

CRB

Healthcare Reform: Selected Topic Seminars

By Michael Dimmitt, Ph.D.



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Introduction

The California Research Bureau (CRB) sponsored this seminar series with financial support from the California HealthCare Foundation. The purpose of the grant was to inform a broad group of legislators, and legislative and administrative staff about policy aspects of achieving universal healthcare coverage in California. The overarching goal of the seminars was to highlight the importance of, and necessity for, cost containment to achieve and maintain a near-universal healthcare coverage program. The grant provided funding for three seminars on topics related to achieving universal healthcare coverage in California.

At the outset of the project, a group of advisers was assembled to provide input to the project team on the selection of the topics and speakers. The issues selected by the advisory group and project team were: Health Information Technology-Electronic Health Records (HIT-EHR); Health Technology Assessment (HTA) and Individual Mandate (IM). The seminars were to be conducted on a policy-neutral and nonpartisan basis.

The seminars were unique because of the scope of the materials produced for them. The materials from the seminars are available on the California Research Bureau website, www.library.ca.gov/CRB, (see the Appendix I for the seminar background reports, PowerPoint presentations of the speakers, transcripts of the seminars, and CalChannel programming). Additionally, a DVD of each seminar was produced and is available on request from the CRB.

This summary report is a synthesis of the materials from the seminars and current updates on the seminar issues. Its core is based on the report for each seminar prepared by the project consultant, Lucien Wulsin, and intern Adam Daugherty, from the Insure the Uninsured Project, as well as the PowerPoint presentations made by the seminar speakers.

The seminars were convened over several months. The backdrop for them was healthcare cost containment. In the absence of an effective cost-containment program, any program to achieve the expanded healthcare coverage is bound to be compromised. The initial seminar was to address what many scholars and professionals regard as a key ingredient of cost control, Health Information Technology-Electronic Medical Record. Some scholars have estimated that a broad-based focus of HIT-EMR could produce substantial cost savings. Others believe the savings from the widespread adoption of Health Information Technology would be nominal so the adoption of HIT-EMR should be directed to the significant quality deficit in the health system. Both paths have significant consequences as they relate to the goals of universal healthcare coverage.

Technology plays a leading role in the increase of healthcare costs. The second seminar focused on the assessment of technology: clinically; comparatively; and in terms of cost-effectiveness. There generally is little evidence in favor of the efficaciousness of new medical technologies. Instead, payment systems seem to encourage providers to acquire the latest technology. Also, providers and patients prefer to have the latest technology for the diagnosis and treatment of disease.

There are a number of efforts to examine the effectiveness of various medical technologies,

nationally and internationally. Efforts to assess technology are viewed with some skepticism. Senator Max Baucus (D-MT), Chairman of the U.S. Senate Finance Committee, went so far as to state that comparative effectiveness research would be patient-centered and not used for rationing care. He further stated “I think we’ll be able to get this included in health care reform, as long as we make it clear that there’s no cost-benefit analysis.”¹

The final seminar, Individual Mandate, centered on the containment of costs. A key feature of such a mandate is the provision of health insurance subsidies for those with low and moderate incomes. Without cost containment, the cost of the subsidies will put at risk the overall financing for any expanded coverage program. A wide range of cost containment tools are available to achieve a successful mandate and program.

The balance of this report is organized as follows. First, we provide a brief background on the current debate over healthcare reform. Second, we discuss in more detail each of the three seminars. The final section summarizes the key findings of our project.

Healthcare Coverage Background

The number of the uninsured continues to grow. According to the Congressional Budget Office, there are more than 46 million Americans currently without healthcare coverage.² In 2007 there were an estimated 6.4 million Californians under 65 who were without health insurance for all or some of the year.³ The rate of growth of healthcare costs has consistently exceeded the growth rate of personal income. Escalating costs cause insurance to be less affordable, thereby increasing the number of the uninsured. An additional factor in the increase in the number of the uninsured is that the country is mired in the worst recession since the Great Depression of the 1930s. Many are losing healthcare coverage because of lost jobs and renegotiated labor contracts.

There have been both voluntary and mandatory cost containment programs in the United States. Voluntary programs have not succeeded and any expectation they might be is ill-founded.⁴ There has been some success with mandatory programs such as the All-Payer rate system in Maryland, price controls under President Nixon, and Medicare's prospective Diagnostic Related Grouping (DRGs) hospital reimbursement.

President Obama made healthcare expansion a key feature of his domestic policy agenda. Congress considered five proposals that were generally consistent with the President's principles for achieving expanded health care coverage. In unprecedented actions, the House and Senate each have adopted a bill and are negotiating a compromise to be submitted to both of the houses for a vote. The President had hoped the bill would be passed by Congress and he would sign it in 2009. However, it cannot be done until 2010.

