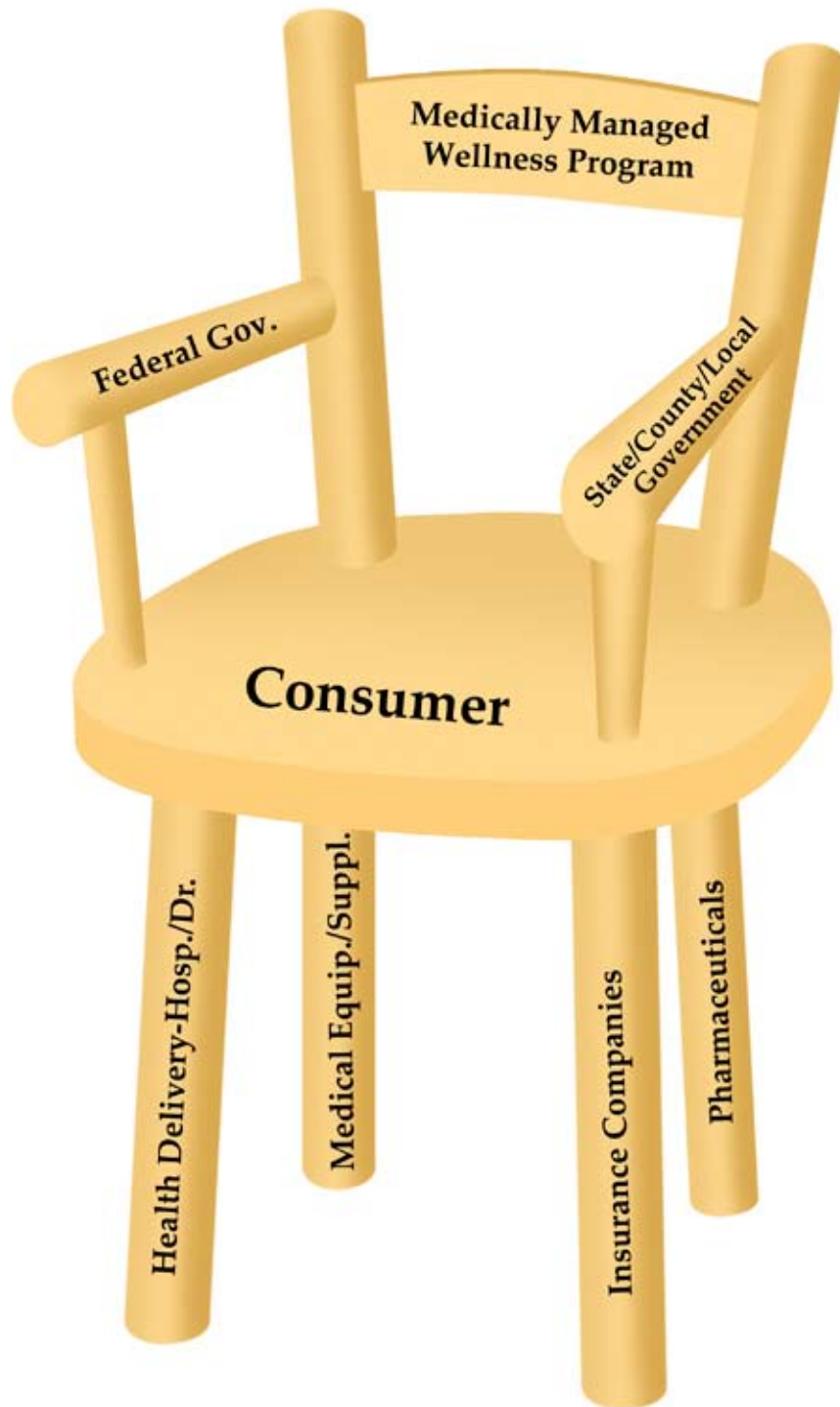




HOUSE OF REPRESENTATIVES
COMMONWEALTH OF PENNSYLVANIA

Have a seat and read about some possible solutions that will provide quality, accessible and affordable health care for all Americans.

Presented by the
NE Pennsylvania Health Care Reform Task Force • Wilkes-Barre, PA
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January 20, 2009

President Barack Obama
Vice President Joseph Biden
Thomas Daschle, Secretary of Health &
Human Services
Washington, D.C.

Dear President Obama,
Vice President Biden and
Secretary Daschle,

It is an honor and a privilege to share with your health research team the information, research and conclusions that the Northeast Health Care Reform Task Force has collected and recorded over the last two years.

As stated in our first communication, December 12, 2008, the Northeast Pennsylvania Health Care Reform Task Force (NEPA-HRTF) is a volunteer group of knowledgeable, active professionals that have come together to share their expertise, ideas and concerns relative to our present Health Care Crisis. The group recognizes that our present Health Care System is out of control, financially unsustainable and there is no end to the crisis in sight. Our main objective is to offer possible solutions to improve health care delivery, control costs and reduce premiums without diminishing Quality or Accessibility. We would like to thank you for the open process you are promoting by engaging all Americans in sharing their concerns, opinions and solutions to the Health Care crisis.

Chinese write the word “crisis” with two characters. One means DANGER and the other means OPPORTUNITY. Together they spell “Crisis”. (Saul D. Alinsky)

No one can dispute that we are in a crisis! But, which one? Financial crisis? Mortgage crisis? Health Care crisis? Economic crisis? CONFIDENCE Crisis?!!! All of the above.... Yes and there is more. And Danger, what about it? (Well, if we do nothing, the Danger of Catastrophic Results is beyond description). (The Danger of an ill conceived solution will create decades of tumultuous problems, diminished health care quality, and a tremendous waste of money). That is why this must be the RIGHT TIME to make the TOUGH DECISIONS to create the RIGHT SOLUTIONS for decades to come.

The extraordinary conditions that we face can become the vehicle to create a political, philosophical and practical atmosphere which will garner the support and will of the American people to motivate our leaders to have the courage and strength to GET IT RIGHT!

Our desire is to be able to help create the RIGHT ATTITUDE for Health Care Reform as well as to provide information to your team which may stimulate creative thinking that will result in a quality, long-lasting Health Care System for all Americans.

