutory change.

March 29, 2010

LIFE AFTER HEALTH REFORM

The hazards of sickness, accident, invalidism, involuntary employement, and old age should be provided for through insurance. (Theodore Roosevelt, 1912)

Running as a third-party candidate, and seeking to pull progressive voters from both the Republican and Democrat parties, Theordore Roosevelt argued for a form of sickness insurance similar to that established in Germany in 1883. The United States, with the passage of the Patient Protection and Affordable Care Act ("the Act"), has taken its most recent step towards this goal of insuring all Americans. The Act expands medical care for the poor through Medicaid, fosters the growth of the private health insurance market with subsidies and tax credits, demands personal responsibility through a controversial individual mandate, and promotes continuity of coverage with robust patient protections. While older generations celebrate today's success after bitter memories of the failure Clinton Health Plan, the young generation of health care advocates must remind itself that the Act will not cover everyone, nor will the issues of affordability, quality, and access to care be fully satisfied during the implementation this new law.



Universality

The Institute of Medicine states that the most important goal of our health insurance system should be universal coverage. This conclusion is reached after examining the exidence that uninsurance promotes problems for individuals, families, and society as a whole. The post-reform era of the next several years

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must keep this primary goal in mind.

Continuity

Health insurance ought to be something that individuals can trust to cover them regardless if they choose to change jobs or lose a job. The COBRA law allows for continuity of insurance only with job loss and for a limited period of time. The health reform law just passed prevents insurance companies from cancelling someone's policy, thereby also fostering improved continuity of coverage. Even more creative solutions to the lack of continuity in coverage must be found so that individuals can keep whichever insurance policy they like regardless of their work status, employer, or place of residence.

Affordability

Many opponents of the Act refer to the health reforms in Massahusetts as a demonstration that costs will increase under the new national health reform law. Some describe double digit increases in health insurance premiums in Massachusetts while nationwide increases ran 3 to 5 percent this past year. Health care costs are unlikely to be adequately controlled until people know how much health care really costs.

Americans need to be aware not only of the share of the health insurance premium they pay, but also the amount contributed by employers.

Quality and Access

Recent reforms have often focused on coverage. However, coverage is only worthwhile when patients can be assured they can actually see a doctor. And doctors are only as good as the quality of care they can provide. Our healthcare system must be re-structured to encourage doctors to deliver effective, efficient, equitable, safe, and timely care centered around the patient. Our system must guarantee that a patient can see their personal doctor whenever the need arises.

The Next Generation

Therefore, while many will pause to celebrate and others will focus on implementation, there is still much work to be done to arrive at the vision conceived nearly one hundred years ago.

But first, in the coming months the executive branch will be attempting to define two critical concepts: (1) "quality" as it applies to health care delivered in federal programs and (2) the "minimum creditable coverage" that all Americans must obtain until full implementation of the Act. For the next generation of health care advocates, this is your opportunity to begin to assert your voice.

Highlights of Health Reform

- 1929 - Dallas Teachers' Union/ Baylor Hospital health plan (the prototype for today's health insurance plans)
- 1934 - Social Security Act excludes health care
- 1954 - Tax-exemption of employer-sponsored health insurance
- 1965 - Medicare & Medicaid created
- 1974 - ERISA shields self-insured firms from state regulation
- 1986 - EMTALA & COBRA
- 1997 - CHIP established
- 2003 - Medicare Part D added
- 2010 - Patient Protection and Affordable Care Act

Then, as the Act's provisions interweave with the fabric of American life, time will again call for a movement to focus on truly covering all in the United States and streamlining the many silos under which health care is currently delivered. Those challenges await the next generation of health care advocates and policy makers.

APRIL 5, 2010

POLICY
PRESCRIPTIONS

SPILLOVER OF MANDATED BENEFITS

The power to regulate health insurance companies rests with the States, with important exceptions. Federal health programs and ERISA plans are exempt from state regulation.

The authors of this study utilize a set of natural experiments enabling them to compare the likelihood of inpatient versus outpatient breast cancer surgery between states that implemented laws which mandate inpatient coverage for such procedures and states without mandates. Instead of looking at the direct effects on patients covered by insurance plans subject to the mandate, the current study explores the indirect effect state mandates have on patients whose insurance plans are exempt from regulation (Medicare patients). It can be assumed that similar indirect effects might exist for patients covered by other insurance types such as ERISA plans (n.b. ERISA, the Employee Retirement Income Security Act, permits "self insured" health insurance plan to be exempt from state regulation. Such exemption often complicates reform efforts at the state level).

The authors selected the time period from 1993-2002 because during this time period many states adopted regulations which forced insurance companies to cover inpatient stays for breast cancer surgery (mastectomy and breast conserving surgery with lymph node dissection) in order to counter a movement towards less costly outpatient surgery led by managed care companies.

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POLICY PRESCRIPTIONS

The data sources came from the Surveillance, Epidemiology, and End Results cancer registries of nine states, Medicare-SEER registries, and Lexis-Nexis (for legal statutes).

Trends in the proportion of breast cancer surgeries performed on an outpatient basis showed stagnation in Connecticut and New Mexico which implemented mandates while states without mandates showed a steady and continuous rise in outpatient mastectomies. In California and Georgia, state laws appear to have decreased the proportion of outpatient mastectomy compared to control states.

Several other factors which significantly affect the decision to perform inpatient or outpatient surgery were noted. Sicker patients and those with higher stage cancer were more likely to have inpatient procedures. HMO penetration encouraged breast cancer surgeries to be performed as an outpatient.

Key Points

- Mastectomies and breast conserving surgery can be inpatient or outpatient procedures
- States can indirectly influence care delivery by imposing regulation

Inquiry. 2009/2010; 46: 433-447.

Commentary

A serious flaw of this and most other natural experiments is that while trends are noted, many other reasons might actually account for the apparent difference between states with and without regulations on the site (inpatient versus outpatient) of breast cancer surgery.

For instance, a federal law known as the Women's Health and Cancer Rights Act of 1999 required reconstructive surgery after mastectomy. This would be expected to increase inpatient surgery rates (albeit such expectations should be equal in all states).

Regardless of the flaw of confounding which negates the ability to assume causation, the evidence would suggest that state authorities can effectively change the landscape of health care even for those whose health insurance plans fall outside of state regulatory authority. The strength of this spillover effect in comparison to direct effects of regulation remain unknown.

One theory to explain the mechanism of spillover effects is that in light of such regulations, physicians may adjust their behavior and apply those principles to all patients regardless of insurance status.

Regulation of the health insurance industry is predominantly a state based policy level, however, with the recent passage of the Patient Protection and Affordable Care Act the federal government has exerted a powerful force to promote continuity of coverage by forbidding risk-selection and guaranteeing renewability of policies. The next step for federal regulation will be the battle of defining "minimal creditable coverage." One can anticipate a fierce debate balancing priorities of interest groups with the reality of the cost of regulation on insurance premiums.

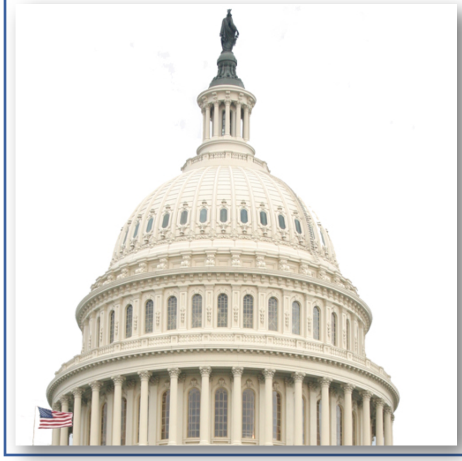
APRIL 12, 2010

POLICY PRESCRIPTIONS

INSURANCE EXCHANGES

An insurance exchange provides managed competition through the use of "sponsors" or collective purchasing agents who negotiate with insurers and offer individuals a menu of choices among different health insurance plans.

Insurance exchanges provide information on each plan's price and quality of care including, but not limited to, customer satisfaction, provider networks, benefits covered, specialized care programs, and geographic coverage. The sponsor is the broker and the individual consumer can purchase as they see fit. Insurers are required to accept any individuals who wants to purchase health coverage, so that risk avoidance is no longer a tool to control the costs of providing care. The goal of a health insurance exchange is to shift the traditional market for health insurance from competition based on risk to competition based on price.



In order for an insurance exchange to be successful in reducing costs, improving quality, and expanding coverage, there are several mechanistic issues that are to be considered.

1) Everyone must be a part of the risk pool. Without an individual mandate, those who find it advantageous to go without coverage will avoid contributing when healthy and will impose costs when sick. Healthy people opting out of the market raises average premium for those who remain. Penalties are

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therefore necessary in order to make the mandate effective. The mandate could be imposed on employers, building on the current employment-based system, though this does not guarantee universal coverage and it removes the competitive use of health benefits in the job market.

2) Risk adjustment must be effectively implemented. Insurance plans with high-cost enrollees would be balanced by those with low-cost enrollees, and therefore insurers would be forced to compete based on cost and quality - not risk selection. Adjustment is difficult however, as the reasons for high costs would need to be parsed out. Are the enrollees sicker? Or is the care provided inefficient?

3) Benefits must be standardized. There must be standardization of benefits to some degree in order to allow for plans to be comparable for both consumers and policy makers.

4) Subsidies must be available to offset costs. Subsidies can be offered in order to ease the impact of insurance costs on vulnerable communities. The exchange should not offer less generous benefit plans with lower premiums as it would eventually shift costs to those plans with the sickest enrollees. Debate persists over who should qualify for subsidies and how to fairly pay for them.

5) Rate variation can be fair. There must be some variation in premiums based on specific demographics (age, gender, health behaviors such as smoking) in order to account for variation in costs. Variation cannot occur on an individual level as that decreases the risk pool and increases transaction costs.

6) Guaranteed issue is required. Insurers must be required to sell coverage to any individual or family seeking it. With a guaranteed issue of insurance, high-risk individuals cannot be excluded from the market. Incentives must therefore be put into place in markets that are less desirable to insurers.

7) Market failure exists. There must be options for coverage in geographic areas that lack private insurers. This fallback coverage might be fulfilled through a buy-in program for a common public plan such as Medicare or Medicaid.

The exchange will not be enough to solve our current predicament alone. The escalating costs of health care must be contained. Even with the expansion of coverage through an exchange, the long-term outcomes of such changes will be unsuccessful if both the costs and the quality of services are not radically altered. The writers argue that an efficient information infrastructure, accountability for health outcomes as opposed to care processes, and optimized payment systems must be in place.

There are possible implications to employment-based health benefits with the adoption of a health insurance exchange. Employers offer health benefits in order to remain competitive in the labor market, a factor that becomes less important in a weak economy. In addition, the costs of offering health benefits are significant for employers. As an affordable health insurance market becomes available, employers may feel overtly comfortable with directing employees towards this cheaper option. Such flight might be avoided by including an employer mandate. Employers traditionally play the role of a watchdog and advocate for their employees, and can maintain a significant role in coverage decisions as an intervening party between insured and insurer.

Fronstin P, Ross, M.N. "Addressing Health Care Market Reform Through an Insurance Exchange: Essential Policy Components, the Public Plan Option, and Other Issues to Consider." Employee Benefit Research Institute, Issue Brief, June 2009, No.330

Commentary

The recently approved health reform legislation includes the following:

1. An individual mandate with penalties barring some exceptions: financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual's income, and those with incomes below the tax filing threshold

2. The creation of state-based insurance exchanges and additional exchanges for small businesses

3. Subsidies for individuals/families with income between 133-400% of the federal poverty level

4. An employer mandate with exceptions for small employers (less than 50 employees)

5. Standardized minimal benefit plan to be updated annually through a transparent and public process

6. Risk adjustment solely based on age, geographic area, family composition, and tobacco use (not gender)

This legislation provides an excellent initial approach to true reform. Per the EBRI analysis, the reform includes many strong components. The RAND corporation has released its analysis of the reform overall - the number of uninsured would be reduced 53-57%, or roughly 30 million. An additional number will be eligible for Medicaid. Several questions remain however - what is the true impact of the exceptions to the individual mandate, the full extent of the expansion of coverage, and the true impact on health care spending? As with all major policy changes, this serves as the first of many incremental steps - and hopefully the political climate can remain amenable to further change.

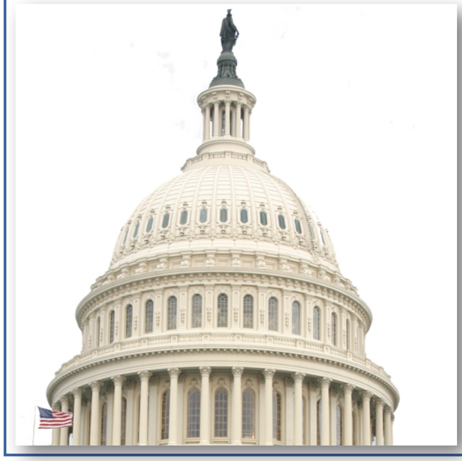
POLICY PRESCRIPTIONS

SAME-SEX DISPARITIES IN ACCESS

Same-sex couples have a level of access to insurance coverage and health care that is intermediate to that of married and unmarried different-sex couples.

The authors of this study analyzed data from the Behavioral Risk Factor Surveillance Survey, a large telephone survey conducted annually by the Centers for Disease Control and Prevention. For the sake of categorizing respondents, the authors opted to define same-sex couples as two same-sex individuals cohabitating as "a member of an unmarried couple." In order to constrain the analysis to comparable situations for different-sex couples, only 2-adult households were evaluated. Therefore, this analysis excludes any other type of household structure other than the 2-adult couple.

The relevant outcomes of this study were access to insurance coverage and unmet medical needs such as routine doctor visits, Pap smears, and mammography. Men and women in same-sex relationships were compared to men and women in different-sex relationships (both married and unmarried). Statistical analysis relied on multiple regression analysis to sort out the many confounding variables affecting the above mentioned relevant outcomes.



Both men and women in same sex relationships are less likely to have health insurance coverage (80 percent and 71 percent, respectively) than individuals in different-sex relationships. However, when inspecting these trends as compared to married

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POLICY PRESCRIPTIONS

different-sex couples versus unmarried different-sex couples, same-sex couples are more likely to be insured than unmarried different-sex couples but less likely to be insured than married different-sex couples.

Same-sex couples are more likely (nearly twice a likely among men) to report unmet medical needs. Women in same-sex couples are about 75 percent less likely to have had a Pap smear or a mammogram than women in different-sex relationships. Women in same-sex relationships are also about 72 percent less likely to have had a routine doctor visit in the prior year. Contrary to these other trends, men in same sex relationships have approximately 36 percent greater chance of having a doctors visit compared to men in different sex relationships.

In addition to these sexual orientation based disparities, several other well known factors causing disparities were confirmed. Racial and ethnic minorities remain less likely that white to have health insurance coverage. Income and educational achievement are both positively correlated with the likelihood of having insurance. Of an interesting note, smokers are less likely than nonsmokers to have health insurance.

Key Points

- Same-sex couples face barriers to access to doctors, preventive care, and insurance
- Same-sex couples are more likely than unmarried different-sex couples to have insurance

AJPH. 2010; 100: 489-495.

Commentary

Health disparities often stem from lack of access to insurance and therefore health care services. This report clearly documents that for same-sex couples, disparities in health insurance exists even though compared to unmarried couples, same-sex couples often do better.

Other apparent contradictions include juxtaposition of higher unmet medical needs among gay men even though these individuals have nearly one-third more doctor visits than their heterosexual counterparts.

One of the obvious reasons why such disparities exist is the difficulty including non-spouse domestic partners under the primary workers insurance policy. Perhaps the reason that same-sex couples are intermediate in health coverage between married and unmarried different-sex couples is that some states extend benefits to same-sex domestic partners for which unmarried different-sex couples may not qualify.

This research should prompt further study into the landscape of health disparities based on sexual orientation and specifically family structure. As the new health reform law evolves during implementation, family structures will play critical roles in the determination of insurance benefits and federal subsidies to pay for health care.

APRIL 26, 2010

POLICY PRESCRIPTIONS

THE SWISS HEALTH CARE SYSTEM

The Patient Protection and Affordable Care Act begins the transformation of the American health system into one that is strikingly similar to that in Switzerland.

As healthcare reform was debated over the past two years, cross national comparisons between the United States and other developed nations (such as the Netherlands, Japan, and France) provided insight into how universal healthcare could be achieve through a multipayer system with managed competition. Switzerland, a nation that instituted similar reforms just over 15 years ago, serves as another case study for American health reform.

The design of the health care system in Switzerland resembles the vision set forth for the American system when President Obama signed the health reform law last month. Prior to it's own health reforms in the 1990s, the Swiss health system was decentralized and subject to 26 different cantonal (similar to US state) authorities. Switzerland's health reform focused on the concepts of an individual mandate, guaranteed enrollment, community rating, and a federally defined basic health care package. Health care was transformed from a locally regulated to a nationally regulated industry following Swiss health reform. In Switzerland, families can choose from among 90 different private health insurers, each offering the basic health plan on a non-profit basis. These insurers are only legally permitted to earn profit by selling supplemental packages which offer amenities like private hospital rooms and services excluded under

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the basic health care package.

The Swiss fund their system very differently than the French or Dutch, nations which focus heavily on payroll and other tax systems. In Switzerland, citizens are required to purchase their own insurance policies directly (and unlike in the United States, employers often do not pick up the tab). To offset this financial burden, Switzerland offers subsidies to cover premium costs that would exceed 8 to 10 percent of an individuals annual income. Nearly one-third of all citizens receive a subsidy. Similar subsidies are featured in the newly passed health reform law in the United States.

Cost sharing by patients in the Swiss systems does appear to be quite high. Out-of-pocket payments represented over 31 percent of health costs in 2002. Consumers directly paid for over 68 percent of health costs (including premium costs) in Switzerland whereas in the United States this figure is less than 25 percent. Some argue that this cost consciousness if a prime driver of lower health costs in Switzerland. Others believe that the tight federal regulation of the Swiss health care industry is the real reason. Whatever the reason, Switzerland has lower per capita spending on health, lower government spending on health, and outcomes that rival the United States.

Key Points

- Individual contribution to health costs: 68% (Swiss) versus 23% (US)
- Government contributions: 25% (Swiss) versus 45% (US)
- Employer contributions: 6% (Swiss) versus 32% (US)

JAMA. 2004;292(10):1213-1220.
JAMA. 2004;292(10):1227-1231.
NPR Story: http://www.npr.org/templates/story/story.php?storyId=92106731
NYTimes Story: http://www.nytimes.com/2009/10/01/health/policy/01swiss.html

Commentary

As the United States implements its own health care reforms, cross national comparisons to places such as Switzerland serve as examples of a future American health system stressing universal care and personal responsibility.

The Swiss system incorporates several of the key pieces of America's health reform contained in the Patient Protection and Affordable Care Act (community rating, guaranteed issue, individual mandate, and a basic health insurance package). Two issues remaining in the Swiss system are excessive costs for consumers and a lack of quality data upon which to influence consumer decision-making. Regardless of those two flaws, US administrators should look to Switzerland for instruction on how to implement the new health reform law. While some call for repeal of the new American law, citizens of Switzerland view their individual mandate as a part of the social compact of their nation.