Achieving healthcare coverage reform has been problematical. National healthcare expansion efforts trace back to the decade of 1910 to 1920.⁷ President Theodore Roosevelt promised national health insurance while campaigning on the Progressive Party ticket for the presidency in 1912. In 1915, the American Association for Labor Legislation proposed creating a national health insurance system.⁸ Later, President Franklin Roosevelt's Committee on Economic Security produced a 1935 report titled, *Report on Health Insurance and Disability*,⁹ which was submitted to Congress but contained no specific policy recommendations. President Roosevelt, in his *State of the Union* addresses in 1943, 1944, and 1945, referenced healthcare but never made a specific proposal.¹⁰ Other presidents, such as Richard Nixon and Bill Clinton, also submitted healthcare coverage proposals to Congress. Perhaps, the closest the country has come to national healthcare coverage program was in a deal between Senator Ted Kennedy and then-President Richard Nixon in the early 1970s.¹¹

California also has not been successful in adopting and implementing a statewide healthcare coverage program. California efforts to achieve expanded healthcare coverage began with the Senate Constitutional Amendment (SCA) 26 authored by Senator William Kehoe from Eureka in 1917. The SCA was approved in the Assembly by a vote of 55-11. The Senate, upon reconsideration, adopted the measure 30-6. Governor Hiram Johnson signed the amendment but it was defeated in the general election of 1918.

In the late 1940s, Governor Earl Warren made the most concerted effort to establish healthcare coverage in California.¹² At least four proposals were introduced in the California

Legislature between 1945 and 1950 but none were adopted. In 2003, Senator John Burton's SB 2 was adopted and signed by Governor Davis. However, the bill was opposed by business interest groups and was repealed by a voter referendum the following year. In 2008, ABX1 1 by Speaker Fabian Nunez, supported by Governor Arnold Schwarzenegger, passed the Assembly but was defeated in the Senate Health Committee. The state's ongoing budget deficit has caused a shift in focus from establishing universal healthcare coverage to preserving the state's programs for the low income and disadvantaged.

Health Information Technology- Electronic Health Record

Health Information Technology-Electronic Medical Records (HIT-EMR) are viewed by many as an important necessity in transforming healthcare.¹³ The United States healthcare system operates primarily with paper record-keeping and, as a result is very inefficient.

The Centers for Medicare and Medicaid Services estimates national health expenditures will total \$2.6 trillion in 2009 and will grow to \$4.3 trillion by 2017.¹⁴ It has been estimated significant savings would accrue as a result of the implementation of HIT-EMR. The methodology and estimate of the savings have been challenged. Others conclude the savings from implementing HIT-EMR would be relatively small when compared to the overall healthcare system expenditures and adoption of HIT-EMR should be to improve the quality of the healthcare delivered in the United States.

The EMR is the electronic version of the patient medical record. In principle, EMRs promise to simplify and unify management of patient records, improving caregivers ability to understand and act upon a patient's history. They are controlled and intended for use by healthcare providers.

Two related concepts are the Personal Health Record (PHR) and the Electronic Health Record (EHR). The PHR would allow individuals to track and manage their healthcare: medications, allergies, immunizations, and lab-test results. An EHR is a record of a patient's healthcare information over time. It is inclusive of an EMR but it contains additional information such as primary care, specialty care, ancillary care, and inpatient care. Because of the integration, EHRs can provide comprehensive records, which will be important for improving quality and patient safety.

Most physicians and hospitals in the United States do not have EMRs or EHRs.¹⁵ There are significant barriers and disincentives standing in the way of a widespread EMR/EHR implementation. The biggest barrier is reimbursement: physicians and hospitals pay for the systems but many of the benefits accrue to the payers and purchasers. Another significant barrier is the diversity of hardware and software systems and their inability to electronically exchange data.

RAND researchers posed a question of what would be the effect on healthcare costs if a system of Health Information Technology-Electronic Medical Record were to be implemented nationally. RAND's research findings include: efficiency savings could reach \$80 billion per year if 90 percent of providers were to adopt the systems. The cost to achieve that in 15 years averages \$8 billion per year. If the 90 percent implementation standard could be achieved, RAND estimates the benefits would include approximately 2.2 million adverse drug events avoided; 20 million fewer hospital days; five million fewer emergency department visits; nine million fewer physician office visits; and 20 million added workdays per year.

The savings projected by RAND have been questioned. The Congressional Budget Office has challenged the methodology and conclusions of the RAND study.¹⁶ If the savings projection of the RAND analysis were to be achieved it would equate to approximately one percent of the National Health Expenditure estimate in 2019. Others, however, have concluded that it is unrealistic to expect widespread adoption of health information technology to yield net

cost savings.¹⁷ In this view, the implementation of the HIT-EMR should be done to address the considerable quality deficit of the United States health care system.