Before we present our proposals, it is important for your team to understand how we function as a team.

Our group conducts all meetings utilizing the following principals.

1. We believe a quality, accessible basic health care plan for all Americans is a RIGHT and a NECESSITY and not a privilege. The basic plan is similar to PA Chip, only for Adults. Former Gov. Robert Casey designed this program

for the children of Pennsylvania.

2. Each meeting we will engage in “FRANK and HONEST” discussions. We have agreed to disagree, however, everyone’s opinion is valued, respected and vetted.
3. We have accepted the opinion that the Health Care Crisis is so vast that everyone will have to “give in order to get” and that evaluation, redefinition and redesign is necessary from **EVERY** aspect of the Health Care Industry. Each major element of the Health Care Industry needs evaluation to determine what works and what doesn’t. Keep what works and FIX what doesn’t.
4. We believe everyone, especially the consumer, must have “SKIN IN THE GAME.” No one will get health care for FREE, including the President of the United States of America. We will all contribute something towards the Basic Adult (CHIP) Program. When people get things for free, they have a tendency to abuse the service and never understand the costs related to health care.
5. We are Americans and, as Americans, we are in this together. We will solve this crisis when we work together for the well being of all. We believe redesigning the present system would be more practical and success more probable than to introduce a completely controlled government system.
6. We work from the first premise that the patient comes before the shareholder and that quality medical protocol trumps dividends and mega salaries.

Although our meetings are always lively and productive, we don’t always agree with certain issues; we do agree that the meetings are beneficial and they must continue.

The information disseminated by the Obama, Biden, Daschle team intimates that the work done by Senator Max Baucus, Senator Kennedy and Senator Wyden will

weigh heavily in the development of the National plan. We sincerely respect their efforts and we believe their positions will be sincere and well conceived.

Our considerations, albeit enormous and aggressive, attempt to address many of the short comings of the major elements in the entire system.

We also view the global economic meltdown as a worldwide physic that was totally necessary to clear the mess and provide an atmosphere that will allow visionary, practical, well thought out solutions that will control and manage the new system for decades to come.

The Economic Crisis has a brilliant and positive side. For those of us that have the authority and resources to create and maintain a vastly improved world, nation, state and family, the crisis has created a new climate, which will allow those with the authority, to make the right changes, institute logical and long lasting Best Practices policies and create a better future for all. More Americans are paying attention to the world around them. They are beginning to recognize the severity of the financial crisis and they will be more receptive to accepting new concepts, consequence and self sacrificing in order to correct the direction of the country.

We, the NEPA-HRTF are attempting to seize this once in a lifetime opportunity to have our positions seriously considered by those that have the “Power to Change. Governor Robert P. Casey once said, “What did you do when you had the power?” This is a quote that I constantly recall when problems arise. It is our responsibility as leaders in all aspects of life to make the tough decisions for the betterment of America and mankind.

In our quest to create solutions to the Health Crisis, we began by identifying the

main components of the system itself. We have created a simple visual to describe the Health Care system, illustrating each part of the system as an equal partner and reliant on each other for strength, durability and function . If any major component fails to carry their load, the strength of the system is compromised.

The visual is a simple chair with four legs, a seat, back and two arms. Each of the four legs represent one of the following: The Health Care Delivery System (hospitals, clinics, doctors, etc.), The Insurance Industry, the Pharmaceutical Industry and the Medical Equipment Manufacturers and Suppliers.

The arms of the chair represent the Federal, State, County and Local governments. The back of the chair represents Education for the public by instituting a Medically Managed Wellness Program and the seat represents the Consumer.

This simple illustration can be expanded to include departments and agencies related to the main components depending on how detailed you want the presentation to be.

Our group's majority believed that a regulatory agency must be initiated in order to oversee and manage the health system. A type of Public Utility Commission only for Health care. Senator Daschle refers to a Federal Health Board in his book. We totally agree that this concept must be the managing vehicle to keep the new system functioning as well as the vehicle to be able to constantly analyze and adeptly react to system errors or breakdowns. This body must have the authority and expertise to fully understand the entire Health Care System and be able to make the technical, medical, financial and operational decisions necessary to maintain an efficient and productive Health Care System. This group must have representation from all major elements of the Health Care System. Each expert on this regulatory commission must be insulated from the incredible influence of those directly involved in the National Health Care system. Safeguards to protect the Health Care Commission members and their families must be devised and placed into the entire package as a required component.

We also believe that there needs to be a FLOW CHART that will identify and CONNECT Regional State Health Boards to the Federal Health Board. Each state will face many health

related challenges unique to their state or section of the country; consequently, exceptions to a universal plan will most likely be necessary.

To support the National Health Care System, we believe that every state should develop their own INDEPENDENT AGENCY that collects and evaluates their health care data. Pennsylvania has the Pennsylvania Health Care Cost Containment Council (PHC4). Senator Daschle refers to this agency in his book.

As a Pennsylvania legislator interested in health care issues, I can say first hand that PHC4's data is objective, accurate and very valuable. In order to make critical decisions, one needs accurate, objective information to determine what course of action is needed. PHC4 does just that.

It is important to NOTE that these state and national Health Boards MUST INCLUDE, NURSES, AIDES and JANITORIAL/MAINTENANCE representatives, pharmacists, technicians, PBM managers, etc., etc., etc. If you really want unbiased objective information, then INCLUDE ALL the people that work in the system. Furthermore, by including all the people associated with the operation of the system, you will empower them to contribute by being a part of the solution. We will need everyone's full cooperation and support in order to implement the kinds of changes required to create an efficient and productive Health Care System.

Statistics indicate that our present Health Care System operates with a 30-40% waste of money due to inefficiencies, errors and deception. Even with these percentages, the NEPA-HRTF believes that retaining the present Health Care System, eliminating the waste and inefficiencies and making the new improvements would make the promotion, acceptance and passage of the new system into law more practical and plausible than to press for a completely controlled government system. All the Players that are in the game at the present time will still have a place in the game even though their roles will be altered to some degree.

We believe if you have the FACTS to prove the TRUTH, you will triumph over Rhetoric, Spin and Fear. Certainly there will be a lot of fear mongering.