A factor distinguishing the Swiss system from the new American health reform is the simple proclamation that no insurance company can profit off the basic health insurance package. While this may be heresy in America, Switzerland, another capitalist democracy, has demanded this very same non-profit mentality in its health care industry. This, of course, requires a shift of mindset and a realization that health care is an imperfect market in need strict regulation to function better.

POLICY
PRESCRIPTIONS

BREASTMILK: DOES A BRAIN GOOD!

Breastfeeding has long been debated as the more beneficial method of infant feeding when compared to bottle-feeding. Many studies strongly associate breastfeeding with improved infant health; however, the long-term effects on mental health had not previously been measured.

In a three year (1989-1992) Australian longitudinal cohort study, 2366 women between 18-20 weeks gestation were enrolled and their children followed until 14 years after delivery to determine whether duration of breastfeeding independently effects child and adolescent mental health.

Participants completed a questionnaire and then were subjected to structured interviews and clinical assessments at each follow-up (1,2,3,5,8,10, and 14 years). Age-appropriate Child Behaviour Checklists (CBCL) were used as a validation tool to assess behavioral psychopathology in children according to several syndrome constructs: withdrawn, anxious/depressed, somatic complaints, attention problems, thought problems, delinquent behavior, and aggressive behavior. Higher mental health scores on the CBCL represented poorer behavior while lower scores represented improved behaviors. Confounding factors were accounted for, including maternal age at child's birth, maternal education, maternal smoking, family income, whether biological father lived with family, life stress events, diagnosed maternal postpartum depression. Birth data included child gender and proportion of optimal birth weight.

Children who were breastfed 6 months or longer had significantly lower mean CBCL mental health scores. Improved behavior, as indicated by lower mental health scores, was related to longer duration of breastfeeding. Younger maternal age at birth, maternal education of 12 years or less, maternal smoking, and low incomes were associated with shorter duration of breastfeeding and also higher mental health scores. For example, at 14 years old, children who were breastfed 6 months or less had a total mean CBCL score of 48.23 as compared with a mean score of 45.17 by children who were breastfed for greater than 6 months. When considering maternal age, children born to mothers less than 25-years-old who breastfed less than 6 months had lower scores than those who breastfed 6 months or greater. Surprisingly, this trend was reversed for children born to mothers aged 25 years or greater; children breastfed 6

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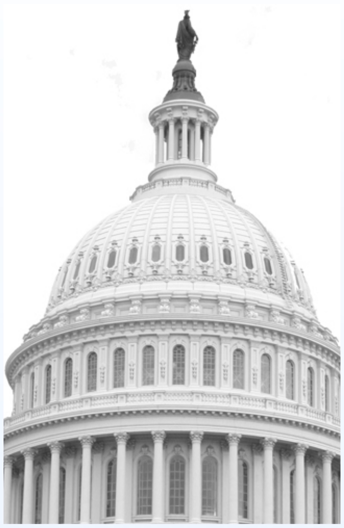

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months or greater had higher CBCL scores. The study also looked at trends of children in mental health morbidity groups (MHMG) at each assessment. Of those children who never breastfed, at the age of 8 years 19.4 percent were in MHMGs as compared to 13.5 percent of their cohorts who breastfed for 12 months or greater. The authors acknowledge that their observed associations do not equate to a causal effect of breastfeeding on subsequent mental health; however, they state that longer breastfeeding duration appears to have significant benefits on child and adolescent mental health. The authors encourage interventions aimed at promoting longer duration breastfeeding.

Pediatrics. 2010; 156: 568-574.

Key Points

- Longer duration of breastfeeding is associated with better mental health scores
- Breastfeeding is more common among higher income women in developed countries
- Dedicated spaces for pumping breast milk are now required as a result of health reform
- Mental health scores do not necessarily translate into mental health illness

Commentary

This and other studies make compelling implications of breastfeeding as the preferred source of infant nutrition. Breastfeeding is associated with decreased infant infections, respiratory illnesses, sudden infant death syndrome (SIDS), and even postpartum depression. While these associations exist, to demonstrate breastfeeding as an independent factor affecting child health continues to be a difficult task. Nonetheless, breastfeeding is the natural source of infant nutrition which has sustained mankind long before formula alternatives.

Of note is the dichotomy of developed and underdeveloped countries in regards to breastfeeding. Studies have shown that breastfeeding is more often practiced by women with lesser resources in underdeveloped countries and, ironically, by women with greater resources in developed countries.

With the advent of US health reform is the introduction of a provision in the Fair Labor Standards Act (FLSA) for breastfeeding working mother. Companies with greater than 50 employees are now required to provide a paid break and designated area (other than a bathroom) for breast-pumping mothers for up to one year following delivery. Perhaps, this provision will increase the number of breastfed infants in the US. Will this translate into a healthier society? Is this just the tip of the iceberg of the new focus on prevention? Only time will tell.

POLICY PRESCRIPTIONS®

WHAT IF EVERY DOC WAS PAID MEDICARE RATES?

Currently, physicians earn reimbursement from multiple different payers such as Medicaid, Medicare, and private insurers. If doctors were paid only according to Medicare rates, most would be losers - specialists more than others.

Researchers from the Urban Institute and the Medical Group Management Association conducted a simulation for MedPAC, the Medicare Payment Advisory Commission. The focus of the simulation was to determine the effect if all physician services in the nation were paid using the Medicare fee schedule. Typically, physicians earn revenue from multiple different sources including public payers (Medicare and Medicaid), private payers (such as Blue Cross/Blue Shield), and even the patients themselves (co-pays and deductibles).

The Medicare fee schedule was revamped in the 1990s to a system which placed relative values on the work of physicians with a goal of minimizing income inequalities between primary care physicians and procedure-based specialties. Unfortunately, the resource based relative value scale (RVRBS) still produces significant disparities in physician income benefitting those performing the most procedures.

Data for this study derived from a 2008 physician compensation survey investigating only those physicians engaged in full time clinical practice. Twenty-six medical specialties were then grouped into five categories: (1) primary care, (2) non-surgical, non-procedural specialties, (3) non-surgical, procedural specialties, (4) surgical specialties, and (5) radiology.

The study produces excellent data comparing actual and simulated compensation for physicians (either hourly or annually). Additionally, the study allows for the contrast of the 26 medical specialties against one another in order to determine relative compensation.

When looking at the first metric, mean compensation, the medical profession stands to lose nearly 12 percent under the simulation (Medicare as sole payer) compared to actual compensation ($240,030 vs. $272,723). No medical specialty wins in this situation, although the following specialties

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The Urban Institute. What if all physician serivces were paid under the Medicare fee schedule? An analysis using Medical Group Management Association data. March 2010. No 10-1.

and subspecialties experience the greatest financial losses (over 10 percent lost income): family medicine, heme/onc, psychiatry, dermatology, gastroenterology, OB/GYN, ophthalmology, orthopedics, otolaryngology, general surgery, neurosurgery, urology, and radiology.

If the Medicare fee schedule was a uniform payer for all physicians, there would not be any significant change in the relative compensation ratio between primary care and other medical specialties. However, large disparities in compensation would still persist. Only psychiatrists would earn less than family medicine doctors (which are used as a reference point). All other specialties remain better compensated than primary care. Radiology and non-surgical, procedural specialties would earn greater than twice the annual compensation of primary care. Non-surgical, non-procedural specialties would earn 44% more and surgical specialties would earn 78% more than primary care.

Highlights

- Annual salaries for physicians of different specialties varies dramatically, from a low of $174,492 for psychiatrists to a high of $689,264 for neurosurgeons
- If all docs were paid at Medicare rates, salaries would drop by 12% with radiologists and surgical specialties taking the greatest hit (nearly 20 percent drops)
- Disparities in compensation between primary care and other specialties would likely be reduced overall even though some fields (emergency medicine, cardiology, and thoracic surgery, among others) would exacerbate the disparity
- The only specialties unaffected by a change to the Medicare fee schedule would be emergency medicine, endocrinology, nephrology, physiatry, rheumatology, pulmonary, and cardio-thoracic surgery.

Commentary

If Medicare were the sole single payer to all physicians, most doctors would see declining incomes of over 10 percent. Implementing such a strategy might reduce overall health care costs by 2.5 percent (physician costs represent 21% of all health care costs) or $58 billion. However, while the nation might save $58 billion dollars a year, there would likely be no change in the distribution of physicians geographically or among the various specialties which results in difficulties accessing health care. The Medicare fee schedule does not adequately score the relative value of physician work across specialties.
The political reality of moving towards a single-payer health care system has largely been obliterated after the passage of the Patient Protection and Affordable Care Act (PPACA) which reinforced the current multi-payer system of public and private insurers. As PPACA becomes implemented over the next decade, advocates for lower cost health care could try to reinvigorate the call for "the public plan." A Medicare buy-in, which might -according to the above analysis -constrain costs by reducing payments to providers, is probably the best strategy for a "public plan". Advocates of any Medicare buy-in would rightly so be met with steep opposition from health care providers, who would stand to lose tens of thousands of dollars, per provider, every year.

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THE APPROPRIATENESS OF AGE RATING

Under the Patient Protection and Affordable Care Act, health insurance companies are permitted to vary premiums based on age by no more than a 3-to-1 ratio for non-elderly adults.

National Health Expenditure Data (NHED) obtained from the Centers for Medicare and Medicaid Services (CMS) allows for the comparison of personal health spending based multiple factors. Considering the debate surrounding the appropriateness of age rating variation, this analysis seeks a simple understanding of how much different age group spend on health care services.

When looking at the annual growth of spending on health care, the group with the highest rate of change are adults aged 45-54. These middle aged adults have experienced over 10 percent growth in annual health expenses in the period from 1987-2004, eclipsing the growth even among the extremely elderly (greater than 85 years old) population.

Per capita expenditures on health, however, reflect a steady increase associated with age. In 2004, total per capita health care expenditures averaged $5,276. The least costly population was children (individuals up to and including age 18), with a per capita spending of $2,650. Health spending continually increased with advancing age up to a per capita average of $25,691 for those individuals 85 and older.

Adults aged 19-44 spent $3,370 per capita in annual personal health care. Adults aged 45-54 expended $5,210 and those aged 55-64 expended $7,787.

Additional data from Medical Expenditure Panel Survey (MEPS) as analyzed by the Kaiser Family Foundation provides an even more refined, albeit slightly different, breakdown of health care costs for American adults. Adults age 18 to 24 accrued $1,282 annually in per capita health expenses in 2004. Americans aged 25 to 44 spent $2,277 per capita annually while individuals aged 45 to 64 averaged $4,647 in annual medical costs.

Depending on the metrics used, the higher cost age group (among non-elderly adults) spent 2.3 times (according to NHED

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data) to 3.6 times (according to MEPS data) as much as the lower cost group.

As legislated in the Patient Protection and Affordable Care Act (PPACA), the maximum variation in premiums for adults in the individual or small group market is limited to a ratio of 3 to 1. This value appears to split the difference between the two estimates obtained for actual costs spent on personal health care. With these differing data sets, it is impossible to tell whether or not the age rating restrictions of PPACA or too strict or too lenient based on empirical evidence.

Centers for Medicare and Medicaid Services. National Health Expenditure Data. 2004.

Kaiser Family Foundation. Health care costs: a primer. Aug 2007; Publication No. 7670.

Highlights

- Health expenses dramatically increase with advancing age
- PPACA restricts insurance premium variation based on age by a ratio of 3 to 1
- The actual ratio of health expenditures among the young and old differs based on the data used and the definition of an age group

Commentary

Legislation is not often evidence-based. The age rating variation restrictions elucidated in the Patient Protection and Affordable Care Act (PPACA) appear to mimic the actual health care costs accrued by real individuals. However, as can be noted by the different values obtained across the two data sets, the true ratio at the extremes of adult age (that is, 18 year olds versus 64 year olds) is probably unknown with absolute certainty at this time.

The Medical Expenditure Panel Survey data appear to underestimate the true costs compared to the National Health Expenditure Data. This might suggest that a more detailed analysis of the National Health Expenditure Data could reveal an even larger variation in actual health costs between adults at the extremes of age. If so, the 3 to 1 ratio permitted for age-based premium variation might be too low.

The Centers for Medicare and Medicaid Services ought to undertake a more detailed analysis of NHED (perhaps limiting age groups to approximately 5 year bands: 18-24, 25-29, 30-34, etc.) in order to answer the question: “How much more does a 64 year old spend on health care than an 18 year old?” The question which unfortunately cannot be answered by evidence but only through the political process will remain: “Should people of different ages pay different amounts for health insurance? If so, how much?”

MAY 24, 2010

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THE TRUCE BETWEEN CHOICE AND LIFE

Conservatives argue that the Patient Protection and Affordable Care Act violates the "truce" between pro-choice and pro-life. We recommend a strategy to negotiate a new, longer lasting truce.

The Patient Protection and Affordable Care Act (PPACA, PL 111-148) specifies that a qualified health plan is not required, as a consequence of the minimal creditable coverage to be defined by the Secretary of Health and Human Services, to provide coverage of abortion services. This language however leaves room for the inclusion of abortion services in qualified health plans at the plan's discretion, although the legislation does permit states to exclude such plans. States that allow coverage beyond the federal funding restrictions (that is, supporting only those abortions in the cases of a maternal life-threatening situation, rape, or incest) are given leeway to create separate allocation accounts that separate premium payments from other federal funds. In this sense, the truce between the pro-choice and pro-life audiences in the case of abortion funding is preserved.

Regardless of the state level decision-making, this notion has left the pro-life audience fearful. Chuck Donovan of the Heritage Foundation believes that these inclusions break the truce that has existed over this very issue - a truce which had been held in place by the Hyde Amendment, an annual attachment to the HHS appropriations since 1976. However the Hyde Amendment allows states to make their own determinations with their own funds. As cited, 33 states have their own strong abortion funding limitations, 4 states fund elective abortions, and 13 states are obligated by the courts to fund abortions for lower-income residents. Unless these states have had a public change of mind, their current levels of support can remain in place and these same 33 states can exclude qualified health plans that include coverage of abortion services. There is legitimacy in allowing each state to re-address this debate, as the permanency of a prior adopted policy might not sit well with the current electorate. But rightfully, that is for the states to decide.

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Donovan also points out that the Hyde Amendment is not applied to the increased funding for community health centers (CHCs) within the PPACA. By Executive Order, the President has directed the Secretary of HHS to observe the longstanding regulations containing the Hyde language in the Secretary's application to future CHC grants. This is admittedly an area of concern where the truce might be called to term, as the Executive Order can be repealed or amended at any time without Congressional approval and future Presidents are not personally beholden.

If the issue remains that tax dollars should not be used to fund abortions, would Donovan and the Heritage Foundation accept a compromise for a permanent Hyde Amendment? In exchange, Congress should enact a permanent law encompassing the essence of Roe v. Wade - that neither the federal government nor the states may restrict the actual practice of abortion by physicians (prior to fetal viability). Would this not be the best way to permanently preserve the "truce" between pro-choice and pro-life?

Acknowlegment

Cedric Dark, MD, MPH contributed to the content and direction of this opinion article.

Donovan, C. Abortion Coverage in President Obama's Health Care Reform Bill. The Heritage Foundation. Mar 4, 2010.

The Patient Protection and Affordable Care Act. Public Law 111-148.

Obama, B. Executive Order: ENSURING ENFORCEMENT AND IMPLEMENTATION OF ABORTION RESTRICTIONS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. March 24, 2010.

Highlights

- Abortion services cannot be required as a part of “minimal creditable coverage”
- Roe v. Wade prohibits the government from intervening in abortion decisions prior to fetal viability
- Roe v. Wade permits the state to restrict or proscribe abortion as it sees fit once the fetus is viable

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HOW MASSACHUSETTS CAN INFORM THE NATION

Massachusetts serves as an experimental guide for a nation seeking to implement dramatic health care reforms.

In November 2009, the Urban Institute conducted a site visit and a series of interviews of key stake holders to analyze the health system reform in Massachusetts. As of 2009, only 2.6 percent of Massachusetts' residents were uninsured. Many assume that this level of participation is due to the new individual mandate; however, the majority of newly-insured residents are not subject to the mandate due to their low income. In addition, the availability of new premium-free health care benefits in many other state and national programs has not produced such high participation in the past. For example, only 60 percent of children eligible for CHIP are actually enrolled and receiving benefits. This analysis focuses on the methods by which Massachusetts reached such high participation in its varying health care programs since the 2006 reform.

To summarize, the Massachusetts health care reform of 2006 implemented a mandate on all adults to have health insurance and a mandate on employers to contribute to employee health plans, with a monetary penalty for noncompliance. The following are the government-funded programs that help to pay for health care of Massachusetts residents. *Health Safety Net* reimburses hospitals and community health centers for uncompensated care. *Medicaid* insures the state's lowest-income adults. *MassHealth* insures children of parents earning up to 300 percent of the Federal Poverty Level (FPL). *Commonwealth Care* Health Insurance Program provides subsidies for adults earning up to 300 percent of the FPL to purchase health care coverage. *Medical Security Program* insures laid-off workers with income up to 400 percent of the FPL.

The analysis found that with so many intertwining programs working together to cover the state's residents, the streamlining of the application and enrollment process, as well as readily available public information, especially through local community representatives, have made participation in the health programs so successful.

For example, the state used existing databases on residents who received uncompensated care, including their demographics and income, to automatically

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Dorn, S, et al. The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage. The Urban Institute. Nov 2009.

Kaiser Family Foundation. Massachusetts Health Care Reform: Three Years Later. Sep 2009. #7777-02.

enroll them in any program they were eligible for at the time the reform legislation passed. This process alone has registered nearly 100,000 residents for new coverage since the 2006 reform, approximately one-quarter of all newly insured residents.

For those not already in the state database, the application process was streamlined. There was one application for every program except the Medical Security Program, available online and submitted online, which was processed by one agency. Through a computerized process, rather than through staff manpower, it was determined for which, if any, program the applicant was eligible. Of note, more than half of the time, this application was filled out by employees of community-based organizations (CBO) or hospitals who are specifically trained to help residents through the process. Massachusetts' reform provided clinics and hospitals a financial incentive to assist residents in correctly filling out these forms because then those clinics and hospitals could be reimbursed for services. Grant money from the state was made available to help fund these community employees.

These CBO employees were useful in assisting residents in the application process and in distributing information about programs. CBO employees were residents of the communities in which they worked. They delivered the message of upcoming benefits and penalties in a culturally appropriate manner, which was key to gaining the trust of the state's diverse population.

Highlights

- Although many low-income households were not subject to the mandate or monetary penalty, the concept of a mandate worried these residents greatly and therefore increased public interest, and secondarily, overall participation.
- Massachusetts' health reform is similar in structure to federal reforms including coverage expansions and insurance mandates
- Over 97 percent of Massachusetts' residents are insured

Commentary

The lessons learned from Massachusetts can be applied to the recently passed national health reform (PPACA), especially with such vast expansion of state Medicaid programs. In order to have the intention of the policy to actually reach its intended audience, the application process in many states needs to be more streamlined. Applicants need to be able to not only fill out the application online but also submit it online. Moreover, states should strive to use existing databases, such as tax returns, which are available for 86.3 percent of uninsured Americans, to automatically enroll their residents in appropriate health care programs. Finally, federal policy should go beyond the regional information and assistance centers to give funding to the states that can financially support trained representatives at the local level, a tool shown to be most useful in Massachusetts.

