



## **Standards Insight Summary—December 2008**

### **The Obama Healthcare Reform Plan**

By Ed Larsen

We now know Barack Obama will be the next president and he will set a different direction for healthcare reform from that of the current administration. The broad outlines of the Obama health plan include strengthening employer-based health insurance, while assuring those not covered can find affordable plans. There are many details yet to be developed or discovered, particularly concerning costs. There are estimates the Obama plan will increase annual healthcare spending from \$60 billion to more than \$100 billion over baseline trends. To offset the increased costs, President-elect Obama has proposed raising all taxes on the upper 1 to 5 percent of tax payers; this is expected to raise \$400 billion over 10 years. Of course, these estimates were made before our current financial meltdown and its spread to the economy.

Other initiatives expected to go forward include reducing payments for Medicare Advantage to the same per-capita level as traditional Medicare and authorizing CMS to use its purchasing leverage to negotiate prescription drug prices with the pharmaceutical industry.

The final major cost-savings proposal is based on the widespread adoption of health IT to reduce administrative costs, eliminate waste and duplication and improve efficiency. This is expected to save from \$50 billion to as much as \$150 billion per year. To realize these savings, Obama has proposed spending \$10 billion per year for five years on health IT initiatives.

In order to save money with health IT, two conditions are necessary: front end investments must be made and the return on these investments must be aligned. A corollary is it is very hard to gain support for hard-dollar investments today on the promise of future cost avoidance, particularly when economic conditions are difficult.

The upfront capital costs of fully adopting interoperable EHR systems and health information exchanges have been estimated at \$60 billion to \$110 billion; some estimates are even higher, up to \$200 billion. Annual operating costs add \$20 billion to \$35 billion. If capital investments are amortized over five years, incremental health IT spending would be approximately \$35 billion to \$65 billion per year, one to two times the current health IT spending levels. When put together with expected savings, one might infer net savings of \$50 billion to \$100 billion per year, or 2.5 to 5 percent of current healthcare spending. It seems like a “no brainer”—except for a few loose ends.

We know the steps necessary to align incentives. Consumers, payors and secondary users must step up and pay providers for saving money for these stakeholders. Moreover, there are two streams of investment: health information exchange and networking infrastructure, and the provider or edge EHR systems. Aligning investment, costs and returns are different for each. Infrastructure should be a public good paid for by and from the returns to primary stakeholders. Like the Canadian Health Infoway, the nationwide health information exchanges, the HIEs adhering to harmonized standards and agreements, must be in place in order to enable participants to realize the benefits of interoperability. This should be the first priority of federal investment, not buying EHR systems for physicians.

The provider systems should be funded through reimbursement incentives that pay providers for using the technology to coordinate and transform care. That is, there must be a business case for providers to use EHR systems and share data with each other and secondary users. If there is a clear business case for providers to share information, then the economics fall into place. Subsidizing IT acquisition without providing clinical practice standards and business cases will not realize the expected benefits. If well targeted, Obama's commitment of \$10 billion a year could produce adoption of interoperable systems within a transformed care system over a five- or 10-year period.

For the complete article, including references, see the December *Standards Insight* on the HIMSS Member Center webpage. Ed Larsen is an independent strategy consultant who tracks interoperability standards for HIMSS. Comments or questions can be sent to [erlarsen@erlinc.com](mailto:erlarsen@erlinc.com).