Every component of our present health care system has something to lose, so those that are profiting by the present system will not want to change the status quo. There will be vigorous opposition to the new Health Care plan launched by all the entities that are making profits.

However, the major differences in TIME and HISTORY, relative to earlier attempts to provide health care to all, is in the fact that the global and national economic crisis will help create a new attitude. Any American citizen with no insurance or poor health care insurance is scared and angry. Those that have a good or decent plan and pay something towards their health care premium are upset because their contributions are constantly being increased and those that have most or all of their health care premiums paid by their employer are very concerned because they know they too will also be contributing to a health care system that is a bottomless pit. Most interesting is the fact that in 2004-2005 many businesses and representative business organizations did not place the cost of health care as one of their top priorities. However, in 2007 thru the present, all businesses are scrambling to find ways to reduce their health care premiums without reducing quality. The American business owner knows that unless the cost of health care insurance is reduced, there is NO WAY that they can compete with other developing nations. We believe the American people will accept their moral and financial responsibility to contribute to improve the health care system as long as they know that their efforts are part of changing the present Health Care System into a better more cost efficient Health Care System.

How we market these truth/facts is just as important as the changes that must be made to improve the health system. If you can't sell it to the American people, you won't get the votes to pass it! Therefore, the marketing campaign is just as important as the product (The New Health Care System). The Marketing Campaign must be simplified so that most Americans will understand their role and how the new plan will benefit them, their family and their country.

Once again, standing behind the truth makes for a very strong sales pitch.

In the preceding information, we highlighted one of our guiding philosophies titled “SKIN IN THE GAME”, which means that all Americans will be guaranteed a quality, accessible Health Care plan titled the “CHEVY” plan and every American citizen will help pay for the plan!!!! Adults would receive a CHIP plan only customized for adults. We identify this as the “CHEVY” plan. Except for a designated group of Americans (Disabled, Jobless, etc.) Everyone would have a small amount deducted from every pay check up to the amount designated as the cost of the “Chevy Plan”. If you earned, \$50,000 or a million dollars you would contribute the same amount towards the Chevy Plan. For additional medical services and increased insurance protection, every American could choose to pay for the “Cadillac” plan. And for very special treatments or exceptional procedures such as Botox, would fall under the “Bentley Plan”. Once again, it would be your choice to pay for the additional benefits, but most importantly every American would be covered under the “Chevy” plan which would meet the basic needs of the vast majority of Americans.

A very controversial concept was also discussed that would have the Federal/State Governments accept the responsibility to handle all catastrophic cases. The Federal system that provides health care for veterans has proven to be cost effective and efficient. Administrative costs as low as 3% compared to 25 to 30% in the private sector. The Federal/State government would be able to negotiate fair prices for pharmaceuticals, supplies and other services that would reduce the cost of catastrophic illness.

The other modification to this proposal is to have all Health Care Insurance companies share the cost of RE-INSURANCE with the Federal Government. This proposal would eliminate the need for insurance companies to carry huge surpluses and in time and with proper management the Re-Insurance Proposal may be able to be managed in the Free Market without government dollars.

If this phase of the plan could be initiated, the result would be NO potential loss to insurance companies for the high cost of catastrophic illness; therefore; health care premiums should be reduced dramatically. This phase could not be initiated until regulatory provisions and safeguards were put into effect to prevent insurance companies from inflating administrative

costs, and executive salaries and benefits.

As stated later in this paper, specific Accepted Efficiency & Best Business Practices MUST be required and operational, in order to protect the new health care system.

We also believe that a significant number of qualified government evaluators/auditors be organized to ensure that the new Health Care System is operating according to design. Monthly and end of year reports must be a part of the new process. All records other than HIPAA (Health Insurance Portability and Accountability) must be available for auditing at any time. This part of the program is also JOB CREATION with a very important purpose. Lower the cost of health care by creating safeguards and preventing abuse.

NEPA HRTF Meeting on Health Care Reform Proposal
Meeting held on December 18th, 2008 at 6 PM.
State Representative Eddie Day Pashinski
152 S. Pennsylvania Avenue, Wilkes–Barre, Pa.

1. Sixteen percent of today's population is without health care coverage. By providing a basic health plan for these people, there will undoubtedly be an increased demand on current services. Hadley (27, no.5, August 2008) recently estimated the cost of such services and medical spending will increase by \$122.6 Billion. This will provide a stimulus to our economy. However, there is a significant likelihood of increased demand based on well established concepts such as moral hazard. The change will likely result in "Moral Hazard". The availability of services being provided at little or no cost will cause the formerly uninsured consumers to increase consumption of those services. Hence, NO-SKIN IN THE GAME equals overuse.

One way to prevent overuse or abuse is to create a best practice approach. A particular procedure will call for a set of guiding practices that should be used for a particular condition. When those procedures are performed and the condition has not been rectified, the physician should always have the authority to order whatever steps are needed to help the patient. However, there must come a point where excess is identified. This can be accomplished by developing a system of checks and balances. Medical auditors will have the responsibility to evaluate any cases that exceed approved best practices protocol. Upon INITIAL REVIEW, ONE MAY CONCLUDE that this system will create more cost and more bureaucracy. However, this system will prevent unnecessary ordering of services and medication, and when implemented properly, will save hundreds of millions of dollars. This system will also help with JOB CREATION. Medical auditors must be highly qualified in order to evaluate medical data and as such must be compensated appropriately.

2. National expenditures in 2007 for Health Care were \$2.4 Trillion. A 16 % increase would mean an increase of \$384 Billion in additional revenue. This would be a tremendous stimulus to our economy. Based on the Hadley study and the fact that 16 % of the population are in need of insurance services, it is logical to assume that under a federally mandated health insurance plan that the current 16% of the population will be insured. They will increase their health care expenditures by 70% (Hadley). The expected increase in expenditures is the \$286.8 Billion ($\$384 \times .70$). Since many of the providers and health related companies are currently making a profit, it is very likely that they will continue to do so, based on this 16% increase in demand. This profit is taxable and consequently will likely generate hundreds of millions in tax revenue. The NEPA HRTF group had differing opinions as to whether or not health related companies were making a profit and collectively felt that because of low reimbursement rates providers were absorbing a significant amount of the costs. There is also the question of cost shifting! We feel that the national health care reform group has access to the US IRS and can solicit their determination of the collective of health related companies and validate above amount of expected revenue or revise this number as appropriate. Our goal is the same as yours which is to enhance quality, increase the number of people insured and control the costs of services.