EMR/EHRs cover less than half of Californians. Kaiser Permanente, an integrated healthcare system with over eight million members, has implemented an electronic health records system. Over six million of the members are in California. There are more than two million active users and more than 80,000 are enrolling each month. It is the largest private-sector implementation of EMRs.

THE ROLE OF GOVERNMENT IN HEALTH INFORMATION TECHNOLOGY

A strong role for government, particularly the federal government, is thought to be necessary for the adoption and diffusion of Health Information Technology in the United States. Potential adopters are faced with a plethora of vendors for the hardware and software, whose systems have very little capability for communications between them. The financial incentives are not geared to the providers; they benefit the payers and carriers. The federal government has taken an active role in the development and dispersion of HIT-EMR. (See Appendix II for a detailed listing of the Federal Government's IT Programs.)

The American Recovery and Reinvestment Act of 2009 (ARRA)¹⁸ includes The Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act), which authorizes roughly \$36 billion over six years for Health Information Technology. This is an unprecedented investment in the nation's health information infrastructure. The most significant funding opportunity for health information technology is \$17.2 billion in federal incentive payments to induce providers – hospitals, clinics, physicians, dentists, nurse practitioners, nurse midwives, and physician assistants who receive payments from Medicare and Medicaid to adopt and make meaningful use of electronic health records. The proposed regulation on meaningful use is expected to be released in late 2009, adopted in 2010 and implemented in 2011.¹⁹

States have initiated efforts to expand the use of Health Information Technology-Electronic Health Record. Indiana, Louisiana, Texas, Mississippi, Alabama and California have HIT-EMR initiatives. California Governor Schwarzenegger issued Executive Order, S-06-07 on March 14, 2007. The order established a goal of having a full information exchange in the state in ten years. The funding for the program is derived from the merger of PacifiCare Health Systems in 2005. The ostensive program goals are to improve the HIT-EMR capabilities of safety-net providers and underserved areas. Several local health organizations are establishing Health Information Exchanges for their providers.

In addition, a few small countries with homogeneous populations such as: Great Britain, New Zealand, Sweden, Netherlands, and Denmark each have broad-based HIT-EMR systems, with nearly 100 percent coverage. The distinguishing characteristic of these countries is they have universal healthcare coverage with a strong governmental presence, which provides the framework to achieve the penetration rate of HIT.

Health Technology Assessment

An estimated 46 million Americans lack health insurance.²⁰ Collectively, we spend nearly \$2.6 trillion yearly on healthcare. Those expenditures are projected to increase to nearly \$4.3 trillion per year by 2017, exceeding 20 percent of Gross Domestic Product.²¹ Nearly half of this projected increase in costs will be the result of the introduction and diffusion of new technologies and the further application of existing technologies to other conditions. In many cases, the effectiveness, whether comparative, cost or clinical, of the new technology has not been established. There are significant national, international and private sector efforts underway to assess the effectiveness of technology.

Technology has been described according to its characteristics: physical nature, clinical purpose, and the stage of diffusion. The physical characteristics include: drugs; biologics; devices and equipment; medical and surgical procedures; and organizational, delivery and managerial systems. The clinical purpose includes: prevention, screening, diagnosis, treatment and rehabilitation. The progressively broader stages of diffusion are described as experimental, investigational, and established.

Technology assessment is the evaluation of the effects of healthcare technology. The ostensive purpose of technology assessment is to inform the public policy process for healthcare technology decision making. The assessments address the intended and unintended consequences of the technologies: technical properties; safety; efficacy and effectiveness; costs; and social, legal, ethical and political effects. There are several related concepts: outcomes research, effectiveness research, evidence based medicine, and comparative and cost effectiveness research.²²

Reasons often cited to explain why the use of new technology spreads without evidence of effectiveness and why costs increase as a result include: fee-for-service payment of physicians, which creates an incentive to provide more expensive care, and the enthusiasm for the newest technology by both doctors and patients.²³

Comparative effectiveness research compares the results of different ways of treating diseases. “Without hard evidence, ... decisions about what treatment to recommend depend on the individual experience and judgment of physicians.”²⁴ Several potential benefits of comparative effectiveness research have been identified and include optimization of health outcomes, improvements in the quality of care, reduction in adverse reactions, limitations on outdated procedures, and reduction in healthcare spending. There are several overriding questions on the conduct of comparative effectiveness research: would it be a governmental or private agency that would be responsible for the research; private or public sources of funding; which questions would be asked first; data utilized (primary or secondary) and research methodology (experiments or secondary, integrative); implementation; and role of costs in decision making.