P4P IN NURSING HOMES

Nursing homes receive the majority of their income through Medicaid. Thus, state administrators wield a powerful lever for improving quality in nursing home care through pay-for-performance programs.

Amidst increasing pressure for higher quality and lower cost health care, monetary incentives for quality health care have become more popular, especially from public payers such as Medicare and Medicaid. Termed pay-for-performance (P4P), this type of incentive program is being used across many health care settings. Nursing homes have been theorized to be the most impactful setting for state Medicaid payers because Medicaid is the largest payer in this market (representing half of all payments) and reimburses for over 65 percent of all nursing home bed-days. Despite the increasing use of P4P, very little is known about its optimal design or ultimate efficacy. Only two reviews of state Medicaid departments describe their use of P4P. One peer-reviewed study from 1992 analyzed whether or not P4P in nursing homes increased quality of care; it concluded that nursing homes respond to payment incentives. Studies looking at payment incentives in other care settings have yielded mixed results.

The current study provides a comprehensive description of presently implemented or planned P4P programs in nursing homes across all 50 states. The authors interviewed state Medicaid directors (or other relevant personnel) from each of the 50 Medicaid departments in regards to planned or implemented P4P programs for nursing home care. Since 2000, nine states (CO, GA, IA, KS, MN, OH, OK, UT, VT) have had such programs and five more (AZ, IN, MD, TX, VA) are planning to implement programs. Interestingly, these P4P nursing home programs vary greatly from state to state based on how they measure quality, how they define quality, and how they reward quality. All programs use three or more clinical (resident pain scores, new pressure sores, restraint use, etc.) or non-clinical (staffing retention, regulatory deficiencies, home-like culture, etc.) measures of quality.

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Werner, RM, Konetzka, RT, and Liang, K. "State Adoption of Nursing Home Pay-for-Performance." Med Care Res Rev 2010; 67; 364 -377.

Highlights

- Nine states currently operate nursing home P4P
- Five states are planning to implement nursing home P4P
- Ohio spent $18.4 million in bonus payments for its nursing home P4P program
- The stakes are often too low for P4P programs
- The validity of quality measures must be ascertained prior to investing heavily in them

Individual nursing homes get "points" for either having better quality than other neighboring nursing homes or by surpassing a quality benchmark set by the state. Nursing homes get bonus pay either as a percentage of their base reimbursement or a fixed dollar amount.

The nine participating states spent between 0.1 and 1.8 percent of their state Medicaid budgets on incentive programs for P4P, in the case of Ohio, over $18 million. This incentive money came either from redistribution of previous Medicaid funds or from money added to the Medicaid budget.

Some worry that these P4P programs may result in unintended consequences. Traditionally, nursing home facilities that care for a disproportionate share of Medicaid beneficiaries are relatively underfunded. They therefore often provide lower quality care. An unintended effect of P4P may be perpetuating this cycle: fewer quality bonus payments would go to nursing homes predominately composed of Medicaid beneficiaries. In effect, P4P might continue to pay nursing homes that already provide high quality care and would only serve to exacerbate existing disparities. The authors suggest incentive payments to reward improvements in quality rather than merely a set benchmark level of quality care.

Commentary

With so much policy talk, and now action, around P4P, it is surprising how little is known about the use of P4P in nursing home care settings, let alone the efficacy of the various P4P strategies in use. The metrics different states use to measure quality range from care processes thought to produce quality outcomes (staff retention) to actual outcome measures of quality (resident satisfaction). As P4P programs focus on the quality, not cost, of care, it seems more intuitive to reimburse for actual outcomes, leaving it up to inventive and resourceful care providers how best to reach those goals. Similar to systems of bundling payments, reimbursing for outcomes rather than processes will allow for more innovation and hopefully less costly care delivery systems over time.

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HEALTH IT USE FOR UNDER-SERVED COMMUNITIES

Much like other technological breakthroughs in medicine, health information technology (HIT) such as electronic medical records (EMR) are assumed to diffuse more slowly to patients and communities that are under-served.

Researchers undertook a challenging question: how well have physicians added health information technology (HIT) to their practices among those who tend to care for America's under-served communities versus those caring for more affluent communities. Study authors utilized the 2005 and 2006 National Ambulatory Medical Care Survey (NAMCS), mapping the use of electronic medical records (EMRs) to patient and practice characteristics. Over 2,300 physicians participated in the survey.

EMRs were categorized as either "limited" or "comprehensive" based on the types of functions available to clinicians. To be classified as a comprehensive EMR, the system must perform the following four features: (1) computerized orders for prescriptions, (2) computerized orders for tests, (3) electronic access to lab test results, and (4) clinical notes for physicians. Two other components important for EMRs but not accounted for by the NAMCS included: patient problem lists and lists of medications taken by patients.

Among the EMRs in use, those with limited function rarely offered computerized orders for tests (21 percent), computerized results for lab tests (49 percent), or computerized prescriptions (36 percent). Only 63 percent allowed for physician note writing. By definition, comprehensive EMRs had all four functions. Additionally, comprehensive EMRs often provided patient demographics (96 percent) and reminder prompts for guideline based interventions (70 percent).

In univariate analysis, practices with higher proportions of charity care patients were less likely to have an EMR. Other practice characteristics associated with not having an EMR included non-metropolitan location, Northeast United States, solo practice, and no HMO affiliation.

In multiple regression analysis, a method which adjusts for all variables simultaneously,

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Li, C. and West-Strum, D. "Patient Panel of Underserved Populations and Adoption of Electronic Medical Record Systems by Office-Based Physicians." Health Services Research. 2010. Online in advance of print.

practices with larger Hispanic populations were statistically less likely to have comprehensive EMRs. The Northeast region as well as non-metropolitan areas continued to demonstrate a relative dearth of technology compared to regions such as the West and metropolitan centers. Solo practices were 60 percent less likely than other practices to have comprehensive EMRs.

By far, the strongest factor prompting the adoption of EMRs was whether or not a practice was under HMO control. Those practices owned by HMOs were nearly 8 times more likely to have a comprehensive electronic medical record.

Highlights

- A comprehensive EMR does the following functions: (1) computerized orders for prescriptions, (2) computerized orders for tests, (3) electronic access to lab test results, (4) clinical notes for physicians, (5) patient problem lists and (6) lists of medications taken by patients
- Solo practices are 60% less likely to have comprehensive EMRs
- Practices in the Northeast are 68% less likely to have comprehensive EMRs compared to practices in the West
- Practices in Metropolitan areas are nearly 3 times more likely to have comprehensive EMRs
- Practices owned by HMOs are 8 times more likely to have comprehensive EMRs

Commentary

Integration of computer technology into the day-to-day practice of medicine has proceeded at a snail's pace. In the current study, only 27 percent of all physicians practiced in an office setting utilizing an electronic medical record. Fever than half of these physicians had access to a comprehensive EMR.

This study reciprocates findings of most prior ones, that medical practices that are smaller, outside of metropolitan areas, or not affiliated with managed care are less likely to have an EMR system. However, the goal of this study - to uncover potential disparities for practices disproportionately caring for the under-served (Medicaid, charity care, or minority patients) - failed. While there was a statistically significant decrease in the prevalence of EMRs in practices with more Hispanic patients, this was only 2 percent less likely.

What may seem surprising to some is that medical practices with more Medicaid and charity care patients are just as likely to have EMRs as practices with greater proportions of privately insured patients.

The American Recovery and Reinvestment Act of 2009 (PL 111-5, commonly known as the Stimulus) allocated over $19 billion for health information technology. As these funds are delivered to the public, policy makers should attempt to direct money towards the nation's solo practitioners so that these physicians might catch up to the rest of their peers. Linking funds to participation in Medicare, Medicaid, and CHIP would encourage physician participation in these programs but remains less important to aiding EMR adoption by solo practitioners.

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THE DOC FIX

Medicare compensates physicians via a universal fee schedule. To limit costs, the "Sustainable Growth Rate" (SGR) was adopted in 1997 to allow for increased Medicare expenditures based on national economic growth.

The sustainable growth rate (SGR) is a statutory formula created in 1997 to annually update physician fee-for-service payments in the Medicare program in order to allow for cost increases tied to growth in the overall United States economy (GDP growth). However, the rate of growth of the medical economy has outstripped that of the general economy most years since 2001, leading the SGR formula to calculate negative updates in order to get expenditures back down to expected levels.

Since cutting payments to doctors that provide care for senior citizens (an extremely powerful voting bloc) does not make much political sense, Congress has often stepped in to avoid SGR-mandated cuts. Unfortunately, in today's economy the archaic formula calls for a 21 percent cut in physician payments. This went into effect on Friday to the dismay of physician groups such as the American Medial Association.

Many health policy experts have declared the SGR a flawed formula for controlling health care costs. In fact, the SGR only affects physician costs (which amounts to 21 percent of national health expenditures) and not hospital or pharmaceutical costs. By trying to put a control valve on only 1/5 of the nation's health care costs, the SGR does nothing to check the growth of nearly 80 percent of national health expenditures.

In 2007, the Medicare Payment Advisory Committee (MedPAc) produced options on reforming the system and presented their findings to Congress. First among MedPac's conclusions was that annual negative updates to the physician fee schedule are unrealistic because Congress has a record of being unable to allow them. And even if large cuts were allowed, as the SGR might suggest, access to care for Medicare enrollees might suffer.

Instead, MedPac recommended that payment policies be designed to place

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MedPac. "Assessing alternatives to the sustainable growth rate system." March 2007.

Highlights

- The SGR is a formula that predicts the expected growth in physician costs in Medicare, when true growth exceeds expected growth a pay cut in the physician fee schedule is necessary
- Alternative 1, base payment on quality not quantity
- Alternative 2, change from national targets to regional expenditure targets
- Alternative 3, bases targets on types of services provided and not all services lumped together
- Alternative 4, increase compensation to physicians in multi-specialty groups
- Alternative 5, base the locus for expenditure targets at the medical staff (hospital) level
- Alternative 6, provide negative updates to physician whose practice patterns for resource utilization are outliers to their peers

incentives on delivering quality care and not worrying about the volume and intensity of care (the two major components of health care costs). As such, MedPac favored policies such as comparative effectiveness research and pay-for-performance, two mechanisms currently in their infancy in the Medicare program.

MedPac also discussed alternatives to the SGR. One would be using regional units to update fee schedules. However, this might be even more difficult to administer as it would ultimately produce multiple fee schedules across the country.

Another alternative would change expenditure targets based on the type of services provided. However, a similar program existed prior to the SGR and was subsequently replaced.

A third alternative would be compensating physicians differently based on membership in a multi-specialty group. Unfortunately only 20 percent of physicians practice in such settings and not all multi-specialty groups necessarily engage in a resource-efficient manner.

A fourth alternative suggested was the hospital medical staff method, creating a virtual multi-specialty group. However, there may not be significant incentive for individual physicians to practice in concert simply because they work in the same hospital.

A final alternative to the SGR would be an outlier method where Medicare would identify individual physicians who were utilizing too many resources and eventually applying negative updates to their fee schedules but not those of all physicians. This too might become administratively burdensome.

Even MedPac, a national panel of experts, could not determine a rational and universally agreed upon way to change the physician payment system. It is no surprise then, that Congress keeps providing short term solutions to a decades long problem.

Commentary

The annual (or sometimes semi-annual) ritual of postponing cuts to the Medicare fee schedule will remain a problem for policy makers until a new payment methodology is established. This, and other important aspects of the health system - such as practice design, tort reform, and workforce diversity - remain to be addressed in the wake of health reform. As implementation proceeds on PPACA, health policy experts should shift attention to these neglected policy questions in order to make a more streamlined and coherent health care system.

JUNE 28, 2010

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THE DIRIGO HEALTH REFORMS

The Dirigo Health Reform Act of 2003 in the state of Maine was enacted to improve cost, quality, and access to care for all. Unfortunately, there appears to be little success with improving the numbers of Maine residents covered.

In 2003, Maine adopted the Dirigo Health Reform Act which sought to improve cost, quality, and access to health care for every Maine citizen. Prior to enactment, 13 percent of Maine's population under age 65 was uninsured. In 2004, 50 percent of Maine's private employers offered health benefits to workers compared to a national average of 56 percent. The state had the second-highest personal health care spending per capita in the country. Therefore, the reform focused on cost containment efforts as well as expansion of coverage to uninsured, low-income working families.

MaineCare, the state's Medicaid program, was expanded to fully subsidize childless adults and low-income parents of children under age 19 with family income of up to 200 percent of the federal poverty level (previously up to 150 percent). The new DirigoChoice offered partially subsidized premiums and deductibles based on a sliding scale of income in order to make small group and individual insurance products more affordable. Through a partnership with a private insurer, DirigoChoice was designed as a joint operation between private and public sectors. The program was to be financed through employer contributions, federal matching funds, and assessments placed on insurers based on demonstrated savings from cost-saving initiatives. Such initiatives were: strengthening the state's certificate of need program, facilitating collaboration between hospitals and other providers, reducing paperwork for providers and insurers, regulating premiums in the small group market, increasing transparency of cost and financial data, and reviewing the state's medical malpractice.

By September 2006, there was a modest enrollment of previously uninsured individuals (11,000) as compared to the total number of uninsured residents of Maine (136,000). About 2.5 percent of all eligible businesses chose to enroll in DirigoChoice,

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whereas there was a stronger enrollment of individuals and sole proprietors. However, twice as many individuals were covered by the Medicaid expansion than were enrolled in DirigoChoice. Financing of the program was difficult due to lower than projected revenues for subsidies.

Lipson, DJ, et al., "Leading the Way? Maine's Initial Experience in Expanding Coverage Through Dirigo Health Reforms." Washington DC: Mathematica Policy Research, December 2007.

Highlights

- 13 percent of Maine's nonelderly population was uninsured prior to reform
- The rate of uninsured was not significantly affected by DirigoChoice and Medicaid expansions
- Newly insured residents gravitated toward Medicaid over DirigoChoice

The rate of uninsured was not significantly impacted by the combination of DirigoChoice and the Medicaid expansions. Small businesses indicated by survey that many small firms still found the DirigoChoice product unaffordable or the differences in savings as compared to other health plans were not large enough to convince them to change plans. Therefore a large number of low-income uninsured people did not have access to DirigoChoice through their employers. In addition, low income-individuals preferred the fully subsidized Medicaid as opposed to the partially subsidized DirigoChoice. The state costs were therefore beyond original estimates, as the state not only paid for the Medicaid expansions but also the subsidies on individuals' premiums and deductibles (who did not have employers providing a share). Lastly, the savings from the above cost-saving initiatives could not be documented, and there was a corresponding drop in revenues that could be raised from the insurers.

Solutions offered to the above problems included: making the DirigoChoice coverage less comprehensive and therefore lowering premiums; combining the small groups and individuals into a single pool; adding more care and cost management initiatives such as formal disease management programs for enrollees with chronic conditions; changing to a self-insured arrangement; offering small firm incentives; and forcing an employer mandate.

Commentary

Maine provides an excellent example of how a lack of the big picture can cause poor outcomes in health reform. Dirigo Health Reform intended to address not only issues of access and affordability, but also the increasing costs of the system. However, the later was not given enough priority. Regardless of who pays for coverage, the dire issue facing our nation remains that we spend too much for too little. Premiums were too high; the question to be addressed is how can our system justify its health care expenditures. This year's national health reforms will most likely undergo the same blunders that Maine experienced if the costs, quality, and health promotion within the current system are not adequately addressed. We must facilitate comparative-effectiveness and cost-effectiveness outcomes and defuse the tendency to practice defensive medicine.

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RE-DESIGNING THE PRACTICE OF MEDICINE

The traditional model of medical practice, where a solo physician controls the management decisions of his or her patients, is slowly yielding to a more collaborative and patient-centered model. Or is it?

The general practice of medicine in the United States tends to be an individualistic and physician-oriented endeavor. Nationwide trends, however, are seeking to redesign the clinical practice into one that is patient-centered and comprised of multidisciplinary teams. A field study of three different primary care practices - a solo practice, a certified patient-centered medical home, and an academic multi-specialty practice - serves to illustrate that the redesign of medical practices is still in its infancy.

The current study utilized an ethnographic approach to describe these three distinct types of internal medicine practices. For each practice type, researchers sought to understand the roles, routines, and experiences of various members of the health care team including physicians and support staff. In total, the study sample consisted of five physicians, nineteen professional and administrative staff, and nine patients.

Over one-third of physicians practice in a solo or two-person practice. This style of practice is typified by one or two physicians, one or two nurses, and a receptionist and/or an office manager. Nearly one-half of physicians practice in a group setting (which includes HMOs) or a medical school or public faculty arrangement.

Over the past 10 years, health policy experts and quality advocates have pushed for primary care physicians to practice in defined patient-centered medical homes (PCMHs). As defined by the National Committee for Quality Assurance, PCMHs are a medical practice model where each patient has an ongoing relationship with a personal physician who leads a team that shares responsibility for patient care.

When comparing these different practice types, researchers noted more similarities than differences. Regardless of practice type, most team members practiced in separate silos. Physicians tended to work in a "frantic

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Chesluk BJ and Holmboe ES. "How teams work--or don't--in primary care: a field study on internal medicine practices." Health Affairs. 2010; 29 (5):874-9.

bubble" of activity, seeing patients in continuous one-on-one interactions scheduled every fifteen minutes. Physicians felt isolated and rarely collaborated with other staff.

The experience of professional staff was more relaxed; staff often assisted and covered for one another. Their experiences were much more collaborative and flexible.

Patient experiences were often marked by unpredictable and consuming waits. Conclusions to office visits were ill-defined and led to confusion for many patients.

The study revealed that the practice of medicine currently is devoid of adequate time and teamwork. Physicians scramble to work in a manner that limits thought, reflection, and collaboration. Staff feel disempowered to collaborate with clinicians. Patients are left in limbo. Office schedules and routines revolve around physicians and not patients.

Highlights

- Over 1/3 of physicians still practice in solo or two person arrangements
- Over half of physicians practice in a group setting
- PCMHs emphasize enhanced care through open scheduling, expanded hours and communication between patients, physicians and staff.
- PCMHs provide for all the patient's health care needs and, when needed, arrange for appropriate care with other qualified physicians
- Click here to learn more about the PCMH model

Commentary

Health policy experts believe that the movement from traditional solo practice designs to group practice and ultimately to the patient centered medical homes will empower patients in the healthcare system. Current observations suggest similar experiences for all the above practice types, casting doubt on the PCMH model.

Realistically, the PCMH model is merely a reiteration of what all primary care physicians should be doing anyway: fostering a personal patient-physician relationship, serving the needs of patients at all hours, and appropriate referral to specialists and support services needed by each patient. PCMH certification appears to identify primary care practices that are doing what they should be doing anyway. What our healthcare system needs to consider is how to best integrate (1) alternative sites of care such as retail clinics and (2) alternative clinicians such as physician assistants and nurse practitioners. Could integrated systems, like Geisinger, sprout across the nation to offer continuity, convenience, and specialty care? Not without the free flow of patient information.