3. RX-1: Pharmacy Benefit Managers (PBM) help to reduce the costs of Pharmaceuticals. However since their dealings are hidden, it appears that they are generating significant profits for the Pharmaceutical companies at the expense of the state and federal government, the patients and the taxpayer. The goal is that the patient and the physician should be part of the deal created by the PBM's and that a transparent transaction would help to make this a reality. We feel that a Health Care Reform Bill should include language which mandates transparency of all deals so that the consumer and the insurer are fully aware of the specifics of the deal and they also have the right to decline the deal

if they feel it is inappropriate. We have been working with the PA Pharmacy association and can provide access to the appropriate language for such a bill.

4. Rx-2: In the Medicare Modernization Act of 2003, the right of the federal government, specifically CMS to negotiate with the pharmaceutical companies for lower drug prices was strictly prohibited in the bill. We feel that this part of the bill must be modified to allow for negotiation with the pharmaceutical companies for lower drug prices. We feel patents are too long and that the current pharmaceutical patent should be reduced to 12 years. We further feel in these times of budget deficits, federal and state funds for research should be reduced appropriately. As the economic climate improves, research dollars can be restored.
5. Rx-3: Pills are packaged in open containers and not packetized. As a result nursing homes employees regularly destroy millions of dollars worth of useful medications. As a nation we have learned how to recycle plastic, paper, oil, cardboard and glass yet we throw millions of dollars away in the form of unused medications. We feel that this is a national problem that should be addressed. We suggest that the industry create a locked vending machine which can be used daily by the nursing staff to dispense daily dosage for the patient. This safe can be monitored in its use by technology and a registered pharmacist. The current practice is costing the US taxpayers millions of dollars and is causing significant drug abuse and theft problems. We recommend that legislation be developed to co-ordinate this procedure to include government, the pharmaceutical industry and all institutions that dispense drugs. In addition, the disposing of drugs into sewer systems is beginning to contaminate larger portions of the water system with toxic poisons.
6. Rx-4: Research reveals that pharmaceutical companies are charging the U.S consumer 3 to 5 times more for pharmaceuticals than Canada, Europe, or Mexico. This practice must stop.

If we had the federal health board in place, they would prevent this form of price gouging and renegotiate a more equitable agreement. It has been estimated that pharmaceutical costs represent approximately 20% of the health care premium. By eliminating the price gouging, DTCA (Direct to Consumer Advertisement) and pharmaceutical sponsored physician seminars, free samples, and dinners, at least 5% could be cut from the cost of health care premiums. 5% equates to tens of billions of dollars in savings.

7. INS-1 Insurance companies routinely add on to the cost of treatment services an overhead cost of operations of 15 to 25%. This is far too high and it has been demonstrated that such cost can be lowered to 7% (Excellus Corporation in Rochester New York-7% and BCNEPA at less than 10%). Price Waterhouse Coopers released a study which (blogs.wsj.com/health/2008/04/10/report-us-wastes-more-than-half-of-health-spending) which stated that the national average is 13%. This means that 50% of the insurance companies are at or below 13% and 50% are above. We feel that one of the likely outcomes will be to create a pool of eligible insurance companies to compete for this new 16% of the health insurance business. We feel that the criteria for entrance into this group should be an upper limit of 13% on administrative costs for all eligible companies. The reasons behind the increasing cost of health insurance have been addressed by the Price Waterhouse Coopers report. A health reform commission should address these underlying cost drivers. The aforementioned PWC report does a fantastic job explaining the true underlying cost drivers in the current health care delivery system that resulted in the 6.1% increase in premiums in 2007. The report demonstrates that for 2007, 46% of the increase in health insurance premium was attributable to general inflation, while 29.5% was due to price increases in excess of inflation, and 24.5% was due to increased utilization. When medical inflation and increased utilization are further examined, it shows that almost three-quarter of increased health care costs were driven by rising provider costs. Over 90% of the increase in health insurance premium in 2007 were attributable to the increasing cost of delivering health care

and the increased utilization while only 9.8% was due to increased administrative costs. Clearly, any true reform will need to address the expense of delivering services as opposed to spreading those costs among larger and larger insured populations. Pooling of people will never reduce the cost of delivering care – it is merely a way to redistribute the cost among different segments of the insured population. We recommend any comprehensive health reform package take a serious look at the cost and benefit of health insurance mandates. Collectively, mandated coverage accounts for over 20% of the cost of health insurance. With no end in sight for legislation trying to implement mandated coverage for numerous conditions there may never be relief from the increasing costs of health insurance however, if the government incorporated the “Chevy plan”, mandates would be moot. The three plans would cover the consumer’s choice to choose and pay for their health insurance to protect their needs.

A key issue that needs to be addressed is the waste that occurs in the system. A separate PWC report recently examined the waste in the system and found that 30% to 40% of all health care expenditures in this country are wasteful. Merely eliminating the waste currently in the US health care delivery system would go a long way to reducing the increasing burden of health insurance on many Americans and could alleviate the growing pressure on GDP because of health care costs.

8. INS-2 Insurance companies routinely build up reserves in excess of 400% of the required amount set by the insurance department in each state. This amounts to Billions of dollars held in reserves by the health insurance companies across the US. We feel that the Federal Government should create a reinsurance pool that protects each member company against catastrophic failure and also allows each company then to operate with a much lower reserve pool. The insurance commissioners in each of the 50 states should be charged by the federal government with researching the risk levels and producing the appropriate maximum level using a similar process which they used to arrive at the current minimum level. Our group

also felt that the required reserves could be further reduced by creating reinsurance pool at the federal level. Individual Insurance companies such as BCNEPA and Geisinger could then have their own reserves at an acceptable level and contribute to the collective pool which could be accessed in a time of need for that insurance company. **It is not acceptable and far too costly to leave the maximum level undefined.** Since nationwide the collective amount in reserves is in the tens of billions of dollars, this money could be pooled and provided to the federal government in terms of low interest loans at this time of need. The NEPA HRTF group had differing opinions as to whether or not maximum levels of reserves should be established by the insurance commissioners.