Cost effectiveness analysis is a complementary tool in technology assessment. It compares the incremental outcomes of using a treatment modality with the incremental costs of that treatment. It is expressed most commonly in quality-adjusted life years, the number of years of life that would be added by a medical intervention. There are objections to considering cost effectiveness as it could stigmatize the analysis of comparative effectiveness research

and might, ultimately, be used to restrict access to treatments. However, research that included an analysis of cost effectiveness could probably have more of an effect on medical practice than research that analyzed only the comparable clinical effectiveness of different treatments, primarily because the results would sometimes highlight that benefits were small relative to the incremental costs.²⁵ It has been estimated that healthcare costs could be reduced by \$368 billion over 10 years through the establishment of a “Center for Medical Effectiveness”.²⁶

THE ROLE OF GOVERNMENT IN HEALTH TECHNOLOGY ASSESSMENT

The American Recovery and Reinvestment Act of 2009 (ARRA), which includes the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act), appropriates \$1.1 billion for comparative effectiveness research.²⁷ It is recognized that it could take several years to get to the point where additional research on comparative effectiveness could have a noticeable effect on healthcare spending.²⁸

Federal comparative effectiveness research initiatives past and present, include: the National Center for Health Care Technology, established in 1978 under the Department of Health and Human Services and ended in 1981; the Office of Technology Assessment, an adviser to Congress was established in the same period and stopped operations in 1995; the Agency for Health Care Research and Quality, established in 1981 as part of the Department of Health and Human Services, is the most prominent federal agency supporting such research; the Department of Veterans Affairs has a substantial research program; the National Institute of Health, part of the Health and Human Services, funds primarily clinical trials; the Centers for Medicare and Medicaid Services has sponsored limited amounts of research. A limited amount of research has been conducted on the state level, including the states of Minnesota, Oregon and Washington. The amount that is spent on comparative effectiveness research at the federal level is difficult to estimate because many types of studies are part of the various research programs.

Internationally, comparative effectiveness research is conducted in the United Kingdom; Germany; France and Australia.²⁹ There are a number of initiatives in the private sector and they include: Kaiser Permanente; the Center for Medical Center Technology Policy, funded by California HealthCare Foundation and the Blue Shield of California Foundation and others;³⁰ Monash University of Australia;³¹ Cincinnati’s Children’s Hospital;³² and the Institute of Medicine’s 2009 Comparative Effectiveness Research Priorities funded by HITECH (See the figure next page).³³

The Individual Mandate

The Individual Mandate³⁴ is a requirement that all permanent residents obtain health insurance coverage. It, or an employer mandate, is considered to be a key element in achieving universal health care. The healthcare coverage would be required to meet a minimum standard of benefits, deductibles, and co-payments. It is believed by many that universal healthcare coverage cannot be achieved unless a mandate is included in the plan because many, such as young adults and the healthy, would seek healthcare coverage only when it was needed. Some observers believe that an individual mandate would not achieve the expected goals and, therefore, would lead to an increased role of government in the health care system.

An individual mandate is a key feature of the healthcare coverage proposals being considered in Congress. It was a pivotal component of the universal healthcare coverage legislation that was nearly adopted in California in 2008.³⁵ An individual mandate has been implemented in the Massachusetts, Switzerland, and The Netherlands.

As healthcare coverage is too expensive for many, some form and level of subsidization will be required to achieve universal healthcare coverage. The level would need to be related to income, the minimum level of coverage, and account for premiums and out-of-pocket costs. Absent the necessary levels of subsidies, exemptions from the mandate would be required (as in Massachusetts). The proposals in Congress would provide a level of subsidies for low-income people but some may be exempt because of an inadequacy of the subsidies.

Universal healthcare coverage cannot be achieved through a voluntary system. It has been estimated that in a system of subsidies and market reforms only 30 to 50 percent of the uninsured would have healthcare coverage. The figure is projected to decline as healthcare costs continue to escalate and coverage costs exceed individuals' ability to pay.

A consequence of a voluntary system is adverse selection; those who would seek the coverage would be older and sicker than the population as a whole, whereas younger healthier individuals would avoid paying for coverage they expect not to need. That would cause the average costs of the new plan to increase and premiums for the enrollees to rise higher. To mitigate the higher premiums, the government would need to absorb part of the risk or reallocate the costs. This adverse risk would discourage the healthy from participating in the program and dissuade carriers from participating in the market. A mandate spreads the risk and does not pose a barrier to the healthy.

Establishment of an individual mandate would require insurance market reforms to be effective. Such reforms would include guaranteed issue and guaranteed renewal. No-risk selection would mean there would be no need for coverage denials or for medical underwriting. Purchasing pools could play an important role in risk-spreading cost containment, and promoting health insurance accountability. The goal also could be achieved by the creation of purchasing options or entities such as the public plan, which is a much discussed component of the national healthcare reform proposals in Congress. California has enacted many of these provisions in prior, unrelated legislation.

Enforcement of a mandate would be necessary and would require several tools. These would

include such things as: easy enrollment, outreach and education, penalties to collect unpaid premiums, and penalties assessed through the tax system. Absent penalties, many of the young and healthy would not enroll in the plan, as they would not perceive the program was for them.