Medicine (and privacy hawks) must take a lesson from the banking industry. Credit cards and ATMs permit secure access to financial information, releasing consumers from their bank's schedule. A universal medical record - accessible by physician offices, retail clinics, hospitals, and patients themselves - will facilitate a patient centered approach to health care delivery.

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THE SOCIAL MISSION OF MEDICAL EDUCATION

Medical educators must train those studying to become physicians in the science of medicine. But because many medical schools fund their endeavors through research money, the social mission of medicine often gets neglected.

This nation, and by extension its medical schools, face the daunting task of addressing three interrelated issues: an insufficient number of primary care physicians, geographic maldistribution of physicians, and the lack of a representative number of racial and ethnic minorities in medical schools and in practice. The authors argue that through its role in educating the future physicians of this nation, our medical education system maintain a social mission that extends to the entire population. Therefore instead of being lauded and ranked based on their research funding, reputation, faculty opinion, and student selectivity, medical schools should instead be judged on these larger societal needs of primary care, access to care for the underserved, and workforce diversity.

Focusing on data for medical school graduates from 1999 to 2001 from the 141 allopathic and osteopathic schools, the authors calculated for each school: 1) the percentage of graduates practicing primary care, 2) the percentage of graduates physically located in health professional shortage areas (HPSAs), and 3) the ratio of underrepresented minority (URM) graduates to the total number of graduates, adjusting for public and private institutions who draw from a single state or a national pool respectively. Each measure was standardized with a mean value of 0. They then assigned a composite score (i.e. the social mission score) to each school by using a simple sum of each of the three standardized measures. For example, Morehouse School of Medicine had the highest ranking social mission score (13.98), with 43.7 percent of its graduates entering primary care, 39.1 percent of its graduates practicing in HPSAs, and a ratio of URMs in the school vs. the state of 3.15. In comparison, Vanderbilt University had the lowest ranking social mission score (-3.95), with 21.9 percent of its graduates entering primary care, 20.8 percent of its graduates

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Mullan F, Chen C, Petterson S, Kolsky G, Spagnola M. The Social Mission of Medical Education: Ranking the Schools. Ann Intern Med 2010; 152:804-811.

practicing in HPSAs, and a ratio of URMs in the school vs. the state of 0.13.

Morehouse School of Medicine, Meharry Medical College, Howard University, Wright State University, and University of Kansas were the top five ranking schools, in order. Vanderbilt University, University of Texas Southwestern Medical Center, Northwestern University, University of California Irvine, and New York University were the bottom five ranking schools. Northeastern schools tended towards more negative social mission scores. Western schools produced more primary care physicians. Southern schools produced more physicians who practice in HPSAs. Schools in smaller metropolitan areas produced more primary care physicians and physicians who practiced in HPSAs. Public schools graduate higher proportions of primary care physicians. NIH funding was inversely associated with social mission score, a school's output of primary care physicians, and physicians practicing in HPSAs.

Highlights

- Schools with the Highest Social Mission scores:
- Morehouse School of Medicine
- Meharry Medical College
- Howard University
- Wright State University
- University of Kansas

- Schools with the Lowest Social Mission Scores
- Vanderbilt University
- University of Texas Southwestern Medical Center
- Northwestern University
- University of California Irvine
- New York University

Commentary

The data undoubtedly show the merits of a primary-care based system in terms of improved quality of care and decreased medical costs. Regardless of the methods used for ranking, this study provides a unique perspective on the individual medical schools and their lack of response to this data. If medical schools compete with each other for funding and reputation, why can they not be provided the incentive to compete for the creation of a primary care workforce? In conjunction with the current discussion of comparative effectiveness research, there is plenty of opportunity to maintain a commitment to the generation of new scientific knowledge through primary care research while also promoting a primary care model.

Both a lack of physicians that provide care to the underserved and a lack of workforce diversity speak to the system's failure to meet supply with demand. This study shows that medical schools are by no means exempt from this failure. Analysis should be made of the obstacles blocking URMs from matriculating into medical school. The argument that the pool of applicants is small is unacceptable. Further insight can be gained by analyzing those schools with higher social mission scores.

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"MEANINGFUL USE" FOR EHR'S DEFINED

Last week, the Department of Health and Human Services set out definitions for the "meaningful use" of electronic health records. Designed to qualify eligible providers for incentive payments, these rules will spark a revolution.

You could read the 864-page document published in the Federal Register which defines the government's ideas of "meaningful use" for electronic health records. But to save time, the National Coordinator for Health Information Technology published a summary in the New England Journal of Medicine.

The Health Information Technology for Economic and Clinical Health Act (HITECH) passed last year by Congress and the Obama administration made available $27 billion over 10 years to promote the adoption of electronic health records by health care providers. Non-hospital based clinicians are eligible to receive up to $44,000 over 5 years through Medicare incentive payments. Medicaid incentive payments total $63,750 over 6 years per clinician. Non-physician clinicians such as podiatrists and chiropractors are also eligible for funding.

In order to qualify, electronic health records must contain a "core set" of 15 objectives plus another 5 choices chosen from a "menu set" of 12 options. The core set of meaningful use objectives requires the following:

- record of patient demographics
- record of vital signs
- maintain up-to-date problem lists of current diagnosis
- maintain active allergy lists
- record smoking status
- provide patients clinical summaries of each office visit (discharge summaries for hospitals)
- provide patients electronic copies of their health information
- computer provider order entry for medications
- create and transmit prescriptions electronically
- drug-drug and drug-allergy checks
- electronic exchange of key information between providers

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Blumenthal, M and Tavenner, M. The Meaningful Use Regulation for Electronic Health Records. NEJM. Online July 13, 2010.

Highlights

- Electronic health records should perform 15 core functions and at least 5 of 12 additional optional functions to be considered “meaningful use”
- To be eligible for Medicaid bonus payments, clinicians must have a Medicaid volume of 30 percent
- Estimates of physician uptake of EHRs range from 10-30 percent

- at least one clinical decision support rule
- protecting privacy and security of patient data
- reporting quality measures to CMS or states

The menu set allows the clinician to choose 5 of the following 12 options to add to their core EHR functionalities:

- perform drug formulary checks
- incorporate clinical lab tests
- generate patient lists sorted by diagnosis
- provide patient-specific educational resources
- perform medical reconciliation
- provide summary of care for transitions/referrals
- submit immunization information to registries
- electronic syndromic surveillance
- record advance directives
- report certain lab results to public health agencies
- send patient reminders for follow up
- allow patients to electronically access their record

Commentary

The rules released by DHHS cover the first two years (2011 and 2012) of the electronic health record (EHR) bonus payment program. Clinicians must purchase and use an EHR that meets all 15 core functions and another 5 (of 12) optional functions.

Unfortunately, one of the most important functionalities - incorporation of clinical laboratory data into the health record - is considered optional. Other required functions, such as recording smoking status or providing patients with an electronic copy of their records are far less important than having access to real clinical data. Other important functions from the menu set include the recording of advanced directives and public health information (reportable laboratory results, syndromic surveillance, and immunizations).

Most of the core set of functions only serve to digitize the medical record. Only three actually act to transform health care from an isolated physician-run endeavor to a collaborative health system: (1) electronic exchange of clinical information among providers and “patient-authorized entities,” (2) clinical decision support, and (3) support for quality improvement metrics. Policy makers must remember, a patient’s medical record ought to be like VISA, “it’s everywhere you want to be.”

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THE GERMAN HEALTH CARE SYSTEM

The German health system health care is two-part: a statutory system tied to payroll and a private system for those with financial means. Recent reforms have sought to infuse competition and market principles.

The German health care system can be viewed as the prototypical Bismarck-style health system in the world. Established in 1883, the German Health Insurance Act introduced compulsory insurance for industrial workers. Over time and after multiple modifications, Germany possesses dueling health care systems. The first (the Statutory Health Insurance, or SHI) system is characterized by private, nonprofit insurance companies (196 different sickness funds) selling a pre-defined set of policies to individuals. Premium amounts are intertwined with an individual's income through a percentage of payroll. High income individuals can opt out of the SHI and join the second system of private health insurance (PHI). PHI is purchased by individuals from 47 different for-profit insurers and is subject to risk-rating.

Recent health care reforms in 2004 and 2007 introduced cost-sharing mechanisms, promoted competition among health care providers and insurers, and mandated that all Germans either get insurance from either the SHI or PHI system.

When Germany implemented a 10 euro co-pay into the system, visits to physician offices declined by about 8 percent. As shown in the United States, by the RAND Health Insurance Experiment, both necessary and unnecessary visits were decreased by introducing cost sharing mechanisms.

Competition within the SHI system was promoted while standardization of benefits became the norm following the unification of decision-making between payers and providers through a basic benefits package. Although some variability exists in what is covered and what is not, approximately 95 percent of all benefits are identical between the sickness funds.

Sickness funds are forced to compete among subscribers because remaining in the SHI system (about 85 percent of the population) are allowed to freely switch

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Lisac, M, et al. "Access and choice - competition under the roof of solidarity in German health care: an analysis of health policy reforms since 2004." Health economics, Policy, and Law. 2010; 5: 31-52.

Highlights

- Switzerland's health reforms (1994) require compulsory health insurance and ban profit on the basic benefit package.
- The Netherlands' health reforms (2006) also have an individual mandate but a significant portion of health insurers are for-profit companies in their system
- Germany's reforms (2004, 2007) foster managed competition but in a backdrop of a society predominated by non-profit insurers
- The American health reform (2010) begins the transformation to managed competition for the 2/3rds of Americans who have employer-sponsored or privately purchased insurance
- 1/3rd of Americans have public insurance (Medicare, Medicaid, VA/Military, or Indian Health Service)

between insurers. Twenty-five percent of enrollees have switched at least once, the most common reason being the contribution rate required by each fund.

Those opting for PHI have a more restricted path in order obtain private coverage. Enrollees must demonstrate sufficient income for three consecutive years (formerly one year) in order to opt-out of the SHI system.

Once in the PHI system, switching plans has been far more difficult as this would require enrollees to undergo medical underwriting to qualify for new insurance. To promote competition within the PHI system, the reforms allowed enrollees to switch insurers and retain coverage defined by the basic benefits package.

Another crucial reform was the implementation of the Health Fund (operational in 2009) which serves to filter funds collected and distribute them to the sickness funds in a risk-adjusted manner. Sickness funds that go over budget must charge enrollees additional premiums; those under budget can provide refunds. Thus, the funds can compete for patients based on their relative efficiency at delivering care.

Commentary

Many view the German health care system as the prototype for universal health care in the world. However, it was only recently that all Germans were mandated to carry health insurance. Now (since 2007) every citizen is obliged , yet entitled, to health care defined by a basic benefits package. Germany still possesses two different systems - the statutory and the private - although recent reforms are attempting to merge the two into one another. Germany has taken a step similar in nature to the reforms of the Dutch (2006) and the Swiss (1994), which similarly instituted individual mandates and insurance market regulations to promote managed competition within the framework of social solidarity. A major difference between these societies is that health insurers in the Netherlands are predominantly for-profit and in Germany are mostly non-profit (the Swiss ban profit-making on their basic insurance package). As the United States transitions to a partial system of managed competition (excluding, of course, Medicare, Medicaid, and the VA), these European nations will serve as international experiments on whether or not health insurance should be delivered on a for-profit or non-profit basis.

CHC'S CAN DELIVER QUALITY

Yet another study demonstrates that it is not the location where a patient sees their doctor, but rather the relationship between the physician and the patient that influences the quality of care delivered.

Community Health Centers (CHCs) are more likely to care for minorities, the uninsured, and patients with Medicaid. They have been shown to reduce health disparities in the communities they serve. CHCs, however, have regular challenges with staff recruitment. A recent national survey showed that 13.3 percent of family practitioner positions and 20.8 percent of obstetrician positions were vacant. This study sought to provide an assessment as to whether these staff challenges lead to poorer performances on patient reports of health care quality.

Using the 2006 Health Care Quality Survey of the Commonwealth Fund, 2,837 respondents aged 18 to 64 participated in 25-minute telephone interviews. The study was limited to respondents who reported a private doctor's office or a CHC has their regular source of care. However, not all respondents have a particular physician they see when they go for care. They were asked about reminders for preventive care visits, cholesterol checks, diet/exercise/healthy weight counseling, amount of time spent with the doctor, the thoroughness of the doctor, and their involvement in their care and treatment plan. In terms of the sample demographics, patients seen in CHCs were younger, less likely to be White, more likely to have family incomes below 200 percent of the federal poverty level, were more likely to be uninsured, and were more likely to be overweight and obese.

More significantly, in adjusted models, having a regular doctor eliminated *all* differences between CHCs and private doctor's offices in patient reports of quality. Patients with a regular doctor were much more likely to report receiving preventive visit reminders, cholesterol checks, and diet/exercise/weight counseling, with odds ratios of 3.33 (95% CI, 1.86-5.98), 3.91 (95% CI, 2.13-7.16), and 2.84 (95% CI, 1.57-5.14) respectively. Patients with a regular doctor were much more likely to report that the

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Beal A, Hernandez S. Patient Reports of the Quality of Care in Community Health Centers: The Importance of Having a Regular Provider. Journal of Health Care for the Poor and the Underserved 2010; 21: 591-605.

doctor spent enough time (OR 3.32, 95% CI, 1.82-6.05), the doctor is extremely thorough and careful (OR 2.32, 95% CI, 1.20-4.50), they were involved in as much as they want in decisions about their care and treatment (OR 2.28, 95% CI, 1.25-4.14), and that they receive the care they need when they need it (OR 2.28, 95% CI, 1.27-4.10). Being uninsured was independently associated with lower rates of reporting that the doctor spends enough time. Respondents with a chronic condition were less likely to report that their doctor was thorough and careful. Asian-Pacific Islanders were significantly less likely to report being involved in decisions about their care. Females reported a lower likelihood of being able to get care when needed.

Highlights

- $2 billion went toward the funding of community health centers in the American Recovery and Reinvestment Act (2009 stimulus)
- CHC's cared for over 17 million patients in 2008
- 38.3 percent of CHC patients were uninsured in 2008
- 35.8 percent of CHC patients were covered by Medicaid

Commentary

As Community Health Centers (CHCs) are shown to directly address health disparities, any influence on their ability to care for more patients requires great attention from policy makers. When properly manned and regular providers are available, CHCs provide excellent care. However, not only is federal support needed for increased number of CHCs and increased services, but a focus on future growth is imperative to the outreach of CHCs. Both medical schools and residency training programs can form partnerships with CHCs to not only provide increased patient care, but to also expose more physicians to potential careers focusing on the underserved. As is evident from the lack of applications for the National Health Service Corps, funding through scholarship and loan repayment is not the only incentive that is necessary to pull medical students towards the CHCs. Perhaps a change of attitude is needed through medical education and academic medicine to instill in a sense of service in young physicians.

AUGUST 9, 2010

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UNITED STATES PREVENTIVE SERVICES TASK FORCE

The USPSTF, first convened in 1984, is an independent panel of non-federal experts in primary care that conducts evidenced-based reviews. These reviews represent the gold standard for clinical preventive medicine.

The United States Preventative Services Task Force (USPSTF) is a volunteer group made up of primary care and public health experts. Its sixteen members make recommendations concerning clinical preventative screening, medication, and counseling based on current scientific evidence and is purposefully devoid of specialty involvement in order to avoid potential conflicts of interest. USPSTF recommendations are given specific gradings:

A: Recommended, with high certainty that the net benefit is substantial.

B: Recommended, with high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

C: Recommended against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small.

D: Recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.

I: Current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

On July 14, 2010, the Department of Health and Human Services issued regulations under the Patient Protection and Affordable Care Act requiring private health plans to cover evidence-based preventative services for new policies beginning on or after September 23, 2010. Insurance companies can no longer charge copayment, coinsurance or deductibles for any services that receive an "A" or "B" grade as determined by the USPSTF.

These "A" or "B" level recommendations include: abdominal aortic aneurysm screening by ultrasound in men

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USPSTF A and B Recommendations, http://www.ahrq.gov/clinic/uspstf/uspsabrecs.htm

age 65-75 who have ever smoked; mammograms every 1-2 years for women aged 40 and older, cervical cancer screening; syphilis, chlamydia and gonorrhea screening in sexually active women; cholesterol screening for men aged 35 and older and women aged 40 and older unless at increased risk for coronary heart disease; depression screening; HIV screening for those at risk; and obesity screening. The recommendations also include counseling on alcohol abuse, tobacco use, sexually transmitted infection prevention, and healthy diet.

Highlights

- abdominal aortic aneurysm screening
- mammograms every 1-2 years for women aged 40 and older
- cervical cancer screening
- syphilis, chlamydia and gonorrhea screening in sexually active women
- cholesterol screening for men aged 35 and older and women aged 40
- depression screening
- HIV screening for those at risk
- obesity screening
- aspirin therapy
- folic acid therapy for pregnant women
- Under the new health reform law, all the above grade “A” and “B” screenings are required to be covered by insurers without additional cost sharing

Commentary

The recent political and academic debate surrounding the United States Preventive Services Task Force's decision to delay routine mammograms until age 50 forecasts future discussions surrounding its recommendations. In response to significant protest, an actual amendment was inserted in the Patient Protection and Affordable Care Act that covered mammograms between ages 40 and 50. Challenges from a range of interests groups will definitely remain a frequent burden for task force members; insurance companies particularly now have a strong interest as they are now required to pay for these services. The United States Congress and Department of Health and Human Services will need to determine if it is proper for political procedures to be utilized to supersede evidenced-based determinations. If so, it will need to be plainly obvious as to why the USPSTF might choose to disobey the evidence. The task force now accepts public comment in order to allow additional perspective to new recommendations. This process will need to remain transparent, perhaps even through public hearings, in order to elucidate any possible lobbying influence that may occur.

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LESSONS FROM THE DUTCH 2.0

A recent Heritage Foundation analysis of the 2006 health reforms in the Netherlands determines that the system of "managed competition" resulted in less competition and increased health costs.

As we have discussed in a prior review, the Dutch passed health reform in 2005 making major changes to the insurance market in that country. Pre-reform, the Dutch system was a mix of public and private systems. The public system covered the elderly, disabled, and those of low financial means. The private system was available to those with the means to purchase it, provided that those individuals were not excluded due to pre-existing conditions.

Implemented in 2006, the Dutch reforms were an attempt to consolidate and restructure the insurance market: citizens were obligated to buy insurance, insurers were obligated to accept all comers, and the government defined the basic benefits to be covered. This concept, known as managed-competition, was championed by healthcare economist Alan Einthoven.

The Dutch reforms now cover all but 1 percent to the population. Even so, 92 percent of Dutch citizens see it fit to purchase supplemental insurance. Low wage earners receive a premium credit in order to help them purchase insurance. All workers can deduct health expenses from their income taxes. Enrollees that did not use any health services in the course of a year were entitled to a cash rebate; this was replaced with a more traditional deductible in 2009.

The Dutch reforms essentially have been recreated in the United States with the Patient Protection and Affordable Care Act: individual mandates, guaranteed acceptance, premium subsidies, etc.