9. MD-1 It has been demonstrated repeatedly that medical errors can be significantly reduced through the introduction and use of e-prescribing and by having Physicians implement and use Electronic Medical Record systems. However, only 15% of the MD's have implemented such systems in their practices. This is because it is very costly to do so and benefit to the MD appears to be minimal. Any Health Care Reform bill should require that all participating physicians implement e-prescribing by a specific date such as December 31st, 2010 and Electronic Medical Record Systems by December 31st, 2011. Such a bill should cover a large portion of the cost of implementing such systems. The impact of such a requirement would be better care to the patient and as research has demonstrated fewer medical errors in the entire system. Serious time and effort must be utilized by government IT experts to prevent price gouging by the electronic/IT companies that would profit from the implementation of EMR, E-Prescribing, and Medical Information Exchange and Interoperability. We also feel that the following conditions should be added to any implementation:

- A. Hold harmless any provider who has engaged a certified (government must so certify) EMR installer for any violations of information privacy under federal, state or other rules. Failure to do so, given the complexities of information entry, storage,

retrieval, segmentation and sequestrations (both patient and guideline driven) will lead to significant increased liability exposure for providers.

B. Eliminate both the strict liability and negligence standards and replace them with a knowing intent standard with respect to release of information by a provider who acts in good faith to release patient information to others and believes that appropriate safeguards are in place.

10. MD-2 Major Hospitals and physicians group practices should form Integrated Networks and implement the chronic care model with the physician office performing the function of a Medical Home. This model when implemented resulted in significant lowering of hospitalization and an overall reduction in costs and an improvement in quality of care to the patients. Integrated medical networks will need some legislative help in negotiating the barriers of jurisdictional discrepancies that are a fact of life and impact health care delivery across such boundaries.

11. Patients and Employers-1 Employers should work with medical group practices in their geographical area and implement medically managed wellness programs with incentives for improving nutrition, reducing Diabetes, cholesterol, obesity, high blood pressure and by stopping smoking, alcohol or drug use. By providing insurance coverage at lower premium rates for willing participants, lower rates of disease can be achieved. Such programs have been successful throughout the US and incentives should be built into the Health Care Reform Bill. **Medically managed wellness programs also positively changes adult behavior which educates children to understand the benefits of a healthy lifestyle.** This program is strictly voluntary and would begin with a blood test to determine the health of the individual relative to the conditions defined above. Example: If an individual that pays for and is covered by the “Chevy plan” decides to enroll in a medically managed wellness program (MMWP) and begins to improve their health by achieving desired levels of success

then their “Chevy plan” premium would be reduced appropriately. The incentive would be lowered monthly premiums and a healthier lifestyle.

12. Patients and Employers-2 Insurance companies should be encouraged by the Health Care Reform Bill to implement high and moderate risk designations for **Smokers, heavy drinkers, drug abusers (both legal & illegal) and obese patients.** These patients will be charged the standard price, The “Chevy” plan, for their insurance premiums. Any participants attaining the quality standard would be entitled to a reduced rate and be entitled to services rendered by a provider in any state. However, this idea runs contrary to several federal proposals being pushed right now which call for more use of community rating in the individual and small group market. Community rating is in conflict to the proposals above because by using community rating those less healthy individuals in the pool are subsidized by the healthier individuals in the pool. Community rating works well for illnesses for which the individual has little or no control such as cancer. However, community rating provides an easy out for those individuals engaged in high risk health behaviors and also provides these same individuals with no incentive at all to change their behaviors because a certain percentage of their true cost of health care is being borne by other people.

13. Hospitals-1 Regulatory agencies such JCAHO and NCQA should be provided with language in the bill which strongly encourages ISO 9001 Certification of hospitals in order to reduce medical errors and improve quality of care. Further, all hospitals should not be paid by insurance companies or Medicaid and Medicare for Hospital induced infections. Hospitals should have to disclose publicly its infection rates and how it compares to state and local rates for other hospitals. This should further be extended to nursing homes or any adult care facilities.

14. End of Life Issues- We have discussed the fact that a disproportionate amount of money is expended during the last 18-24 months of life. While maintaining better health will reduce costs in a given year, eventually everyone will enter the last 18-24 month window.

A. We must be open to discussions of Elective scheduling of treatment based on the time necessity to have the procedure or operation done now. This is a form of rationing of health care that is practiced in other countries and should be explored further here and now. If you want the Miracle cure and can pay for it then Ok, if NOT then everyone will have to settle for The Chevy Plan. **To be clear we are not encouraging an end of life without offering every scientific and medical technique available to continue the life of the patient. The medical diagnosis and prognosis must be the bench mark to determine the viability of the patient surviving. There must be a medical standard which defines the difference between quality of life, existing life (machined controlled), and the miracle, given the precept of “do no harm”.**

B. Discussions of FUTILITY CARE (physiologic, qualitative, and quantitative) must be part of any proposal for health care reform. Failure to engage these topics will render any policy planning incomplete and unauthentic. A significant amount of research has addressed this issue. The concepts of Quality Adjusted Life years (QALS) and Creation of Living Wills should be further explored and applied to this problem nationwide. Although this issue will be very controversial, it must be addressed, **honestly and directly. The cost of futility care is staggering. (ONCE AGAIN, IF THE FAMILY CHOOSES TO PAY FOR EXISTING LIFE OR THE MIRACLE CURE, SO BE IT).**