An important issue in establishing a mandate is the financing of the program. A key aspect of the program financing is the control of costs. Healthcare cost increases continue to outpace the rate of growth of income and general consumer prices. Healthcare costs increase in a large measure because of the application of new health technologies. Without control of healthcare costs, subsidies would need to increase to make the program affordable to those with lower incomes. If the costs continue to increase and the subsidies don't increase, the insurance could become unaffordable to many. One of the more effective tools in controlling costs could be the imposition of an all-payers rate system, similar to what is in place in Maryland and was in New York, Massachusetts, and Pennsylvania.

Many see national healthcare reform as problematic because many issues seem to be intractable. Chief among them is the seemingly unmanageable control of healthcare costs. Several observers conjecture that in the absence of significant efforts to control costs widespread healthcare coverage expansion may not be achievable. Notwithstanding the issue of cost containment, the role of the Individual Mandate is viewed as being essential in achieving universal healthcare coverage.

The Individual Mandate: Summary

NATIONAL HEALTH CARE REFORM: INDIVIDUAL MANDATE

The President and Congress are trying to develop a universal healthcare coverage program. An individual mandate is a component of President Obama's proposal and the five Congressional proposals under active consideration in Congress: Senate Finance Committee, Senate Committee on Health, Education, Labor and Pensions; House Tri Committees (House Ways and Means, Energy and Commerce, House Education Committee and House Labor Committee).³⁶ Negotiations on a universal health reform bill continue. Key features of the proposals are summarized below.

[Senate Bill]

Require U.S. citizens and legal residents to have qualifying health coverage. Those without coverage pay a tax penalty of the greater of \$750 per year up to a maximum of three times that amount (\$2,250) per family or 2% of household income. The penalty will be phased-in according to the following schedule: \$95 in 2014, \$495 in 2015, and \$750 in 2016 for the flat fee or 0.5% of taxable income in 2014, 1% of taxable income in 2015, and 2% of taxable income in 2016. Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, if the lowest cost plan option exceeds 8% of an individual's income, and if the individual has income below 100% of the poverty level. ...

[House Bill]

Require individuals to have "acceptable health coverage". Those without coverage pay a penalty of 2.5% of their adjusted income above the filing threshold up to the cost of the average national premium for self-only or family coverage under a basic plan in the Health Insurance Exchange. Exceptions granted for those with incomes below the filing threshold (in 2009 the threshold for taxpayers under age 65 is \$9,350 for singles and \$18,700 for couples), religious objections and financial hardship. (Effective January 1, 2013)³⁷

Seminar Series Conclusions

Achieving universal healthcare coverage faces a series of conundrums that has troubled both the nation and the state for nearly one hundred years. National efforts date back to 1912 when President Theodore Roosevelt campaigned on a ticket to establish a universal healthcare program. California's efforts began with Senator Kehoe's Senate Constitutional Amendment 26 in 1917. In 2003, Governor Gray Davis signed SB 2 (Chapter 673, Statutes of 2003), a universal healthcare coverage bill by Senator John Burton. In 2004, a ballot measure was placed on the ballot to repeal SB 2. It was successful and the program was repealed. In 2008, the Speaker of the Assembly, Fabian Nunez, with support of Governor Arnold Schwarzenegger had a bill passed out of the Assembly that died in the Senate Health Committee.

In the 2008 presidential campaign, there were 16 universal healthcare coverage proposals. After being elected, President Obama made achieving universal healthcare coverage his top domestic priority. Five bills are being considered in Congress. The House Energy and Commerce Committee was the third committee of the House to send a bill to the full House. The Senate Health, Education, Labor and Pensions Committee has sent a bill to the full Senate, neither of which are bi-partisan bills. The Senate Finance Committee is continuing its efforts to pass a bi-partisan measure out of the Committee.

Congress recognized the role that Health Information Technology-Electronic Medical Records and Technology Assessment could play in achieving healthcare cost containment. The House and Senate proposals recognize that achieving a measure of cost containment from these measures would take years to achieve. There are some who believe any cost containment dividend from HIT-EMR and Technology Assessment should be invested in improving the quality of healthcare. The Congressional Budget Office declared that there could be a role for developing several competing sources of information on Health Information Technology.³⁸

Some commentators see the 2008 California legislation for universal healthcare coverage as a model for the nation.³⁹ The bill contained insurance reforms that built on reforms previously adopted. It contained an individual mandate and provided subsidies for all residents of the state who could not afford to purchase healthcare coverage without some assistance. The Individual Mandate in the California bill was different from the one in the Massachusetts program. There is not adequate funding of the Massachusetts program and many low-income families are exempt from the mandate. Each of the bills under consideration in Congress rely on an individual mandate. The common consensus is a mandate is necessary to achieve universal healthcare coverage, but cost containment is necessary for achieving and maintaining a universal healthcare coverage program.