The authors of this report compare the theory of managed competition to the realities seen in the Netherlands. The first lesson is that the Dutch reforms achieved nearly universal health care while health care expenditures remained flat (9.8 percent of GDP).

The second lesson is that the insurance market is surprisingly more concentrated after the reforms than before. Four insurance

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Ryan Lynch and Eline Altenburg-van den Broek. The Drawbacks of Dutch-Style Health Care Rules: Lessons for Americans. The Heritage Foundation. July 22, 2010. Backgrounder #2435.

companies control 88 percent of the marketplace. The authors is a formula known as the Herfindahl-Hirshman Index to calculate the degree of market concentration. The Herfindahl-Hirshman Index (used also by the US Department of Justice and Federal Trade Commission) increased from 1,346 in 2005 to 2,111 in 2010. Higher indexes indicate higher market concentration. In the Netherlands, the authors describe the current state of the Dutch health insurance marketplace as an oligopoly.

The third lesson is that there is less information for health consumers to differentiate between insurers. Standardized benefits have apparently reduced price variation of insurance products. In the Netherlands, premiums vary by only 17 percent. In the United States, premiums may range for a similarly situated enrollee by over 500 percent. This price variation obviously allows for consumers to differentiate between products, if only on one dimension.

Highlights

- Alan Einthoven presented the idea for managed competition in 2 NEJM articles in 1978.
- The Dutch insurance market is more concentrated after managed competition than before
- Life expectancy in the Netherlands in 78 for men and 82 for women
- Dutch expenses for health are $3,383 per capita or 9.3 percent of GDP

Commentary

The Dutch health care system is probably the closest international comparison to the health reforms recently passed in the United States. This analysis points to several potential problems in the new health reform law. While promises of increased access to care are valuable policy objectives, serious risk of market consolidation might decrease choices for purchasers of care. A potential solution to to this issue might be statutory limitation in the amount of market share allowed by individual health insurers, say 20 percent.

The other major issue with managed competition is that the purchasers of care appear to not have enough information to determine which insurers is best for them. Limited cost differentials between insurance plans are a natural result of a standardized benefits package. However, the US reforms are not as restrictive as the Dutch reforms in terms of deductibles and other cost-sharing provisions. Thus, price variation should remain in effect.

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REFORM LEFT-OVERS MAKE TASTY ELECTION ISSUE

The Patient Protection and Affordable Care Act fails to responsibly address two major issues of concern to most physicians - malpractice reform and physician payment in Medicare.

A year ago, the American people were up in arms over the health reform debate unfolding in Congress. Nevertheless, after a long and bitter winter, Congress proceeded to pass the Patient Protection and Affordable Care Act in the spring of 2010. The health reform law's first year will usher in benefits for many American health consumers.

This fall, parents will be able to keep their children covered on their health insurance plans up to the age of 26. Insurers will be prohibited against lifetime limits on coverage and must provide care for preventive services, including all services with a grade "A" or "B" recommendation from the United States Preventive Services Task Force. And seniors that hit the coverage gap in the Medicare prescription drug plan (the "donut hole") will be eligible for a $250 rebate.

Yet, two issues of extreme importance to physicians - malpractice reform and physician payment reform -merely got superficial window dressing.

Congress authorized $50 million to fund state demonstration projects experimenting with alternatives to the traditional system of tort law. However, patients seeking remedy to claims of injury are not required to participate in these alternative systems.

Existing studies and natural experiments have already demonstrated that certain tort reforms (most notably "direct reforms" such as caps on awards) have constrained the growth of malpractice premiums for health care providers (Mello, 2006). Unfortunately, this has not resulted in downstream savings for health care consumers (Morrisey, 2008).

Research has shown that in states that have tort reforms there is an increase in physician supply ranging from 3 to 12 percent. (Kessler, 2005; Mello, 2006). This change in physician supply is mostly attributed to either retirement of physicians or entrants of young doctors, not due to movement of physicians between states. Thus, in the states without malpractice caps

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(20 as of 2006), lawmakers can look to these proven strategies to improve the malpractice environment and lure bright, young physicians to their state.

But, to put the issue of malpractice into context, it should be noted that medical malpractice premiums only account for only one-half of one percent of all health care costs (Hunter, 2009).

A second area left out from the health reform law was a permanent solution to the annual charade popularly known as the "doc fix". Since 1997 physician payments in the Medicare program have been tied to growth in the general economy. Because medical inflation has outpaced general inflation, the formula (the Sustainable Growth Rate or SGR) that calculates how much physician payments should be increased or decreased has consistently called for a reduction in payments to physicians treating senior citizens.

It seems unfair that physician compensation is tied to the overall growth in Medicare costs (which includes hospitals and pharmaceuticals) when physician costs represent only one-fifth of national health expenditures. It is akin to putting a loose fitting cap over a raging oil leak. Although you may catch a fraction, the bulk of the problem is still spilling out of control.

Congressional action conveniently postponed the debate over the SGR until after the November elections. However, Congress' inability to act creates a tremendous opportunity for physicians and seniors to demand a true solution to the SGR.

Those affected by Medicare should make this an election issue for 2010. Whether lawmakers want to simply nix the SGR or replace it with another system of physician payments is a debate long overdue.

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Kessler, D. et al. Impact of Malpractice Reforms on the Supply of Physician Services. JAMA. 2005; 293(21): 2618-2625.

Hunter, JR, et al. True Risk: Medical Liability, Malpractice Insurance And Health Care. Americans for Insurance Reform. 2009.

Highlights

- Malpractice costs represent only 1/2 of 1 percent of health care costs
- Physician costs represent only 1/5 of total health expenses
- The current physician pay cut is set to take effect December 1.

Commentary

Earlier this month, Policy Prescriptions participated in the National Medical Association's Annual Conference in Orlando. In addition to explaining to young physician the basic provision in the health reform law, we saw fit to expose potential political issues relevant to these physicians. Among these issues are the ones discussed above (medical malpractice and physician payment). A third issue, defining minimal creditable coverage, should also encourage physician input. We hope to take up this issue later as Section 1302 of PPACA moves toward implementation.

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EXPANDING MEDICAID IN OREGON

The Oregon Health Study will demonstrate what happens when low-income persons transition from the ranks of the uninsured to having insurance. It offers an opportunity to predict what might happen in the next few years once federal rules expand eligibility for Medicaid to another 17 million Americans.

Oregon has recently opened its Medicaid program, the Oregon Health Plan Standard, by allowing the application of about 30,000 names drawn randomly from its waiting list.

Such an expansion allows for an analysis akin to a randomized controlled trial of expanding public health insurance coverage for low-income adults. Such an analysis is of obvious interest with the adoption of the recent federal expansion of Medicaid due to the Patient Protection and Affordable Care Act. Oregon offers the first opportunity for a randomized evaluation of such an expansion.

The only other randomized study of health insurance in the United States, the RAND Health Insurance Experiment, was completed in the mid-1970s and followed participants for three to five years. The RAND study did not allow for the analysis of the impact of having no insurance at all, unlike the Oregon Health Study which seeks to compare the treatment group to a "no coverage" group. Data can be collected from this "no coverage" group through administrative databases that have been maintained on those persons from the waiting list. Data will be collected through late 2010.

There is concern for extrapolation of the findings of this study to the national expansion of Medicaid. Initial comparisons were made between the low income uninsured adult population of Oregon and the low-income uninsured population of the United States. The health care environment in Oregon was noted to be similar to that in other states as far as number of public

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Allen H, Baicker K, Finkelstein A, Taubman S, and Wright BJ. What the Oregon Health Study Can Tell Us about Expanding Medicaid. Health Affairs 2010; 29 (9): 1498-1506.

hospital admissions, amount of uncompensated care as a fraction of gross hospital charges, and number of physicians per 100,000 residents. The main difference noted between the Oregon and national populations is one of race, with Oregon having a higher percentage of whites than that of the country as a whole. Another area of possible contention is that the Oregon Medicaid expansion is voluntary, as opposed to the mandate imposed by the federal health reform. Such a difference might influence the type of person applying through the federal expansion program.

Individuals in Oregon who joined the waiting list were older and sicker than the overall target low-income population of Oregon. Second, individuals in Oregon from the waiting list reported incomes that were much higher than those of the low-income uninsured populations of Oregon or the United States. Actual enrollment in the program was low because many applicants from the waiting list were not eligible, for reasons including incomplete paperwork, unqualified income, or procurement of alternative insurance.

Commentary

The prospects of the Oregon Health Study will lead to a fascinating though limited set of data that will only be applicable to populations, insurance plans, health care environments and enrollment mechanisms that are similar to that of Oregon.
The acknowledgement of these limitations prior to the completion of the data collection is commendable - and should continue by means of more than the traditional statement of weaknesses at the end of future papers. As other states will be expanding under the federal legislation, the federal government might consider an additional requirement of data analysis from the onset with similar methodology and sought outcomes. Thereby, a national mapping of real time information can be collected and compared for effectiveness.

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HOLDING CAREGIVERS ACCOUNTABLE

Payers for health services have attempted to restructure payment methodologies to align provider incentives with the production of efficient and quality care. Accountable care organizations are the latest iteration of this trend.

Section 3022 of the new health reform law authorizes the Medicare program to contract with accountable care organizations (ACOs) beginning in January 2012. A recent brief from Health Affairs and the Robert Wood Johnson Foundation attempts to describes what ACOs will look like in the coming years.

Under the statutes established by the Patient Protection and Affordable Care Act (PPACA), ACOs are designed to be networks of physicians, hospitals and other clinicians which participate in Medicare parts A and B. These groups are eligible for payments under a the "shared savings plan." Whatever Medicare determines are savings as a result of care coordination, the ACO will be entitled to a portion of that money. The goal of such a plan is to find a replacement for the traditional fee-for-service system in Medicare.

At minimum, the ACOs must participate in the shared savings plan for 3 years and must cover the care of at least 5000 Medicare enrollees. Most primary care physicians have patient panels of 1500 to 2500 patients; a fraction of these are usually Medicare enrollees.

Five main classes of delivery systems are thought to be possible models for ACOs. Integrated delivery systems like Kaiser Permanente represent one potential model. In the integrated delivery system, hospitals and physician practices are all owed by a single entity. As with Kaiser Permanente, all the enrollees are insured under the same health plan. This allows the aligning of incentives for both the payer and the provider.

A second potential model for ACOs is the multispecialty group practice, such as the Cleveland Clinic. Here, the clinicians all comprise one cooperative medical group with mechanisms to coordinate care. The multispecialty group often will own or at least have a strong relationship with a single acute care hospital.

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"Health Policy Brief: Accountable Care Organizations." Health Affairs. July 27, 2010.

Highlights

- Private physicians are paid according to a fee-schedule which dictate how much each visit or procedure is worth
- Hospitals are paid through diagnosis-related groups for an admission of a certain type
- For example, all pneumonia patients generate a fixed fee for the hospital regardless of the resources needed to care for that individual
- The ACO concept is designed to improve quality and reduce cost for Medicare patients
- Financial incentives are less likely to change solely as a result of ACO structure
- Integrated delivery systems and multispecialty groups often employ salaried physicians
- Physician-hospital, independent practice, and virtual physician organization will likely retain profit-maximizing financial incentives

A third model, the physician-hospital organization, operates similarly to the multispecialty group except that the medical staff are not employees but remain independent providers. Theoretically, physicians in this setting agree to work collaboratively with others practicing at a particular hospital. Advocate Health in Chicago is one example.

The independent practice association represents the fourth possible model for ACOs. These independent practices jointly contract with insurers (instead of hospitals) to help coordinate care.

Virtual physician organizations are the rural answer to ACOs, which might be more natural developments in metropolitan areas. Community Care of North Carolina practices this type of structure. Virtual networks help small practices share resources.

The goal of ACOs is to bridge the disparate roles of inpatient care and outpatient care which in today's medical world are experienced in separate silos.

The ACO experiment in Medicare will not change the way clinicians and hospitals deal with the remainder of their patient populations with other insurance sources. Fee-for-service payment will still be the predominant reimbursement scheme for office based physicians; DRG reimbursement will still apply to hospitals.

Another important issue is how much of the savings will be shared with the ACOs. And then, how much of that money will subsequently be shared with the clinicians. If those amounts remain insignificant, the ACO movement may not catch on.

Commentary

Accountable Care Organizations (ACOs) are an idea floated by policy experts with the goal of creating seamless and efficient care between the inpatient and outpatient settings. However, convincing individual physicians to restructure their businesses (which are each independent profit-making endeavors) and create a single entity may prove difficult. Organizations which best accommodate this philosophy also tend to compensate their clinicians as salaried employees (integrated systems, multispecialty groups). ACOs structured in ways where clinicians still try to maximize their individual income may do a good job of coordinating care, but will fail at decreasing costs. Policy researchers must look diligently at the model of the physician-hospital organization, which likely represents the greatest opportunity for change, innovation, and impact.

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EVIDENCE-BASED HEALTH POLICY

The policy process involves making difficult and sometimes arbitrary decisions about what to allow, what to prohibit, what to tax, and what to spend.

Rarely does policy take an informed or evidence-based approach. This presentation [given to the American Medical Student Association on September 19, 2010] explains the concept of evidenced-base health policy.

Most studies of evidence-based policy are from the public health perspective. Few are from the private health perspective – that is, health insurance, delivery systems, workforce issues, etc. While knowledge and data exist, it is often not known or understandable to policy makers.

Three case studies will help describe the challenges with implementing policy based on science.

Case 1: Scurvy

Scurvy, as we all know today, is a disease caused by Vitamin C deficiency. James Lind determined as far back as 1747 that this disease, common among sailors on long voyages, could be prevented by adding citrus fruit to sailor's rations.

Unfortunately the evidence behind this common sense measure was not implemented for another 42 years. Imagine how many sailors wound up with scurvy as a result of 42 years of political inactivity.

So just how does policy get made? It is surely not just the simple codification of interventions deemed reasonable and efficacious by science. Policy may be manufactured as a reaction to something terrible, like 9/11 and the PATRIOT Act. It may occur by a chance happening like AIDS funding after the death of a young boy named Ryan White. Or it may occur in a visionary process such as what occurs when an agency or interest group develops model laws such as anti-tobacco legislation.

However, research has indicated that few model public health laws are based on readily identifiable evidence. One study found 107 model laws and determined only 6 percent were evidence-based.

So what is evidence-based policy?

Evidence-based policy is the continuous process of using the best available qualitative

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and quantitative evidence to inform policy decisions.

Case 2: Fluoride in drinking water

The fluoridation of drinking water has been hailed by the CDC as one of the greatest achievements in public health during the 20th century. Fluoride's benefit to the oral health of all Americans occurs irrespective of socioeconomic status.

While not common in Europe, the United States began inserting fluoride into drinking water around 1945. Approximately half of all Americans have access to it. It is cheap and effective in reducing tooth decay and tooth loss.

However, something as simple as fluoride in drinking water has been and remains quite controversial. (see TIME Magazine. March 10, 1952. Medicine: Fight over Fluoride.)

Communities in Long Island, the Pacific Northwest, and everywhere in between have often voted against fluoridation of water supplies when up to a vote. It has even been deemed by some to be a communist plot. So why wasn't the evidence about the beneficial effects of fluoride able to outweigh the negative political viewpoint?

What types of evidence exist?

First, let's look critically about the evidence used to inform policy decisions. In terms of policy making, there is qualitative type evidence – stories and narratives – which provide a focus for the target of such evidence. And then there is quantitative evidence – which can offer more objective and substantial "proof" that something works or doesn't work.

One study demonstrated that of 52 laws, only 27 were found to be effective based on evidence. 1 was ineffective. 1 was harmful. And 23 had insufficient evidence.

While qualitative studies help shape an agenda and anchor data, quantitative studies can be manipulated and lose their objective meaning if not interpreted in context or in totality with conflicting data.

That's one reason why systematic reviews are more robust, in the policy world, than solo studies. Multiple studies – aggregated in a systematic review – that all point the policy maker in the same direction offer substantially more influential evidence than a solo study.

While scientists are often expecting randomized controlled studies, these are often impossible for policy research. Often we are limited to natural experiments to compare and contrast the outcomes before and after implementation of a policy or law. Or to compare between different communities with different rules. This is of course open to confounding and bias.

Another type of data comes from modeling. Modeling is limited by the assumptions put into the model. It may be one reason why the politics of our next case study diverges from the science behind it.

Case 3: Mammography and Health Reform

In November 2009, the United States Preventive Services Task Force changed its prior recommendations on mammography (screening for breast cancer). Instead of starting at age 40, it recommended starting at age 50 for most women.

Remember during this time, the health reform debate was raging in the Senate.

And since the USPSTF was about to be empowered with a new authority – any grade "A" or "B" recommendations had to be covered without cost sharing for new insurance plans – this change in policy could have meant that women might have to pay for mammograms if under age 50.

So while the evidence suggested one thing; politics suggested another. An amendment was added to the health reform bill by Maryland Senator Barbara Mikulski explicitly ignoring the recent mammography ruling in lieu of the prior 2002 recommendation. Senator Mikulski, and those voting for her amendment, went ahead and created policy in direct contradiction to the evidence. In the battle of science vs. politics, as with this example, science often loses.

"How do you turn evidence into policy?"

First, let us understand what the role of evidence is. Evidence should demonstrate that a burden exists and demonstrate the priority of one issue over another. Data should explain relevance to local districts. When directed at the level of the voting district it is likely to be most effective.

Evidence should clearly show a benefit or a harm and must personalize the issue for stakeholders. Lastly, evidence must give an estimate of costs. Since health policies must compete against everything else in the budget, it helps to quantify the cost for policy makers.

When preparing evidence, make data easy to understand and distribute. Communicate data in ways most understandable by your target audience. Scientific papers are often not the best medium if policy makers are the target audience.

The active ingredients of good policy must be identified and delivered as easy, broad concepts.

A good evidence base should rely on multiple types of research data: that is, modeling, observations, natural experiments, and rarely narrative approaches. Randomized trials, although rare, are the best.

Once policy is implemented, it is critical to monitor it along multiple outcome measures to ensure effectiveness and make sure it has the intended effects.

Wanting our policy makers to use evidence is not enough; we must do the hard work of finding and translating the evidence for them. Only then can we expect to turn myth into reality and get evidence-based health policy.

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SCHOOL-BASED HEALTH CENTERS

School-based health clinics bring care to where it is needed. By placing children in proximity to health care providers, communities can avoid emergency room visits and hospitalizations, keep kids in class, and save money.

School-based health centers (SBHCs) are thought to be one solution to reduce health care disparities by overcoming barriers to access to care. Such barriers include lack of transportation, lack of providers, lack of insurance coverage and inconvenient appointment times. This study sought to measure the impact of SBHCs on disparities and their ability to produce a positive net social benefit to the population.

Seven schools with newly implemented SBHCs in Greater Cincinnati, Ohio, were matched with 6 schools without SBHCs based on urban or rural status, percentage of non-White students, and percentage of students in the free or reduced price school lunch program.

In this cost-benefit analysis, data was collected from student enrollment databases, Ohio Medicaid claim database, the SBHC encounter data, and surveys of parent and SBHC coordinators. The costs analyzed were health care costs (operational, equipment, and work hours), patient and family costs (travel, co-payments and lost work time), and infrastructure costs (start-up and facility use). The benefits measured were the students' health status change, value and/or grants created by SBHCs, resources saved by the SBHCs that were not spent on the above costs, and other unquantifiable benefits such as better attendance, better learning performance, and increased access to care. The concept of net social benefit was calculated as total benefits minus total costs.