15. Improve Quality across the system.

Background statement: the cost of poor quality in health care wastes 30 to 60 cents of every health care dollar. It will be difficult if not impossible to provide affordable health

care to all Americans if this waste is allowed to continue.”Health care providers’ cost of poor quality is estimated to be as high as 30-50 percent of the total paid for health care. For some companies the cost of employee health insurance is now higher than profits.” [1]”The national numbers for waste in health care are between 30% and 40%, but the reality of what we’ve observed doing minute-by-minute observation over the last three years is closer to 60%,” asserts [Cindy Jimmerson of Lean Healthcare West [2]. “Costs of poor-quality care for employers are at least \$1,800 per employee per year for health care coverage, the estimated direct cost of poor-quality care in 1998 averaged between \$344 billion and \$698 billion” (or about \$1,200 to \$2,500 for every American). [3]To put this in perspective: In 2005, General Motors’ health care costs were \$5 billion, of which 30 to 60 percent (\$2.65 to \$5.30 a share) was wasted on the cost of poor quality in health care. Given GM’s close of \$4.49 per share as of December 19, *GM’s tolerance of poor quality by the health care providers that treat its employees and retirees is enough by itself to wipe out the company’s remaining market capitalization in no more than 21 months.* Another way to put this waste in perspective is to compare it to GM’s dividend of \$1.00 per share, assuming that GM continues to pay a dividend; *the company wastes \$2.65 to \$5.30 on medical mistakes and inefficiencies for every dollar it pays in dividends. The highest priority in health care reform must therefore be reduction and elimination of the cost of poor quality in health care, which wastes far more money than the estimated cost of providing health insurance to people who currently do not have it.*[1] Godfrey, Blanton. 2000. “Managing Key Suppliers.” Quality Digest, September, 2000, p. 20 [2] Panchak, Patricia. “Lean Health Care? It Works!” in Industry Week, November 2003 [3] Swayne, Brian J. 2003. “First Aid for Health Care.” Quality Digest, December 2003.

Recommended “Off the Shelf” Action- *Technology and management systems already exist to solve this problem.* The Automotive Industry Action Group (AIAG) developed an International Workshop Agreement (IWA-1) that was a health care specific adaptation of the ISO 9001:2000 standard, which is similar to ISO/TS 16949. The auto industry has ignored

recommendations to require their health care providers that treat their employees and retirees, implement this standard, or the one that succeeded it. GM's annual waste of \$2.65 or more per share on activities that provide no benefit to its employees and retirees, and that may actually harm them (e.g. medical mistakes) largely rules out positive earnings per share in the foreseeable future even in the absence of the company's other problems. The auto sector's failure to act on this problem (let alone exercise leadership) is astounding, given that:

A. The industry and the UAW complain repeatedly about the cost of health care. (2) The industry requires its part suppliers (but not its health care suppliers) to register to a quality system standard (3) the industry failed to act on a spoon-fed off-the-shelf solution from its own industry association, the AIAG. *Medicare and Medicaid can and should require registration to ISO 9001:2008 (the successor to ISO 9001:2000) as a condition of continuing eligibility for reimbursement under these programs, and private insurers should be encouraged to do the same.* Medicare is already refusing to pay for certain so-called "never" events, or medical mistakes that should never happen under any circumstances. Doctors, hospitals, and clinics must be educated as to how quality management standards will actually help them make money despite the cost and effort of implementation. The quality system prevents system-related medical mistakes that at best waste money and can expose doctors and hospitals to malpractice liability. Electronic medical records and computerized physician order entry systems (CPOEs) are merely *tools* of a good quality management system. CPOEs, for example, can prevent medication errors that take up to 25,000 lives per year. The Institute for Healthcare Improvement (IHI, <http://www.ihl.org>) has developed "bundles" or best practices for the prevention of hospital-acquired infections, patient falls, ventilator-acquired pneumonia, and similar problems. *Medicare and Medicaid can and should require hospitals to implement these "bundles" as a condition of*

eligibility for reimbursement under these programs, and private insurers should be encouraged to do the same. Alternatively, Medicare, Medicaid, and insurers could institute a policy of refusing to pay for hospital-acquired infections, falls; and so on *unless* the hospital has implemented the “bundles” (i.e. the problem occurs despite the bundle, which should be very rare). **Additional information** State representative Phyllis Mundy (120th district) proposed a state law, HB 743, that was similar in principle to the PENNSAFE workplace safety program. PENNSAFE offers employers a discount on worker’s compensation insurance premiums if they implement a workplace safety committee program that meets state standards. HB 743 would have given health care providers such as hospitals a substantial discount on malpractice insurance premiums for implementation of a quality management system standard that was acceptable to the Pennsylvania Department of Health. The rationale is that system-related problems are generally responsible for 80 to 85 percent of all mistakes and errors (this is a general rule for organizations with divisions of labor), while carelessness and negligence -- what we generally think of as “malpractice” -- cause the remaining 15 to 20 percent. This is something that should be considered at the national level. It must also be pointed out that insurance companies that provide liability coverage for providers have been raising their rates based primarily on the cyclical events of the markets and not on the number of law suits or size of the awards. This kind of practice conducted by the insurance industry drives up the cost of delivering health care because the providers must inflate their charges in order to help pay for their liability insurance.

16. Hospitals-2 It has been demonstrated in numerous institutions nationwide that the implementation of Six Sigma quality programs will reduce medical errors and improve overall quality of care. The Health Care Reform Bill should provide incentives to

hospitals to implement six sigma programs. Everyone who participates in the health care system should have “skin in the game”. This includes everyone, senators, the President, representatives as well as those currently uninsured. In the healthy American’s Act there is a payment scale which provides for payment rates for all participants. We would like to see an addition to this Health Care Reform Bill which spells out that all employers and employees should pay. The NEPA HRTF is currently in the process of defining the basic adult package or what we call the “chevy” plan. A few of our representatives are working with actuaries to define the basic adult package as well as the high end or “Cadillac” plan and a catastrophic plan. There are already commercial products available for that price and lower; however, they do not contain all the bells and whistles of coverage that many Americans have come to know, therefore, most Americans won’t buy it because it does not provide the level of coverage they want, regardless of whether it is the level of coverage they can actually afford.

17. Loans-We also discussed the concept of low interest government loans, 1% or less could be initiated for catastrophic cases. Basically, it would be a financial mechanism to eliminate personal bankruptcies or financial hardship due to costly and severe illness. The government would negotiate and pay all costs for the procedure. The patient or patient’s family would pay back in part or in full the loan over a lifetime of small affordable payments. This would help defray the cost to government and once again illustrate “SKIN IN THE GAME”. This would allow a family to continue on with their lives without being financially decimated. If the patient or patient’s family was unable to work because of the particular circumstance, then no payments would be made to government. If the patient or family was capable of some income then an affordable payment schedule would be developed.
18. Health Information Technology- The application of health information technology must leverage:

A. The methodology of RASS, Reliability, Accessibility, Supportability, and Sustainability. Hence, the EMR or CPOE must demonstrate that it will continue to work at the patient-doctor interface without an outage and that all information captured will be secure. Hence, three levels of security must be mandated authentication, authorization and encryption.