Appendix I

Listed below are the materials available on the California Research Bureau link on the California State Library's web site (www.library.ca.gov/crb/CRBSearch.aspx). That which is available are the: background report for each seminar; PowerPoint presentations of the speakers; and transcription of each seminar. Each of the seminars is available for viewing on the California Channel. They are accessible by searching California Research Bureau on CalChannel Video On Demand. The DVDs, bibliographies, and peer-reviewed articles are available on request from the California Research Bureau.

I. HEALTH INFORMATION-ELECTRONIC MEDICAL RECORDS

- ✓ Health Information Technology Electronic Medical Records: A Primer
Lucien Wulsin and Adam Daugherty
 - www.library.ca.gov/crb/08/08-013.pdf
- ✓ PowerPoint Presentations
 - Clifford Goodman, Ph.D. – Savings in Electronic Medical Record Systems? Do It For the Quality
 - www.library.ca.gov/crb/08/Goodman0808.pdf
 - Richard Hillestad, Ph.D. – Can Information Technology Transform Healthcare
 - www.library.ca.gov/crb/08/Hillestad0808.pdf
 - Andy Wiesenthal, M.D., SM – Health Information Technology 101: The Basics of Health and Why it Matters
 - www.library.ca.gov/crb/08/Wiesenthal0808.pdf
- ✓ California Channel Programming
 - www.calchannel.com/channel/sr1/bureau
- ✓ Transcript
 - www.library.ca.gov/crb/08/Transcript0808.pdf

II. HEALTH TECHNOLOGY ASSESSMENT

- ✓ A Briefing on Health Technology Assessment
Lucien Wulsin and Adam Daugherty
 - www.library.ca.gov/crb/08/08-019.pdf
- ✓ PowerPoint Presentations

- Clifford Goodman, Ph.D., – Health Technology Assessment: A Policy-Maker Starter Kit
 - www.library.ca.gov/crb/08/Goodman1208.pdf
- Alan Garber, M.D., Ph.D., – Comparative Effectiveness and the Limits of Evidence
 - www.library.ca.gov/crb/08/Garber1208.pdf
- Jed Weissberg, M.D., Technology Assessment at Kaiser Permanente
 - www.library.ca.gov/crb/08/Weissberg1208.pdf
- ✓ California Channel Programming
 - <http://www.calchannel.com/channel/sr1/bureau>
- ✓ Transcript
 - <http://www.library.ca.gov/crb/08/Transcript1208.pdf>

III. INDIVIDUAL MANDATE

- ✓ Individual Mandate: A Background Report
 - Lucien Wulsin and Adam Daugherty
 - www.library.ca.gov/crb/CRBSearch.aspx
- ✓ PowerPoint presentations
 - Linda Bloomberg, Ph.D., – Individual Mandates: What Are They, Do They Matter, and How Do We Make Them Work?
 - www.library.ca.gov/crb/09/Blumberg0409.pdf
 - Michael Cannon, – Individual & Employer Mandates: Government Run HealthCare in “Private” Clothing
 - www.library.ca.gov/crb/09/Cannon0409.pdf
 - Richard Curtis
 - Did not make a PowerPoint Presentation
- ✓ California Channel (CalChannel) Programming
 - www.calchannel.com/channel/sr1/bureau
- ✓ Transcript
 - www.library.ca.gov/crb/09/Transcript0409.pdf

Appendix II

Federal Health IT Strategic Plan⁴⁰

Goal 1 Patient-Focused Healthcare: Enable the transformation to higher quality, more cost-efficient, patient-focused health care through electronic health information access and use by care providers, and by patients and their designees.

- Objective 1.1 – Privacy and Security: Facilitate electronic exchange, access, and use of electronic health information while protecting the privacy and security of patients' health information.
- Objective 1.2 – Interoperability: Enable the movement of electronic health information to where and when it is needed to support individual health and care needs.
- Objective 1.3 – Adoption: Promote nationwide deployment of electronic health records and personal health records that put information to use in support of health and care.
- Objective 1.4 – Collaborative Governance: Establish mechanisms for multi-stakeholder priority setting and decision making to guide development of the nation's health IT infrastructure.

Goal 2 Population Health: Enable the appropriate, authorized, and timely access and use of electronic health information to benefit public health, biomedical research, quality improvement, and emergency preparedness.

- Objective 2.1 – Privacy and Security: Advance privacy and security policies, principles, procedures, and protections for information access and use in population health.
- Objective 2.2 – Interoperability: Enable the mobility of health information to support population-oriented uses.
- Objective 2.3 – Adoption: Promote nationwide adoption of technologies and technical functions that will improve population and individual health.
- Objective 2.4 – Collaborative Governance: Establish coordinated organizational processes supporting information use for population health.