Of the 5,056 students, 3,673 students were enrolled in SBHC schools and 1,383 students were enrolled in schools without SBHCs. The total net social benefit estimation of the SBHCs over the three years of the study was $1.35 million, with total costs just under $2 million and total benefits of $3.35 million. Of interest, the resources saved from the health care sector included potential costs savings for

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Guo, JJ, Wade, TJ, Pan, W, et al. School-Based Health Centers: Cost–Benefit Analysis and Impact on Health Care Disparities. Am J Public Health. 2010;100: 1617–1623.

hospitalizations estimated around $228,000, the potential savings for prescription drugs estimated around $443,000, potential prevented productivity losses around $542,000, and estimated travel expenses for parents around $42,000. The unquantifiable benefits of the SBHCs included 1) increased care for African American children and adolescents, 2) approximately 80 percent of students returned to class after SBHC encounters, 3) increased early mental health services, 4) increased dental care, and 5) lower risk of hospitalization and emergency room visits for students with asthma.

Highlights

- School-based health clinicis saved $1.3 million over three years
- SBHCs lower the risk of hospitalization and emergency room use
- SBHCs reduce racial and ethnic disparities

Commentary

The traditional model of health care within our society must be questioned due to both disparities and access issues - and SBHCs provide an excellent approach. The doctor's office - a necessary part of the primary-care focused medical home - does not have to remain stagnant within its current physical framework. By bringing care and resources to children where they are, our system will not only deliver more efficient care, but also allow for greater opportunities for public health outreach. Similar to the efforts of many states to expand the opportunities to exercise a citizen's right to vote (*e.g* in malls, by mail, on weekends, and early voting), our health care system must aim for greater creativity, flexibility, and responsiveness with the delivery of health care.

October 4, 2010

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PHYSICIAN NETWORK OVERLAP

Many health insurers pride themselves on being highly-rated in terms of the quality of care they provide. However, physicians tend to contract with many different insurers and with each additional contract, quality of care declines.

Recent interest in sparking competition in the health care marketplace has prompted comparative rankings of physicians, hospitals, and even health plans. This study, seeking to validate the quality measures used to rank health plans, attempts to determine whether such quality measures are the result of plan differences or individual physician differences within each plan.

However, there is significant overlap of physician networks between plans. Most physicians contract with multiple insurers and competing insurers often contract with the same physicians. Thus, it is no surprise that a patient switching from one health plan to another needs to change his or her physician only fifty percent of the time.

Many of today's quality outcomes for health plans refer to process measures largely determinable by physicians: prescribing beta blockers after a heart attack or the use of preventive screening tests such as mammography and Pap smears.

The hypothesis tested by this study is that as physician networks begin to overlap, health plan quality measures will converge. The data sets used for this study derived from a proprietary list of physicians at health maintenance organizations (HMOs) covering two-thirds of the nation's HMO enrollees. Data from the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) data sets (two commonly used data sets for quality measures) were matched to physician lists in order determine health plan quality.

Results from this study clearly indicate that as health plan networks converge, so do quality measures such as breast cancer screening, childhood immunization rates, diabetic blood sugar control (HbA1C), and the patient's perception of getting care quickly. However, these quality measures tend to converge toward lower levels of quality as

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Maeng, DD, Scanlon, DP, Chernew, ME, et al. The Relationship between Health Plan Performance Measures and Physician Network Overlap: Implications for Measuring Plan Quality. HSR. 45; 4: 1005-1023.

Highlights

- The is a good deal of overlap between physicians in different health plans
- As network overlap increases, quality decreases
- Physicians with more insurance contracts to provide slightly lower quality care

health plans share overlapping networks of clinicians.

A similar analysis demonstrated that as physicians contract with more and more health plans, their individual performance on these same quality measures also declines. Yet, these reductions in quality measures, although significant statistically, are often small in magnitude.

For instance, the performance of diabetic eye exams, performed by about 60 percent of physicians who contract with only one health plan, declines only 1.5 percentage points for each additional health plan with which the physician contracts. Network overlap has no stronger effect on any other quality measure studied by these researchers.

Adding strength to the findings of this study was the use of a negative control variable: claims processing. Claims processing is believed to be a health plan specific outcome that should occur irrespective of the contracted physicians' behavior. In both analyses, this negative control variable failed to demonstrate any significant correlation with network overlap or the number of contracts per physician. Thus, the authors conclude that when there is network overlap, health plans' quality scores converge and usually to a lower level.

Commentary

This study demonstrates empirically a concept believed by most who view competition as the best ways to promote benefits for consumers, in this case quality care for patients.

Health plan network overlap decreases the competition between physicians. As physicians contract with multiple plans, the quality of care delivered tends to suffer. Although the real effect is quite small, policy makers may wish to investigate further whether or not there is a maximum number of physician-insurer pairings that may be beneficial prior to declines in quality.

The evidence from this study also suggests that efforts to promote quality care from programs such as Medicaid and Medicare may be limited if a physician elects to accept multiple other insurance types.

While promoting exclusive contracting between physicians and insurers seems extreme, it would offer payers of health care services the most leverage in promoting goals such as quality, health information technology, and pay-for-performance.

October 11, 2010

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911 VERSUS 7-11

Americans have increasingly been taking their medical ailments around the corner to the local urgent care or retail clinic. These alternatives to emergency departments may help offload some of the strain with ever-rising ED volumes.

The delivery of urgent health conditions ranges from the private physician offices to hospital emergency departments, with settings such as retail clinics and free-standing urgent care centers representing the middle road. However, as opposed to the traditional physician office, the last three sites of care focus on providing acute care services to walk-in patients and do not require appointments.

Emergency departments are legally bound to see and evaluate all comers, regardless of insurance type. Urgent care centers and retain clinics, while not mandated to the same extent, do see uninsured patients. In fact, over one-quarter of retail clinic patients lack insurance compared to 17 percent of emergency department patients.

Personnel staffing these different sites are care are often overlapping. Typically, retail clinics and urgent care centers are staffed by nurse practitioners and physician assistants. Within emergency departments, "fast tracks" are often staffed by these same providers. Within these "fast track" areas, the types of ailments evaluated typically overlap with what presents to urgent care centers and retail clinics.

Retail clinics seem to concentrate on the treatment of two major classes of conditions. Upper respiratory infections (ear, nose, and throat complaints) comprise 60.6 percent of all visits. Preventive care services account for another 21.6 percent.

Urgent care centers and emergency departments only experience 33.3 percent and 9.8 percent of their total volume with upper respiratory complaints, respectively. The proportion of preventive health services at these two sites is infinitesimally small.

More common conditions encountered in the emergency room and the urgent care center are musculoskeletal injuries and dermatologic conditions like lacerations and skin and soft tissue infections (nearly 20

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Weinick, RM Burn, RM, and Mehrotra, A. Many emergency department visits could be managed at urgent care centers and retail clinics. Health Affairs. 29; 9: 1630-1636.

Highlights

- 29% of the US population lives within a 10 minute drive of a retail clinic
- Over 1 million people use retail clinics annually
- Fewer than 3 percent of patients at retail clinics and urgent care centers get sent to other sites like the emergency room
- Emergency department visit total over 104 million per year
- An estimated 17 million ED visits could be diverted at a cost savings of $4.4 billion

percent and 10 percent, respectively, of each sites' patient volume.

Over one-third of conditions encountered in the emergency department are things which urgent care centers and retail clinics are ill-equipped to handle. But, some conditions are amenable to care at a potentially lower cost clinical site. The researchers suggested that 13.7 percent of all emergency department visits could be successfully, and perhaps safely, diverted to retail clinics and another 13.4 percent to urgent care centers. If accounting for times when these sites are open, the estimate drops to 7.9 and 8.9 percent, respectively.

Patient demographics show that the extremely young (less than 2) and the elderly (65 or older tend to self triage toward hospital emergency departments versus urgent care centers and retail clinics (5.9 percent, 1.5 percent, 0.2 percent and 10.8 percent, 8.7 percent, and 7.2 percent, respectively). Other factors which predispose a patient to self triage to an emergency room versus a retail clinic or urgent care were not studied.

Commentary

Hospital emergency departments remain the only truly accessible, and universal, source of care to hundreds of millions of Americans 24/7/365. Certain other sites of care such as retail clinics and urgent care centers are capable of evaluating certain minor conditions and could likely off-load some volume from emergency departments. If following the estimates given by the researchers, this could represent an additional 17 million visits to retail clinics and urgent care centers. While the subsequent cost savings seem promising ($4.4 billion annually), this amount only represents 0.2 percent of national health expenditures.

Instead of looking to retail clinics and urgent care centers as a cheaper mode of acute care, policy makers must look at how to best expand their capacity and promoting the continuity of care with community physicians.

Ultimately, the health care delivery system must seamlessly incorporate retail clinics and urgent care centers, uniting them with the outpatient setting. Emergency departments will continue to serve as the nexus between the inpatient and outpatient worlds.

An approach focusing on portability and sharing of medical information (with electronic records) would help ensure the smooth transition of the patient through these discrete medical silos.

OCTOBER 18, 2010

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MALPRACTICE...A $56 BILLION POISON PILL

Malpractice litigation is supposed to remedy the situation where patients are damaged by the negligent behavior of clinicians. Unfortunately, this costly system does a poor job of compensating patients or ensuring safety in patient care.

In an effort to pinpoint potential areas of cost-savings within the health care system, attention has been directed at tort reform to decrease the costs of the medical liability system. However, it is difficult to explain how expensive the current liability system is and to estimate the magnitude of cost savings as a result of tort reform. The current study by Mello and others aims to accomplish this feat.

These authors break down the total costs of the liability system into subcategories of indemnity payments, administrative expenses (of insurers and attorneys), and defensive medicine. Notably missing are insurance premiums, which theoretically would equal the amount of administrative expenses plus indemnity payments (and would include malpractice insurance company profits). Additional areas of minor and likely non-quantifiable liability system costs include lost physician work time, increased cost of physician services, and damage to physicians' reputations and psychological well-being.

The estimate of indemnity payments is based on the National Practitioner Data Bank (NPDB) of the Health Resources and Services Administration (HRSA). Every time a physician makes an indemnity payment, it is mandated to be reported to the NPDB database. Physicians pay an estimated $2.4 billion in indemnity payments annually. However, this does not include payments made by hospitals, which are the paying defendants in about 30 percent of cases. Adding hospitals, the estimated total rises to $5.7 billion in indemnity payments each year. It is interesting to subdivide these total payments into economic, non-economic, and punitive damages. Unfortunately these data are not generally available because the great majority of cases are settled out of court, where the breakdown of payment amounts is not necessarily made transparent. In addition, these ratios vary greatly based on

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Health Affairs. 2010; 29(9):1569-77.

Health Affairs. 2010; 29(9):1578-84.

the type of case (scars in an adult versus neurological deficits in an infant) as well as the presence or absence of non-economic damage caps in each state. Of note, economic and non-economic damages are estimated to be roughly 55 percent and 42 percent of indemnity payments, respectively, whereas punitive damages represent a very small portion of these payments.

Administrative expenses include plaintiff's and defense attorney fees, the overhead costs of insurers, and of risk management programs. Attorney fees tend to be 20 to 40 percent of award payouts, with plaintiff's attorneys at the higher end and defense attorneys at the lower end of the spectrum. Since hospitals are named as sole defendants in approximately 30 percent of cases, it is assumed that the general capacity and annual financial support of risk management programs based at hospitals across the country ($1 billion) is much more substantial than quality improvement programs would be in a non-litigious environment.

Of note, defensive medicine costs are estimated to be, by far, the largest portion of liability system costs, but at the same time have the least data to support their actual cost. Defensive medicine is estimated to cost $46 billion annually, whereas indemnity payments and administrative costs are estimated at $6 billion and $4 billion, respectively. In this study, these defensive medicine estimates are subdivided into hospital services ($39 billion) and physician services ($7 billion). Hospital estimates are based on the most widely cited set of studies regarding the costs of defensive medicine by hospitals, which examines expenditures on care for cardiac disease in Medicare patients before and after tort reform in certain states. The Kessler and McClellan study concluded that there was a 4 to 9 percent reduction in spending on cardiac disease in those states that underwent tort reform. Data on costs of physician defensive medicine is extrapolated from increased reimbursement rates from Medicare Part B over time and the correlating increases in malpractice premiums or award payments over that same period of time, with the former assumed to be a result of the latter.

Commentary

This study defines the actual costs of America's medical liability system according to the best available evidence (estimated at $56 billion). Arguably the largest factor in medical liability, defensive medicine by hospitals, has the least reliable data on which to base these estimates. Noteworthy is the fact that the results by Kessler and McClellan showing substantial cost savings opportunities through hospital expenditures after tort reform have not been generalizable in other studies looking to validate their findings.

This study estimates that 2.4 percent of total health care costs are due to medical liability. What's more, a study by Thomas et. al. in the same issue of Health Affairs estimates that even if malpractice premiums were reduced significantly, it would only reduce total health care costs by less than 1 percent. Even if tort reform were to completely erase the $56 billion in medical liability costs, it is debatable how significant a 2.4 percent reduction in overall health care costs would be.

Although there may be many reasons to pursue tort reform, the evidence as it stands today does not support large system-wide reforms based on the oft-touted-presumption that medical costs for Americans would significantly decrease.

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LESSONS FROM THE SPANISH HEALTH SYSTEM

After the fall of the dictatorship of Francisco Franco (1939-75), Spain took on a rapid reorganization of its health care services.

After Franco, health protection and care was declared a right of every Spanish citizen and a universal, general, and free national health system became the national goal. The central government sets basic principles by means of national standards and pharmaceutical policy.

Jurisdiction over health care is distributed amongst Spain's 17 Autonomous Communities (similar to states in the United States) that control health planning, public health, and management services. Autonomous Communities are divided into Health Areas that are responsible for management of facilities, health services and benefits, and each Health Area is composed of several Basic Health Zones that are organized around a single primary care team. The Basic Health Zone coordinates prevention, promotion, treatment and community care activities for its 5,000-25,000 inhabitants. This transformation included a shift in basic financing from a social insurance model to one that is tax-based. An estimated 15 percent of the population maintains private supplemental insurance, but the majority of care is publicly funded.

Outcomes have been positive. In 2007, Spain spent $2,671 per person (8.5 percent of GDP) on health care, below the OECD average (8.9 percent of GDP) or that of the United States (16 percent of GDP). Spain also ranked 6th in life expectancy among 30 OECD industrialized democracies and 17th in infant mortality out of 224 nations. From 1986 - 2006, mortality from disease of the circulatory system decreased from 322.1 to 159.0 per 100,000 population, adjusted for age. Deaths from diabetes mellitus also declined during the same period, from 19.8 to 12.5 per 1000,000 population, adjusted for age.

Eight major principles have been accredited for the success of the transformation:

1) Stronger Primary Care - Family and Community Medicine was established as a specialty with the mission to promote comprehensive health care. Spain also set as its goal that there be a primary care center

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OCTOBER 25, 2010

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Borkan J, Eaton CB, Novillo-Ortiz, D, et al. "Renewing Primary Care: Lessons Learned From The Spanish Health Care System." Health Affairs. 29 (9): 1432-1441.

Highlights

- The Organisation for Economic Co-operation and Development (OECD) tracks statistics on health spending and outcomes in many developed nations
- Spain will have a comprehensive electron health record by the end of 2010
- Spain spends about half as much on health care than the United States

within a fifteen minute radius of any place of residence, establishing multidisciplinary primary care teams that offered a broad range of services. By 2008, these teams now handle more than 70 percent of all health care visits in the country.

2) A Voice of Citizens - Public forums are held in order to not only engage, but to also communicate about time and resource constraints. Technological systems included phone, email, web, TV, DVD and text messaging are also used to communicate with patients.

3) Electronic Health Records - A comprehensive system will be fully accessible in every region by the end of 2010.

4) Community Pharmacies - New regulatory criteria for the opening of pharmacies has been enforced in order to achieve greater equity and access.

5) Regional and Local Levels - Each branch of the system is provided some autonomy within the implementation of national guidelines.

6) Best Practices - Multiple demonstration projects are in place in order to redesign clinical processes and to share lessons learned.

7) Systemwide Approach - The multiple actors within the health care system (e.g. physician groups and practices, hospitals, and specific health insurers) are involved that transcend traditional geographic, sector and institutional boundaries.

8) Sustained Commitment - Spain's political leadership has adopted a bipartisan approach to the stable funding of a universal access system.

Commentary

In addition to its common national structure, the final two principles greatly distinguish Spain's advancements from those of the United States. Steps towards comprehensive health reform in the U.S. traditionally rely on change pertaining to single institutions and/or players within the health care system - for instance, the recent reform focused on select issues pertaining to health insurers but neglected to address the involvement of pharmaceutical companies, the courts, and other parties.

A holistic approach must be adopted in order for successful and widespread health reform to take place. There was little agreement between the controlling American political parties of Republicans and Democrats. Singular issues were highlighted with the outcome being that everyone had to "choose sides" instead of working towards a common goal. As noted in Spain, perhaps an initial discussion and fundamental acknowledgment of health care as a right and/or other basic principles is necessary to provide our government with direction.

NOVEMBER 1, 2010

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P4P IMPROVED CHILD IMMUNIZATION RATES

Pay-for-performance can alter physician behavior if structured with appropriate and large enough incentives. This study based in New York showed that a P4P intervention can improve immunizations in children.

This study used a case-comparison and an interrupted time series design to compare Hudson Health Plan's Pay for Performance (P4P) program -- an intervention to improve immunization rates of children 0-2-years-old. The interrupted time series allowed Hudson Health Plan to observe trends in immunization rates of its own patients and those covered by other plans before and after the implementation of the P4P program. This study design sought to account for secular trends that might have confounded immunization rates for patients in the intervention population.

From 2003-2007, Hudson Health Plan, a not-for-profit Medicaid managed care plan out of New York, introduced a piece-rate P4P program offering financial incentives at the physician practice level to improve immunization rates for 4,429 eligible two-year-old children. Hudson health plan contracts with 115 eligible practices. Sixty-five percent of the practices are solo or small. Thirty-five percent are medium (4-9 physicians) or large practices (10 or more physicians). The intervention was two tiered, offering $100 for each child fully immunized by their second birthday and an additional $100 if the immunizations were administered in compliance with Health plan Employer Data and Information Set's (HEDIS) 2003 guidelines for timeliness.

Additionally, the program provided administrative support by providing monthly lists of patients turning two in the previous month, and quarterly reports on each practices immunization rates. The principle findings show Hudson Health Plan immunization rates increasing at a moderate (7 percent from 2003-2005; 11 percent from 2005-2007) yet statistically significant higher rate than trends observed in comparison health plans. The mechanisms by which this improvement took place remain unclear. Examination of patient-level claims data showed no significant change in number of visits, number of shots per visit, immunization rates, or preexisting conditions.