B. Any federal health information system must support the idea of regional health information organization (RHIO) and all of the regional RHIO's must feed into a national NHIO. Regional Networks and a National Health Information Network will provide for a better opportunity for the survival of any US citizen when they are away from home since the doctors and other providers will be able to access the person's medical record anywhere in the US even if the person is unconscious.

C. Because of the costs involved, the federal government will have to provide incentives for individual providers and institutions to participate.

D. The new technologies creating E-prescribing, Medical Information Exchange, and interoperability, etc. will create more efficiency and provide for real time information enhancing the clinician's ability to appropriately treat the patient. This is not fool proof and standard medical protocol must be agreed upon by the medical community in order to incorporate nationally. This discussion has begun, must continue and must reach a national consensus by the end of 2009.

In order for the Chevy Plan to work successfully, the CORE elements for improving the Health Care System must be in place together.

*Caution- Since the Tech industry can see that electronic innovations will play an even greater role in the Health Care System, EVERY SAFEGUARD and REGULATION must be created to protect personal medical information and to PREVENT PRICE GOUGING! We do not want taxpayer dollars going for incentives to Health Providers to incorporate these new technologies only to have TECH industry overcharge the system to make unfair profits. Simple business

mathematics will identify price gouging. (Remember we are all in this together, for the future of our children and our country)

E. There was also considerable discussion about the patient record staying with the patient and the family doctor in the form of a credit card or a “medical spot”. We did not pursue this idea sufficiently to formulate a proposal, but we all felt the idea retained enough potential that we would include the concept into your teams discussions.

19. Nursing Shortage- by Alice McDonnell, DPH.

It might be useful to reintroduce legislation on Certificate of Need (CON). Since home care programs were draining the nurses from hospitals. Alice and Jean Dyer Ph.D., Dean of Health Sciences at Misericordia University stated that working in a hospital is difficult work and when programs open up such as home care where the pay is similar but the work is easier, nurses will leave the hospital setting for home care. Upon graduation nurses need hospital experience, so they accept a job in a hospital. Hospital Administration often puts nurses at risk with unsafe practices, and after six months of hospital regulations, stress and mandatory overtime, the nurse will leave the hospital for a better, less stressful nursing job. Alice said that the homecare programs were useful but since the operators can operate on very low margins there may be too many programs in existence. Certificate of need (CON) would investigate the supply of home care and determine how many home care programs should exist.

A. The results should reduce the demand for nurses in home care and more nurses would be eligible to work in hospitals. Furthermore, Reimbursement for hospital staff should be significantly higher than for home care staff.

Alice and JR confirmed the positive impact the Chronic Care Model is having on reducing hospital costs. Alice stated her studies at Scranton CMC demonstrated a savings of 130 days for CHF and diabetes patients. JR Vought stated that Kingston Pediatrics was having success using the CCM treating their 23,000 asthma patients.

An effort to calculate actual savings is being developed. Everyone agreed the CCM will save billions of dollars and must be standardized through the country.

20. I am adding this last section submitted by Bill Levinson to reflect on some innovative thinking presented so long ago, yet relevant today. Here is the information on the Henry and Clara Ford Hospital. The source is Henry Ford's "My Life and Work" (1922).

Executive Summary

1. Each patient was evaluated independently by at least three doctors to obtain a complete picture of the patient's health, as opposed to the specific complaint for which he or she was admitted. This seems to tie in with the concept that problems (whether organizational or health-related) are often system-related as opposed to local. That is, organizational problems are often cross departmental boundaries, and an illness may involve more than one part of the patient's body.
2. All physicians were employed by the hospital, and did not have any financial interest in the patient's specific course of treatment. (This is in contrast to the situation that Phyllis Mundy has often cited, in which doctors own their own MRI equipment and therefore have a financial interest in referring the patient to it, and the problem we have discussed in which pharmaceutical companies give doctors an incentive to prescribe products).
3. No nurse was required to care for more than seven patients (and the load was lower for patients who needed more care).
4. The hospital used the same principles that Ford's factories used to minimize non-value-adding walking by the nurses. Ford recognized that the time a nurse spends walking (e.g. to get medications or to fill out charts) is not spent in caring for patients.
5. All rooms were private, an arrangement that could have easily reduced the incidence of hospital-acquired infections.

Items 3 and 4 are directly relevant to hospitals' current difficulty in attracting and

keeping registered nurses. If nurses have to care for too many patients, and/or exhaust themselves with non-value-adding walking, it is not surprising that many decide that direct patient care is not for them. Note that Ford was able to achieve this at a daily charge of \$4.50 per day, which was less than the daily minimum wage at his factories.

Ford's "Today and Tomorrow" (1926) recognized the role of diet and exercise in disease prevention, a topic that we have also discussed. "Men who are careful of their diet do not often fall ill, while those who are not careful always seem to have something or the other the matter with them". I also recall reading that the hospital had temperature and humidity controls. Humidity control is especially important in the winter, when dry air can dehydrate patients and possibly promote respiratory diseases. (When my father was in a hospital in December, I had to get his doctor to order a humidifier for him room, and my experience with his nursing home was similar.)

Material from Ford's "My Life and Work"

The Ford hospital is being worked out on somewhat similar lines, but because of the interruption of the war—when it was given to the Government and became General Hospital No. 36, housing some fifteen hundred patients—the work has not yet advanced to the point of absolutely definite results. I did not deliberately set out to build this hospital. It began in 1914 as the Detroit General Hospital and was designed to be erected by popular subscription. With others, I made a subscription and the building began. Long before the first buildings were done, the funds became exhausted and I was asked to make another subscription. I refused because I thought that the managers should have known how much the building was going to cost before they started. And that sort of beginning did not give great confidence as to how the place would be managed after it was finished. However, I did offer to take the whole hospital, paying back all the subscriptions that had been made. This was

accomplished, and we were going forward with the work when, on August 1, 1918, the whole institution was turned over to the Government. It was returned to us in October, 1919, and on the tenth day of November of the same year the first private patient was admitted.