Objective 1 - Privacy and Security

Agency	Programs
AHRO (Agency for Healthcare Research and Quality)	Health IT Portfolio - Goal 1 and 2
CMS (Centers for Medicare & Medicaid Services)	HIPAA Security Rule - Goal 1 and 2
NIST (National Institute of Standards and Technology)	Security Technology - Goal 1 and 2
ONC (Office of the National Coordinator for Health Information Technology)	Anti-fraud Activities - Goal 1 CCHIT - Goal 1 Health Information Security and Privacy Collaborative (HISPC) - Goal 1 and 2 Health IT Standards Panel (HITSP) - Goal 1 and 2 Nationwide Health Information Network (NHIN) - Goal 1 and 2 State Alliance for e-Health - Goal 1 and 2
SAMHSA (Substance Abuse and Mental Health Services Administration)	Health IT Initiatives - Goal 1 and 2
Federal Advisory Committee	Programs
NCVHS (National Committee on Vital and Health Statistics)	Subcommittee on Privacy and Confidentiality - Goal 1 and 2
AHIC (American Health Information Community)	Confidentiality, Privacy, and Security Workgroup - Goal 1 and 2
OCR (Office for Civil Rights)	HIPAA Privacy Rule and Health IT - Goal 1 and 2

*Federal Health IT Programs**

Objective 1 - Privacy and Security

Agency	Programs
AHRQ (Agency for Healthcare Research and Quality)	Health IT Portfolio – Goals 1 and 2
CMS (Centers for Medicare & Medicaid Services)	HIPAA Security Rule - Goals 1 and 2
NIST (National Institute of Standards and Technology)	Security Technology – Goals 1 and 2
ONC (Office of the National Coordinator for Health Information Technology)	Anti-fraud Activities – Goal 1 CCHIT – Goal 1 Health Information Security and Privacy Collaborative (HISPC) – Goals 1 and 2 Health IT Standards Panel (HITSP) – Goals 1 and 2 Nationwide Health Information Network (NHIN) – Goals 1 and 2 State Alliance for e-Health – Goals 1 and 2
SAMHSA (Substance Abuse and Mental Health Services Administration)	Health IT Initiatives – Goals 1 and 2

Federal Advisory Committee	Programs
NCVHS (National Committee on Vital and Health Statistics)	Subcommittee on Privacy and Confidentiality – Goals 1 and 2
AHIC (American Health Information Community)	Confidentiality, Privacy, and Security Workgroup – Goals 1 and 2
OCR (Office for Civil Rights)	HIPAA Privacy Rule and Health IT – Goals 1 and 2

* Federal Health IT Programs, Office of the National Coordinator for Health Information Technology (ONC).
http://healthit.hhs.gov/portal/server.pt?open=512&objID=1141&parentname=CommunityPage&parentid=7&mode=2&in_hi_userid=10741&cached=true

Objective 2 – Interoperability

Agency	Programs
AHRQ (Agency for Healthcare Research and Quality)	Health IT Portfolio – Goals 1 and 2 U.S. Health Information Knowledgebase – Goals 1 and 2
ASPR (Assistant Secretary for Preparedness and Response)	Homeland Security Presidential Directive 21 – Goal 2 Pandemic All-Hazards Preparedness Act – Goal 2
CDC (Center for Disease Control and Prevention)	BioSense – Goal 2 EPI-X – Goal 2 National Healthcare Safety Network – Goal 2 Public Health Information Network – Goal 2 Public Health Preparedness Systems – Goal 2
CMS (Centers for Medicare & Medicaid Services)	ICD-10 – Goal 1 Medicaid Information Technology Architecture – Goals 1 and 2 Medicaid Transformation Grants – Goals 1 and 2 Beneficiary Information Services – Goal 1
FDA (Food and Drug Administration)	Structured Product Labeling – Goal 1 Sentinel Network – Goal 2
HRSA (Health Resources and Services Administration)	Health IT Electronic Health Record and Innovations Grants – Goal 1 Telehealth Grants – Goal 1 Regional Genetic and Newborn Screening Service Collaboratives – Goal 1 Connections Project – Goal 2
IHS (Indian Health Service)	Resource and Patient Management System – Goals 1 and 2 National Data Repository – Goal 2
NIH (National Institutes of Health)	Cancer Biomedical Informatics Grid – Goal 1 Support, Maintenance, & Dissemination of Standard Clinical Vocabularies – Goals 1 and 2 Health Informatics R&D – Goal 2 National Network of Libraries of Medicine – Goal 2

Objective 2 – Interoperability (continued)

Inter-Departmental and Inter-Agency	Programs
AHRQ , FDA , NLM (National Library of Medicine), NCI (National Cancer Institute), and VA	Data Standards Program – Goals 1 and 2
DoD and VA	Exchange of Information – Goals 1 and 2 Joint EHR – Goals 1 and 2