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Chien, AT, Li, Z, and Rosenthal, MB. "Improving timely childhood immunizations through Pay for Performance in Medicaid-Managed care." HSR. Online in advance of print.

Concerns over the program's negative impact on children with chronic conditions or the exacerbation of racial/ethnic disparities did not come to fruition.

Two major limitations discussed by the authors of this study and those similar are an inability to account for secular trends at the patient or practice level that may affect immunization rates. The other limitations are an inability to differentiate between improved documentation and more complete immunizations in the intervention population possibly due to system gaming.

Highlights

- P4P programs can improve childhood immunization rates
- Certain P4P programs can be "gamed" by health care provider by simply improving documentation without increasing quality

Commentary

Many P4P programs are able to demonstrate improvements in incentivized behaviors. The fundamental basis of program success remains a topic for further research. In this era of healthcare quality improvement, secular trends geared toward educating patients and providers, increasing use of quality measures, improved reporting of quality indicators, movements toward evidence-based practice, and payment system reforms exist as confounders skewing the evaluation of P4P programs. The authors attempted to account for this potential confounding using a study design allowing for comparison of immunization rates of children in and out of Hudson Medicaid health plans before P4P implementation and post intervention. Hudson's immunization trends were significantly improved compared to those of non-Hudson plans.

The potential for system gaming in P4P programs (i.e. improved documentation of incentivized behaviors versus actual improvement in behaviors; denial of care for sicker patients to achieve incentivized standards), requires further investigation.

NOVEMBER 8, 2010

POLICY PRESCRIPTIONS®

UPDATE ON ELECTRONIC HEALTH RECORDS

Recent actions by Congress have sparked a slight uptick in the adoption of electronic health records by physicians and hospitals. However, 7 out of every 8 hospitals and 6 of every 7 physicians still lack even a basic electronic record.

Incentives included in major legislation passed by the Obama administration have encouraged health care providers to enter the digital age over the past two years. Most recently, the administration has promulgated regulations defining what the "meaningful use" of electronic health records means for both hospitals and private physicians.

In light of these new regulations and incentives, researchers familiar with electronic health records sought to determine whether or not hospitals had experienced an up-tick in electronic record systems. The data came from the Annual Survey Health Information Technology Supplements conducted by the American Heart Association. Over three thousand acute care, nonfederal hospitals were surveyed each year during 2008 and 2009.

The investigators sought to determine the prevalence of electronic health records (EHRs) - subdivided as either basic or comprehensive - in American hospitals. Basic EHRs perform a set of ten clinical functions and are deployed in at least one hospital unit. By contrast, comprehensive EHRs execute twenty-four clinical functions and are deployed in all hospital units.

During the time from 2008 to 2009, hospitals across the country increased their use of electronic health records. Hospitals increased their use of basic EHRs from a baseline of 7.2 percent to 9.2 percent. Those hospitals with comprehensive EHRs increased from 1.5 percent to 2.7 percent. Ultimately, by 2009, 11.9 percent of hospitals had some type of electronic health record implemented.

Of the electronic health records already implemented, most allow for the viewing of results (lab reports, 82 percent; radiology images, 83 percent; radiology reports, 85 percent) or offer assistance with medications (medication lists, 66 percent; drug allergy alerts, 63 percent; drug interactions, 63 percent).

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NOVEMBER 8, 2010

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Jha, AK, DesRoches, CM, Kralovec, PD, et al. "A progress report on electronic health records in U.S. hospitals". Health Affairs. 2010; 29 (10): 1951-1957.

Core functions for EHRS

- record of patient demographics
- record of vital signs
- maintain up-to-date problem lists of current diagnosis
- maintain active allergy lists
- record smoking status
- provide patients clinical summaries of each office visit (discharge summaries for hospitals)
- provide patients electronic copies of their health information
- computer provider order entry for medications
- create and transmit prescriptions electronically
- drug-drug and drug-allergy checks
- electronic exchange of key information between providers
- at least one clinical decision support rule
- protecting privacy and security of patient data
- reporting quality measures

Certain hospitals are more likely than others to have an electronic health record. Compared to larger hospitals, small-, medium-sized, and critical access hospitals are significantly less likely to have EHRs. Public hospitals, non-teaching hospitals, and rural hospitals are also less likely to have EHRs compared to their counterparts.

The authors of this study also sought to determine how well current electronic health record systems would fare if held to the challenge of meeting the government's new "meaningful use" criteria. While the survey instrument did not explicitly ask about all of the criteria, 9 of the 15 core criteria were surveyed. Only 2.1 percent of the hospitals with electronic health records would satisfy all nine of those criteria. Meaningful use regulations also require users to choose 5 from a menu of 12 optional criteria. Of the 3 menu criteria available for the current survey, 34 percent of EHRs could comply.

Commentary

As we have detailed multiple times before, the American health care system lags behind other industries in its investments in information technology. Prior studies indicated that only about 13 percent of physicians have electronic health records (EHRs). This study suggests that only about 12 percent of hospitals have EHRs.

Over the next two years financial incentives should help to improve the adoption of information technology in health care. Improvements in quality can be expected as a result.

In the year 2015, incentives will turn to penalties. Health care providers that are not using EHRs will see reductions in their payments from the Medicare program.

Incentives and penalties imposed by large health insurers such as Medicare (47 million patients) can have profound impact on the behavior of clinicians. Other large private insurers should adopt similar, if not the same, stance as the Medicare program to help spur the adoption of EHRs.

Ultimately, it would be ideal if all electronic records in the nation were interoperable and accessible anywhere and anytime as a single, universal medical record. While privacy concerns have certainly limited the concept of the universal record, other countries do this already and Americans do it with their banking information every day.

NOVEMBER 15, 2010

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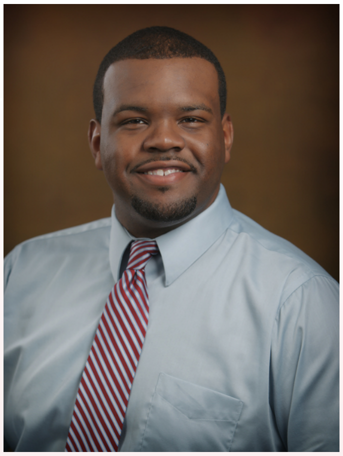
UPGRADED CHILD RESTRAINT LAWS

Motor vehicle crashes are the leading cause of death for children 3 to 14 years old. Upgraded laws in New York State how shown that child restraint laws aimed at pre-school children can improve behaviors and reduce injuries.

The National Highway Traffic Safety Administration (NHTSA) has been a strong proponent of establishing federal, state and local guidelines for the use of child seat restraints. Motor vehicle crashes are the leading cause of death for children 3 to 14 years old based on figures from the National Center for Health Sciences (2006). NHTSA currently recommends the use of belt-positioning booster seats (child restraints) for children 4 to 8 years of age, greater than 40 pounds, and shorter that 4 feet 9 inches long who are too big for small infant/toddler car restraints but too small for standard adult lap and shoulder seat restraints in most vehicles.

As of September 2010, 29 states including the District of Columbia have adopted this law. (referred to as the upgraded child restraint law). However, 21 states and two U.S. Territories have not adopted the recommendation or only accepted parts of the NHTSA recommendation as a state law. Florida is the only state that only requires children 3 years or younger to have child seats restraints by law. Arizona , South Dakota, American Samoa and Puerto Rico all have laws that only require children 4 years or younger to have seat restraints. Twelve states have child seat restraint laws for children 5 years or younger, and six states have laws for children 6 years or younger. Since adoption of these laws, there have been several studies conducted to show the effectiveness of child seat restraints.

A recent study examined traffic injury rates of children 4-6 years old in the state of New York since its March 2005 implementation of upgraded child restraint law (UCRL) that mandated child seat restraints for this age group. Researchers compared the number of traffic injury rates for children 4-6 years old to children 0-3 years old who were previously required to be in infant/toddler child seat restraints. Data derived from the Accident Information



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Sun, K, Bauer, MJ and Hardman, S. "Effects of Upgraded Child Restraint Law Designed to Increase Booster Seat Use in New York." Pediatrics. 126 (3): 484-489.

System for New York, covering 27 months before and 33 months after UCRL implementation. The population-based, injury rates for children, the child restraint use rate, and the front seat rate were examined for children aged 0-6 years of age.

When compared to the 0-3 year old infants and toddlers, 4-6 year old children experienced a twenty percent increase in their restraint use rate and four percent decrease in their front seat use rate after UCRL implementation. The population-based injury rate decreased significantly for the 4 to 6 year old group ($p<0.0001$) most likely as a result of the upgraded child restraint law.

Commentary

Despite evidence from numerous studies and the NHTSA recommendations on establishing state laws for child car restraints in children 4-8 years of age, 21 states still do not currently have laws that follow their recommendations. There are several road blocks that may inhibit a state from creating a new law. These road blocks include: deciding whether to implement this potential law as a primary or secondary offense, budgeting for increased manpower to enforce the potential law, and providing educational services on proper placement and installation of the child car restraints.

Although the benefit appears to outweigh the risks, there may be resistance from parents and political constituents for a new law. This resistance may be due to lack of financial means to afford child car restraints for a large family or limited space in a smaller vehicle to transport multiple children with child car restraints. Despite these limitations, state lawmakers should continue to review and seriously consider implementing child car restraint laws for better child safety.

NOVEMBER 22, 2010

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WHEN POLITICS TRUMPS SCIENCE

As happened following the controversial decisions of the United States Preventive Services Task Force on breast cancer screening, another controversy embroils the independent panel regarding prostate screening.

A report last month from the Wall Street Journal describes the recent decision of the United States Preventive Services Task Force, a 16-member panel of independent medical experts, to cancel a meeting set around Election Day.

One of the important items on the agenda would have been a vote on the utility of prostate cancer screening. The most recent recommendations (2008) state that prostate screening should not be conducted for men older than 75 years. For younger men, the evidence around the preferred screening test (the prostate specific antigen, PSA blood test) was inconclusive.

Dr. Kenneth Lin, now a former member of the USPSTF panel, implied that the cancellation of the November meeting was more than just a coincidence surrounding Election Day. Declaring that "politics trumped science," Dr. Lin tendered his resignation from the USPSTF.

Why would the USPSTF avoid voting on the prostate cancer screening issue during the spotlight of Election Day? We only need to look back to the policy debates surrounding the passage of the Patient Protection and Affordable Care Act. In the new health reform law, the USPSTF was granted the power to require health insurers to cover any preventive services with a grade "A" or "B" rating.

The leaders of the USPSTF may have anticipated another controversy similar to the one surrounding their last mammography recommendation. As you may recall, the USPSTF revised its breast cancer screening recommendations in November 2009. Then, the scientific evidence recommended against routine screening mammography for women under age 50.

However, in response to constituents, an amendment by Senator Barbara Mikulski was added to the Patient Protection and Affordable Care Act. The amendment

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Grade "A" Recommendations from the USPSTF from 2009 and 2010

- ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products
- ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for those who smoke
- use aspirin for men age 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage
- use aspirin for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage
- screen for hepatitis B virus (HBV) infection and syphilis in pregnant women
- all women planning or capable of pregnancy should take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.

explicitly forbids using the USPSTF's November 2009 breast cancer screening recommendation. The Mikulski amendment flexes its political muscle by directing all health insurers to cover mammography for women under age 50 even though the scientific evidence does not support this coverage decision.

It is no surprise that if the USPSTF anticipated another controversy around prostate cancer screening, the influential panel might postpone their vote to a less conspicuous time.

While the enhanced power granted to the USPSTF's recommendations will likely help promote better health in the nation, the formerly obscure expert panel now faces public and political scrutiny over every critical decision it will make in the future.

PPACA essentially begins the transformation of the USPSTF into an entity similar to the National Institute for Health and Clinical Excellence (NICE), the organization tasked with determining coverage decisions for the British health care system. Medicine and therapies recommended by NICE are required to be covered under the British health system. USPSTF recommendations now carry this same authority in the United States. The unfortunate flip-side of the coin is that in cases where the USPSTF cannot make a cogent decision based on the available evidence (i.e. level "I" recommendations), insurers might elect to deny coverage altogether.

However, if politics is allowed to trump science, the concept of evidence-based health policy will never become reality.

Commentary

Clinical guidelines and practice recommendations aid clinicians in standardizing care and in disseminating proven, effective treatments.

Where the evidence exists, we should follow it. Where the evidence is lacking, we should be aware.

Similarly, the practice of health policy should allow for positive evidence to be supported with legislation and regulation; negative evidence should direct decision-makers to avoid unnecessary (even if popular) decisions. The danger lies in the unknown. Areas of health policy without a strong research base are subject to pure ideologic thinking. In other areas - such as medical malpractice, pay-for-performance, improved access to care - policy makers must trust the evidence and make difficult decisions that will move our health care system forward.

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THE CONCEPTION OF COVERAGE

Contraceptive options for women often vary based on their socioeconomic status. Some of this variance can be explained by the unwillingness of some providers to prescribe intrauterine contraception to low SES women.

Disparities in health outcomes by race and ethnicity are well documented. The role of provider bias in perpetuating disparities is an area of ongoing research. Contrary to other areas of medicine, contraceptive management involves not only consideration of clinically appropriate options but also patients' personal preferences.

This study sought to determine if race, ethnicity, or socioeconomic status (SES) affect provider recommendations for intrauterine contraception (IUC; commonly the intrauterine device, IUD). Using standardized patients, three women portrayed patients that varied by race and ethnicity (White, Black, or Latina), SES (low or upper-middle class), and gynecological history (one with no perceived risk factors and two with perceived risk factors - (1) never pregnant and (2) history of pelvic inflammatory disease). Both the high SES and low SES patients were portrayed by the same actress within each racial/ethnic category.

Videos of the standardized patients were shown to healthcare providers recruited from professional society meetings of family medicine and obstetrics and gynecology. Each provider was told that the patient was 27-years-old, had normal blood pressure, had a recent negative test for sexually transmitted illnesses (STIs) and a normal Pap smear, was in a monogamous relationship, did not want to become pregnant for several years, and had insurance coverage for all contraceptive methods. Each of the 524 providers was randomly assigned to one situation and then completed a survey which included ranking their recommendations for several methods of contraception.

In considering the patients with no perceived risks, providers were less likely to recommend IUC to low SES women than to high SES women (57 percent versus 75 percent, $p=0.01$). Black women were

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Dehlendorf C, Ruskin R, Grumbach K, et al. Recommendations for Intrauterine Contraception: a randomized trial of the effects of patients' race/ethnicity and socioeconomic status. Am J Obstet Gynecol. 2010. 203 (4): 319.e1-8.

Highlights

- Low SES women as less likely to get recommendations to use IUC
- IUC is 99.9% effective

significantly more likely to have IUC recommended compared to white women (75 percent versus 57 percent, p=0.04). Recommendations between Latina and White women showed no difference. Amongst White women, providers were less likely to recommend IUC to low SES women than to high SES women (p=0.01). The same trend was found amongst Black women (p=0.04).

Amongst low SES women, providers were more likely to recommend IUC to Black and Latina patients than to White women (p=0.4 and p=0.3, respectively), although there were no significant difference amongst high SES women.

The authors concluded that race, ethnicity, and SES did play a role in IUC recommendations. They also suggested that epidemiological evidence or clinical experience might result in "statistical discrimination" whereby the appropriate individualization of care is hindered. They considered as a limitation that providers would be less likely to recommend IUC to low SES women because of concern about insurance, though they considered this unlikely.

Commentary

Nearly half of all pregnancies in the United States are unintended, with a higher percentage amongst low SES women than high SES women. Unintended pregnancies often precede abortion. A previous study showed increases in contraceptive use, particularly IUCs, when insurance companies covered contraception under state mandate. Can equitable contraceptive coverage decrease disparities in unintended pregnancies? Proponents of contraception coverage are advocating its placement on the list of required preventive services under healthcare reform law. The Health Resources and Services Administration has been directed to draft a guideline addressing family planning which would be included in the Women's Health Amendment. Without insurance, a woman's contraceptive decision is highly based on affordability rather than pregnancy prevention effectiveness. IUC, which approaches 100% effectiveness, ranges in price from $150 - $500. While equitable coverage would likely not eradicate provider bias, it would offer currently unaffordable, highly effective options for groups at risk for unintended pregnancy. Increasing these options will prove both financially and socially beneficial.
Unfortunately, this study demonstrates that bias goes well beyond equitable insurance coverage. Including contraception coverage in the Women's Health Amendment would put low SES women one step closer to receiving the care they deserve. In the coming months, regulators will decide if all women, regardless of SES, deserve the same opportunities for effective family planning. Amongst other things, this will provide great insight to the nation's commitment to its goals of reducing unintended pregnancies and abortion.

DECEMBER 6, 2010

POLICY PRESCRIPTIONS®

UNHEALTHY COMPETITION

Competition among health plans is supposed to yield benefits for "consumers." However, health care is not a true market. In certain situations, increased choice can lead to detrimental effects on patients.

Market-oriented thinkers believe that greater choice on the part of patients will lead to benefits in either quality, cost, or both. A recent study explores this question among Medicaid patients in California. With costs relatively controlled, researchers could focus on the quality of care delivered to this population.

Twenty-one of California's counties (accounting for 90 percent of all state Medicaid beneficiaries) participated in the study. While all beneficiaries were a part of managed care, in some counties the patients had a choice of health plans (13) whereas in others (8) there was no choice. Counties with choice typically had a commercial plan competing with a state-run plan; two counties had competition among multiple commercial plans.

The two outcomes of interest were the duration of health plan enrollment and the percentage of ambulatory care sensitive hospital admissions (a proxy for the quality of outpatient primary care). Data were derived from a 2002 Medicaid Eligibility File linked to hospital discharge data. The sample consisted of 2.1 million individuals continuously enrolled in Medicaid during 2002; 1.9 million lived in a county with a choice among health plans.

A mere 2.5 percent of eligible enrollees made a switch in their health care plan during the year. Compared to enrollees without a choice, enrollees living in counties with a choice of health plans were significantly less likely to have 12 months of continuous coverage (79.2 percent versus 95.2 percent, $p<0.001$). In fact, even the best performing county of those with a choice of health plans performed worse than the worst county without health plan choice (85.6 percent versus 89.5 percent, $p<0.001$).

Greater than ninety-five percent of enrollees in counties with zero choice were assigned a health plan within the first month. By comparison, among enrollees in counties

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Millett C, Chattopadhyay A, Bindman AB. Unhealthy competition: consequences of health plan choice in California Medicaid. Am J Public Health. 2010. 100(11):2235-40.

Highlights

- Competition and choice appear detrimental for health plans serving the Medicaid population
- Too much choice can lead to delays in selecting health plans
- Delays in selecting health plans are associated with greater risk of hospital admission for ambulatory care sensitive diagnoses

with choice, fewer than 1 percent of beneficiaries were assigned to a health plan during the first month and nearly half remained without a health plan after three months.

Not surprisingly then, ambulatory care sensitive conditions were significantly more likely to occur in Medicaid enrollees in counties with plan choice (6.58 versus 6.27 admissions per 1000 enrollees). For appendicitis, a medical condition not sensitive to the quality of outpatient primary care, admission rates were roughly identical (1.02 versus 1.01 admissions per 1000 enrollees).