The hospital is on the West Grand Boulevard in Detroit and the plot embraces twenty acres, so that there will be ample room for expansion. It is our thought to extend the facilities as they justify themselves. The original design of the hospital has been quite abandoned and we have endeavored to work out a new kind of hospital, both in design and management. There are plenty of hospitals for the rich. There are plenty of hospitals for the poor. There are no hospitals for those who can afford to pay only a moderate amount and yet desire to pay without a feeling that they are recipients of charity. It has been taken for granted that a hospital cannot both serve and be self-supporting—that it has to either be an institution kept going by private contributions or pass into the class of private sanitariums managed for profit. This hospital is designed to be self-supporting—to give maximum of service at a minimum of cost and without the slightest coloring of charity.

In the new buildings that we have erected there are no wards. All of the rooms are private and each one is provided with a bath. The rooms—which are in groups of twenty-four—are all identical in size, in fittings, and in furnishings. There is no choice of rooms. It is planned that there shall be no choice of anything within the hospital. Every patient is on an equal footing with every other patient.

It is not all certain whether hospitals as they are now managed exist for patients or for doctors. I am not unmindful of the large amount of time which a capable physician or surgeon gives to charity, but also I am not convinced that the fees of surgeons should be regulated according to the wealth of the patient, and I am entirely convinced that what is known as “professional etiquette” is a curse to mankind and to the development of medicine. Diagnosis is not very much developed. I should

not care to be among the proprietors of a hospital in which every step had not been taken to insure that the patients were being treated for what actually was the matter with them, instead of for something that one doctor had decided they had. Professional etiquette makes it very difficult for a wrong diagnosis to be corrected. The consulting physician, unless he be a man of great tact, will not change a diagnosis or a treatment unless the physician who has called him in is in thorough agreement, and then if a change be made, it is usually without the knowledge of the patient. There seems to be a notion that a patient, and especially when in a hospital, becomes the property of the doctor. A conscientious practitioner does not exploit the patient. A less conscientious one does. Many physicians seem to regard the sustaining of their own diagnoses as of as great moment as the recovery of the patient.

It has been an aim of our hospital to cut away from all of these practices and to put the interest of the patient first. Therefore, it is what is known as a “closed” hospital. All of the physicians and all of the nurses are employed by the year and they can have no practice outside of the hospital. Including the interns, twenty-one physicians and surgeons are on the staff. These men have been selected with great care and they are paid salaries that amount to at least as much as they would ordinarily earn in successful private practice. They have, none of them, and financial interest whatsoever in any patient, and a patient may not be treated by a doctor from the outside. We gladly acknowledge the place and the use of the family physician. We do not seek to supplant him. We take the case where he leaves off, and return the patient as quickly as possible. Our system makes it undesirable for us to keep patients longer than necessary—we do not need that kind of business. And we will share with the family physician our knowledge of the case, but while the patient is in the hospital we assume full responsibility. It is “closed” to outside physicians’ practice, though it is not closed to out cooperation with any family physician who desires it.

The admission of a patient is interesting. The incoming patient is first examined by the senior physician and then is routed for examination through three, four, or whatever number of doctors seems necessary. This routing take place regardless of what the patient came to the hospital for, because, as we are gradually learning, it is the complete health rather than a single ailment which is important. Each of the doctors makes a complete examination, and each sends in his written findings to the head physician without any opportunity whatsoever to consult with any of the other examining physicians. At least three, and sometimes six or seven, absolutely complete and absolutely independent diagnoses are thus in the hands of the head of the hospital. They constitute a complete record of the case. These precautions are taken in order to insure, within the limits of present-day knowledge, a correct diagnosis.

At the present time, there are about six hundred beds available. Every patient pays according to a fixed schedule that includes the hospital room, boards, medical and surgical attendance, and nursing. There are no extras. There are no private nurses. If a case requires more attention than the nurses assigned to the wing can give, then another nurse is put on, but without any additional expense to the patient. This, however, is rarely necessary because the patients are grouped according to the amount of nursing they will need. There may be one nurse for two patients, or one nurse for five patients, as the type of cases may require. No one nurse ever has more than seven patients to care for, and because of the arrangements it is easily possible for a nurse to care for seven patients who are not desperately ill. In the ordinary hospital the nurses must make many useless steps. More of their time is spent in walking than in caring for the patient. This hospital is designed to save steps. Each floor is complete in itself, and just as in the factories we have tried to eliminate the necessity for waste motion, so have we also tried to eliminate waste motion in the hospital. The charge to patients for a room, nursing, and medical attendance is

\$4.50 a day. This will be lowered as the size of the hospital increases. The charge for a major operation is \$125. The charge for minor operations is according to a fixed scale. All of the charges are tentative. The hospital has a cost system just like a factory. The charges will be regulated to make ends just meet.

There seems to be no good reason why the experiment should not be successful. Its success is purely a matter of management and mathematics. The same kind of management which permits a factory to give the fullest service will permit a hospital to give the fullest service, and at a price so low as to be within the reach of everyone. The only difference between hospital and factory accounting is that I do not expect the hospital to return a profit; we do not expect it to cover depreciation. The investment in the hospital to date is about \$9,000,000.

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GAMING OVERSIGHT

We thank you once again for providing this open invitation to share everyone's concerns, expertise, and proposals to help initiate the correct health care reforms.

We humbly ask you to carefully consider the concept of "SKIN IN THE GAME". Everybody pays for and is guaranteed the Chevy plan. We have vigorously discussed this concept with a large cross section of people and the vast majority agrees that this concept will work if the entire system is revamped.

Since we have devoted considerable time and effort in developing this proposal, we ask your team to respond to us by critiquing the information and allowing us the opportunity to respond. We are ready, willing, and able to serve in any capacity to help you create a viable health care system for all Americans and we wish you good luck and success. America is Depending on you.

Respectfully,

A handwritten signature in black ink that reads "Eddie Day Pashinski".

Eddie Day Pashinski

Pennsylvania State Representative



Seated L-R: Sabatini Monatesi, Alice McDonnell DPH, Rep. Eddie Day Pashinski, Conrad Schintz and Jack McNulty.

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