Federal Advisory Committee	Programs
NCVHS (National Committee on Vital and Health Statistics)	Subcommittee on Privacy and Confidentiality – Goals 1 and 2
AHIC (American Health Information Community)	Consumer Empowerment Workgroup – Goals 1 and 2 Electronic Health Records Workgroup – Goals 1 and 2 Personalized Health Care Workgroup – Goals 1 and 2 Population Health and Clinical Care Connections – Goal 2

Objective 3 – Adoption

Agency	Programs
AHRQ (Agency for Healthcare Research and Quality)	Health IT Portfolio – Goals 1 and 2
ASPE (Assistant Secretary for Planning and Evaluation)	Health IT Activities – Goal 1
ASPR (Association of Staff Physician Recruiters)	Homeland Security Presidential Directive 21 – Goal 2 Pandemic All-Hazards Preparedness Act – Goal 2
CDC (Center for Disease Control and Prevention)	BioSense – Goal 2 Public Health Information Network – Goal 2

Objective 3 – Adoption (continued)

Agency	Programs
CMS (Centers for Medicare & Medicaid Services)	EHR Adoption Demonstration – Goal 1 E-Prescribing Efforts – Goal 1 ICD-10 – Goal 1 and 2 Medicaid Information Technology Architecture – Goals 1 and 2 Medicaid Transformation Grants – Goal 1 Beneficiary Information Services – Goal 1 Reimbursement for Telehealth – Goal 1
FDA (Food and Drug Administration)	Structured Product Labeling – Goal 1 and 2 Sentinel Network – Goal 2
HRSA (Health Resources and Services Administration)	Rural Hospital Flexibility Grant Program – Goal 1 Health IT Electronic Health Record and Innovations Grants – Goal 1
IHS (Indian Health Service)	Resource and Patient Management System – Goal 1 TeleHealth – Goal 1 National Data Repository – Goal 2
NIH (National Institutes of Health)	Cancer Biomedical Informatics Grid – Goal 1 Support, Maintenance, & Dissemination of Standard Clinical Vocabularies – Goals 1 and 2 Health Informatics R&D – Goals 1 and 2
ONC (Office of the National Coordinator for Health Information Technology)	Certification Commission for Healthcare Information Technology – Goal 1 Secure Messaging Pilot – Goal 1 Standardized Measures for Adoption of EHRs – Goal 1 Use Case Development – Goals 1 and 2
HHS/OS (Department of Health and Human Services, Office of the Secretary)	Personalized Healthcare – Goals 1 and 2 Value-driven Health Care – Goals 1 and 2
SAMHSA (Substance Abuse and Mental Health Services Administration)	Health IT Initiatives – Goals 1 and 2
DoD (Department of Defense)	AHLTA – Goal 1 and 2
VA (Department of Veterans Affairs)	Electronic Health Record – Goal 1 Personal Health Record – Goal 1

Objective 3 – Adoption (continued)

Federal Advisory Committee	Programs
AHIC (American Health Information Community)	Consumer Empowerment Workgroup – Goal 1 Electronic Health Records Workgroup – Goal 1 Personalized Health Care Workgroup – Goal 1 Chronic Care Workgroup – Goal 1
OCR (Office for Civil Rights)	Health IT and Health Disparities/ Special Needs Populations – Goal 1

Objective 4 - Collaborative Governance

Agency	Programs
AHRQ (Agency for Healthcare Research and Quality)	Health IT Portfolio – Goal 1
ASPR (Association of Staff Physician Recruiters)	Homeland Security Presidential Directive 21 – Goal 2 Pandemic All-Hazards Preparedness Act – Goal 2
NIH (National Institutes of Health)	Security Technology – Goals 1 and 2
ONC (Office of the National Coordinator for Health Information Technology)	Anti-fraud Activities – Goal 1 CCHIT – Goal 1 Health Information Security and Privacy Collaborative (HISPC) – Goals 1 and 2 Health IT Standards Panel (HITSP) – Goals 1 and 2 Nationwide Health Information Network (NHIN) – Goals 1 and 2 State Alliance for e-Health – Goals 1 and 2
SAMHSA (Substance Abuse and Mental Health Services Administration)	Health IT Initiatives – Goals 1 and 2

Objective 4 – Collaborative Governance (continued)

Federal Advisory Committee	Programs
NCVHS (National Committee on Vital and Health Statistics)	Subcommittee on Privacy and Confidentiality – Goals 1 and 2
AHIC (American Health Information Community)	Population Health and Clinical Care Connections – Goals 1 and 2 Quality Workgroup – Goals 1 and 2
OCR (Office for Civil Rights)	Health IT and Health Disparities/ Special Needs Populations – Goal 1

Other Public-Private Sector Initiatives	National Quality Forum – Goal 1
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Endnotes

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