The authors went on to find a dose-response relationship between the duration of continuous health plan coverage and ambulatory care sensitive admission rates. Patients with less than 3 months of continuous coverage had over twice the rate of these unnecessary admissions compared to patients with 12 months of continuous coverage (6.01 versus 13.45 per 1000).

Commentary

Many countries have bought into the philosophy of "managed competition." Championed by Alain Enthoven, implemented by the Dutch, and recently adopted (albeit in part) by the Obama Administration, such competition may not be all that it is advertised to be.

While managed competition is probably better than unregulated competition within an imperfect healthcare marketplace, this study shows that, at least for the Medicaid population, competition and plan choice appears detrimental to one's health. The obvious explanation is that beneficiaries with choice procrastinate too long when choosing health plans. When outside the health system, beneficiaries are unable to get appropriate medication or doctor advice. Therefore, it is no surprise that instead of dealing with health issues in the doctor's office, these patients wind up in the hospital receiving far more expensive medical care.

These findings may be generalizable to Medicaid populations in other states. Common sense would suggest that a default choice be made for all enrollees where competition exists to eliminate lapses in coverage.

While the findings of this study cannot be generalized to the portion of the population with privately purchased insurance, regulators crafting "health insurance exchanges" in the coming years should remain alert to the lessons learned to avoid similar problems.

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THE FUTURE OF NURSING

Typical nursing tasks - medication administration, direct care of patients, and patient education - are often subsidiary to physician work. Advanced practice nursing, however, operates as a physician substitute.

The Robert Wood Johnson Foundation (RWJF) and the Institute of Medicine (IOM) developed a diverse committee comprised of nursing leaders across the country to study the future needs of the nursing profession. The Committee on the RWJF Initiative on the Future of Nursing produced a report after a two year study period that evaluated barriers that prevent nurses from being able to respond effectively to a rapidly changing health care system.

The final report was recently released and focuses on several key themes: nurses should practice to the full extent of their education and training, they should achieve higher levels of education and training, they should become full partners with physicians, and they should become leaders in redesigning health care in the United States.

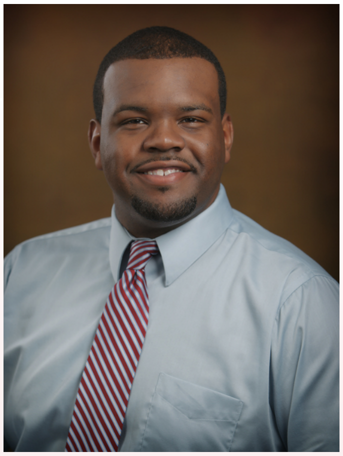
The consensus report contained eight recommendations supporting its key themes and provided "an action-oriented blueprint for the future of nursing." The recommendations are as follows:

Recommendation 1: Remove scope practice barriers. Extend Medicaid, Medicare and third-party reimbursement rates for primary care physicians' services to include Advanced Practice Nurses (APN) services. Allow APNs hospital admitting privileges.

Recommendation 2: Create new opportunities in various health care arenas for nurses to lead and manage collaborative efforts with physicians and other members of the health care team in research and policy.

Recommendation 3: Implement nurse residency programs. Support nurses' completion of a transition-to-practice programs (nurse residency) after they have completed a pre-licensure or advanced practice degree program or prior to new clinical responsibilities.

Recommendation 4: Increase the proportion of nurses with baccalaureate degrees to 80 percent by 2020.



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Recommendation 5: Double the number of nurses with a doctorate by 2020.

Recommendation 6: Ensure that nurses engage in lifelong learning.

Recommendation 7: Prepare and enable nurses to lead change. Nurses, nursing education programs, and nursing associations should prepare the nursing workforce to assume leadership positions across all levels of health care.

Recommendation 8: Build an infrastructure for the collection and analysis of inter-professional health care workforce data.

Robert Wood Johnson Foundation Initiative on the Future of Nursing at the Institute of Medicine. The Future of Nursing: Leading Change, Advancing Health Consensus Report: Report Recommendations. October 5, 2010, Washington, DC.

Highlights

- Advance practice nurses (APNs) include nurse practitioners (NPs)
- NPs currently work side-by-side with physicians in some states; in others they are independent and yet others they are subsidiary
- *The Nurse Practitioner*, a journal for APNs provides an annual survey of scope-of-practice realities in all states
- NPs and other non-physician clinicians can provide similar quality of care as physicians

Commentary

The RWJF IOM's recommendations have not gained full support throughout the health care community. Leaders from various medical associations including the American Medical Association and American Osteopathic Association met with several RWJF IOM committee members to discuss the pros and cons of their recommendations last month. While the further advancement, education, and training of nurses has been applauded, the expansion of services provided by APNs has been met with criticism by medical associations.

The intensity and length of physician education and training is typically greater than APN education and training. Therefore, extending the scope of practice and compensation of APNs may not be warranted.

Patient safety has been an argument used by medical associations when previous attempts were made to extend APN's scope of practice. In the recent years, however, there have been eye-opening studies that show similar medical error outcomes and similar quality of care whether the health care provider was a physician or an APN. Proponents of expanding the role of APNs argue that the RWJF IOM committee's recommendations to the double the number of APNs with doctorate degrees and require a "residency" program will bring APNs' medical knowledge and experience similar to their physician counterparts. However, as APN training becomes more similar to the training of a physician, will there still be much practical difference between the two professions?

RISK EQUALIZATION SCHEMES

Health insurance is designed to pool risk among individuals. Profit-seeking health insurers attempt to limit their risk by selecting healthier consumers. To counter this behavior, many nations have implemented risk equalization schemes.

A recent article in the journal *Health Policy* aims to analyze the techniques of risk equalization employed by several countries in the setting of voluntary health insurance systems. All these systems maintain the goal of keeping health insurance affordable in the competitive marketplace by cross-subsidizing the high-risk insured. Interestingly, this step of implementing risk equalization is often seen as a way to transition a health care system from voluntary to mandated insurance. This step, however, was not used by the United States in its pending health reform.

Specifically, the authors discusses the details of the use of risk equalization in South Africa and Ireland, as well as claim equalization in Australia. Risk equalization is insurers' payment to or from an unspecified fund based on the health risk of each insured individual. This payment can be in an external system, where the fund is managed by a third party (such as a governmental body) or internal system, where funds are paid from one insurance company to the next through a solidarity fund. Ireland currently uses an external system, whereas Australia and South Africa use internal systems. Similar to risk equalization, claim equalization is payment to or from insurers, but is based on actual claims costs instead of individual risk profiles of the insured.

All three countries in this analysis seem to have needed to move toward a system of risk equalization as a result of attempting to control the costs of health insurance for all individuals after implementing community-rated premiums. Community-rating means that the cost of premiums is mandated to be the same for all individuals within that community regardless of individual health risk.

This community-rating, however, motivates insurance companies to attempt to insure lower risk, and therefore less expensive, individuals. This is termed risk

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Armstrong J, Paolucci F, McLeod H, van de Ven WP. Risk equalisation in voluntary health insurance markets: A three country comparison. Health Policy. 2010 Nov;98(1): 39-49. Epub 2010 Jul 24.

selection. Insurers often do this risk selection through selective advertising, designing benefit packages that cater to target individuals, or offering plans with high deductibles and low premiums.

Of note, this analysis also concludes that the policy makers of all three countries underwent significant lobbying efforts by insurers against the implementation of risk equalization, which must be anticipated in any country attempting to integrate such measures against risk selection by insurers. Understandably, insurers staunchly oppose risk equalization because it eliminates, or at least lessens, their ability to risk select, which is more effective at producing profit than efficiently managing health care.

Highlights

- Sections 1341-1343 of PPACA describe reinsurance programs and risk adjustment for individual and small group markets beginning 2014
- Premium variation under PPACA (section 1201) must only be by:
- individual vs. family coverage
- geographic area
- age (3:1)
- tobacco use (1.5:1)

Commentary

While this analysis looks at risk equalization in voluntary health insurance systems, it also mentions that many countries with mandatory health insurance (Belgium, Germany, Israel, the Netherlands, and Switzerland) have implemented risk equalization to control costs of health insurance and prevent competition based on risk selection. Looking ahead to the reformations to the American health system, it will be interesting to see if the range of health insurance premiums allowed – somewhat community rated but also based on health risk (age and tobacco use only) – will provide enough profit for the insurers, or if the limits placed on premiums will spur on more risk selection among them. If risk selection does enter the equation among health insurers in the near future, risk equalization strategies will be needed not only for individual and small group markets, but also for the large group marketplace.

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2010 YEAR IN REVIEW

The past year has been more monumental for health policy unlike any other time since the enactment of Medicare. Yet, the Patient Protection and Affordable Care Act, delivered by Congressional Democrats and President Obama, will be viciously challenged by Republicans in the new year.

1. Health system reforms from around the world illustrate the search for universal coverage.

While the details of such plans are as diverse as the populations they serve, healthcare reforms implemented in Spain, the Netherlands, France, Switzerland, Germany, and Japan share the drive to provide basic insurance coverage for all citizens. The common thread in the majority of these efforts is mandated insurance obligating citizens to enroll in a basic level of government defined health coverage. These basic plans are often offered on a not-for-profit basis with for-profit supplemental products offered in lieu of, or in addition to base plans. Some systems foster a market of managed competition where guaranteed issue prevents denial of coverage based on pre-existing health conditions. Each of these reforms typically has a tax based financing plan whether the government pays upfront, or provides subsidies in the form of credits, deductions, or rebates.

See International Comparisons

2. **The Patient Protection and Affordable Care Act takes its cues from foreign health reforms on the road to universal coverage but challenges remain.**

The United States has followed suit with the reforms of other countries by incorporating community rating, guaranteed issue, individual mandate, and a basic health insurance package into the federal healthcare reform law. Issues the U.S. health reform still faces involve the implementation of health IT and electronic health records to meet the

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standards of meaningful use requirements, network overlap, issues of malpractice reform, and decisions between uninsured and over-insured while increasing the number of covered individuals.

See Health Reform

3. Tort reform is a means to curb the rising costs of medical malpractice premiums.

Medical liability cost estimates break down into indemnity payments (payouts to defendants), administrative expenses (plaintiff's and defense attorney fees, the overhead costs of insurers, and of risk management programs), and defensive medicine (performing tests or therapies that provide little or no value to the patient in order to prevent threat of lawsuit.) To date, tort reform as a significant means of decreasing medical costs to Americans is based on little evidence. Published studies raise questions concerning the significance of direct (caps on damages) or indirect (liability reform and limits on plaintiff attorney contingency fees) tort reform effects on physician practices, the true costs of defensive medicine, and the estimated impact malpractice premiums have on the cost of health care. Research demonstrates that capping malpractice insurance premiums shows no downstream savings for health care consumers. Even if malpractice premiums were reduced significantly, it would only reduce total health care costs by less than 1 percent. Total medical liability costs, including estimates of defensive medicine, are estimated to account for only 2.4 percent of overall health care costs.

See Malpractice

4. Tying financial costs and benefits to providers may improve healthcare quality.

New payment models are being tested that attempt to align provider incentives with improved efficiency and quality of care. The underlying strategy of these models is to shift provider behaviors from treating acute episodes to managing patients across a continuum of care. To achieve this goal, public and private insurers intend to shift the financial risk of care delivery from payer to provider. Implementation of these methods may manifest as reserving a portion of reimbursement for activities known to improve quality as in pay-for-performance (P4P), or by making providers responsible for the costs surrounding hospital stays (Post Acute Management), hospital based procedures (Acute Care Model), and care coordination (Chronic Care Model or Community Wide Cost Management).

See P4P, Payment Systems

5. The U.S prepares for the era of electronic health records (EHRs)

Between 2008-2009 research shows an increase in the use of basic EHRs in the United States from 7.2 percent to 9.2 percent of providers. By 2010, 11.9 percent of hospitals surveyed had some form of EHR. Smaller and medium size hospitals and critical care facilities were significantly less likely to have EHRs. The same study speculated that very low numbers of those facilities, who already have EHRs, will meet meaningful use criteria. Meaningful use requires EHRs to meet 15 core objectives, and to select 5 additional criteria from a list of optional choices. The American Recovery and Reinvestment Act currently offers financial incentives for ERH implementation, but in 2015, those incentives will turn to penalties.

See Health IT

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6. Evidence Based Health Policy: The role of evidence in developing health policy.

Evidence-based health policy seeks to inform policy makers by demonstrating a burden exists, clearly showing a benefit or harm, prioritizing one issue over another, explaining relevance to local populations, and outlining costs. Quality of evidence must be considered before policy makers decide to act. The United States Preventive Service Task Force grades its recommendations based on the quality of the evidence. Strong policy is transparent, and the underlying evidence is easy for stakeholders to understand. Finally, once a policy is implemented, it is critical to monitor and evaluate it's outcomes for intended and unintended effects.

See Our Mission

7. The United States Preventive Service Task Force must avoid the politics of policy.

The USPSTF is a sixteen member panel of independent medical experts charged with making recommendations concerning clinical preventive screening, medication, and counseling based on scientific evidence. The panel's recommendations are give specific grades based on strength of evidence. The Patient Protection and Affordable Care Act requires health insurers to cover preventive services with a grade "A" or "B" rating. The task force has come under fire recently with its recommendation against routine screening mammography for women under age 50 and again for postponing a vote on the prostate cancer screening. These decisions, along with their new found influence under federal health care reform, will undoubtedly bring about intense scrutiny of future recommendations.

See Advocacy

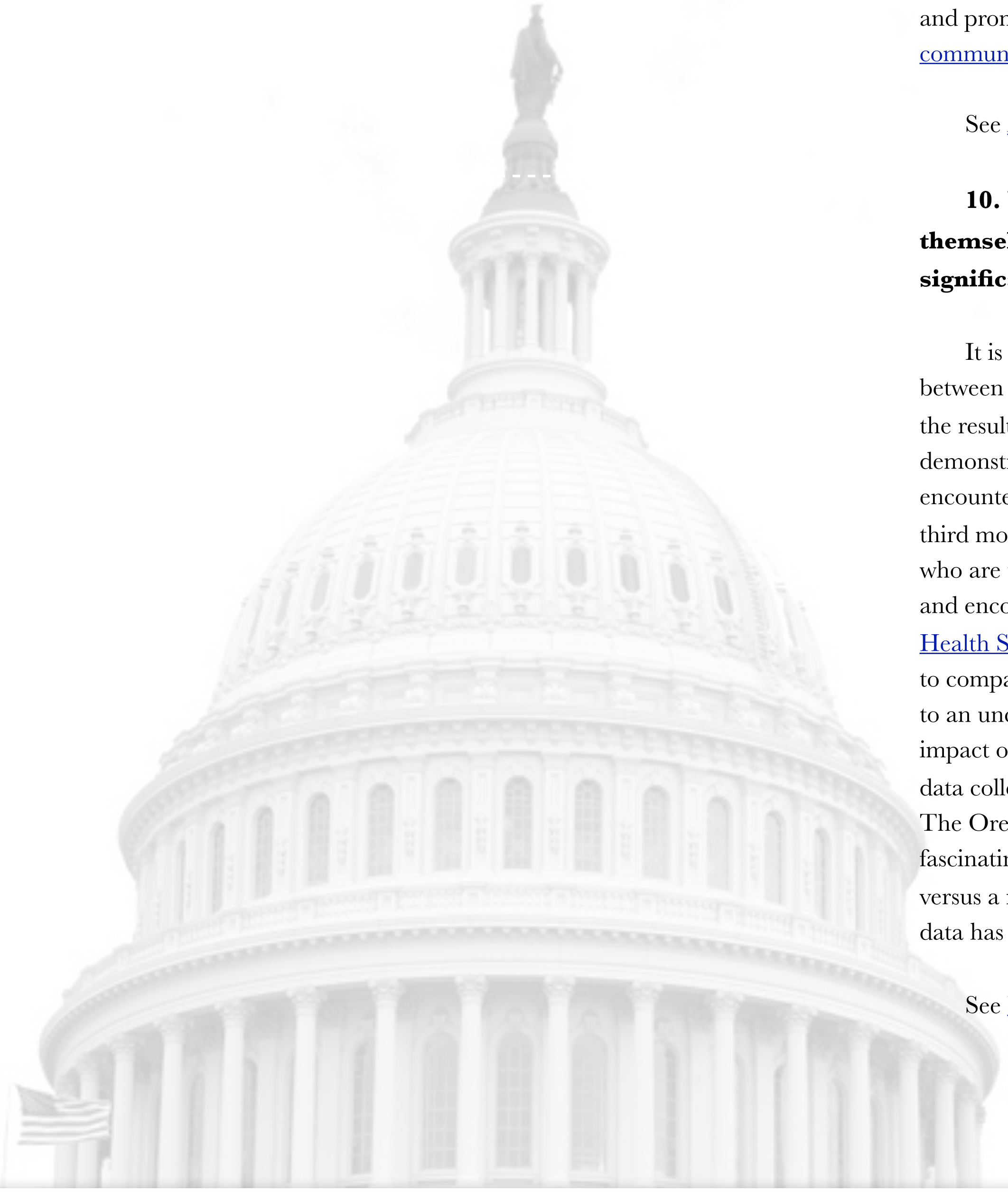
8. Delivering healthcare quality requires a multifaceted approach.

Healthcare quality improvement requires changes at every level of the healthcare system. Health IT, payments system reforms, and improved access to care are all key elements of delivering improved care. Health IT and electronic health records seek to improve patient care coordination, reduce mistakes, and track patient outcomes. New payment systems that align financial incentives with measures of quality and care coordination including Pay for Performance, Post Acute Management, Acute Episode Bundling, Chronic Care Models, and Community Wide Cost Management seek to decrease unnecessary and repetitive treatment by shifting financial responsibility for these procedures to the providers. Finally, alternative approaches to improving access to care including School Based Health Centers and Community Health Centers demonstrate improved outcomes in the populations they serve.

See Access to Care, Quality, Payment Systems

9. Access to care means moving beyond private physician offices and Emergency Rooms to retail clinics and classrooms.

Emergency Departments (EDs) continue to be ready source of care for millions of Americans due to their 24/7/365 accessibility, the requirement that they treat all patients regardless of insurance type, and the ability to provide treatment for conditions urgent care centers and retail clinics are ill equipped to handle. However it is estimated that 13.4 and 13.7 percent of ED visits could safely, and more cost effectively, be diverted to retail clinics and urgent care centers, respectively. Instead of looking to retail clinics and urgent care centers as a cheaper mode of acute care, policy makers must look at how to best expand their capacity



and promote the continuity of care with community physicians.

See Access to Care, Workforce

10. Uninsured individuals put themselves at higher risk for significant loss of assets.

It is estimated that anywhere from between 50-62 percent of bankruptcies are the result of medical illness. Research demonstrates uninsured individuals who encounter new illness lose one quarter to one third more assets when compared to those who are uninsured and healthy or insured and encounter new illness. The Oregon Health Study provides a unique opportunity to compare 30,000 new Medicaid enrollees to an uncovered population to examine the impact of having no health insurance. The data collection concludes at the end of 2010. The Oregon Health Study promises a fascinating comparison of an uninsured versus a newly insured population once its data has been analyzed and published.

See Uninsured, Medicare & Medicaid

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