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## **State Level Options For Reducing Private Sector Health Care Costs**

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## **About this paper**

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# State Level Options for Reducing Private Sector Health Care Costs

By Daphne A. Kenyon, Ph.D., and Bethany Paquin

***NOTE:** The New Hampshire Center for Public Policy Studies takes no formal position in favor or against any of the options listed in this paper. The objective of this paper is to present some selected options with the potential for controlling private sector health care costs in New Hampshire. Options have been chosen after a scan of the literature and an examination of other states' experiences. They were selected for their potential to reduce health care costs or their rate of growth, without shifting costs to other payers, or reducing health care access or quality. Some options have already been considered in New Hampshire; others have not. The rationale for each option is presented along with one or more counter-arguments.*

One of the most critical issues in public policy today is the relentless increase in health care spending or costs.<sup>1</sup> At present, health care spending represents about 16 percent of the economy of our state and nation, and that percentage is growing.<sup>2</sup> If growth in health spending continues at its historical pace, health care spending will account for over one-third of the total economy by 2040. In the spring of 2004 and 2005, New Hampshire voters were asked whether 25 different public policy problems were of serious concern for the state; cost of health care insurance and cost of medical and hospital care topped the list.<sup>3</sup>

Although this is a nationwide problem that may best be tackled by the federal government, there is no indication that a comprehensive federal solution is imminent. For this reason, various states have taken diverse actions in the hope of reducing the growth in health care costs.

States have no “silver bullet” for solving the problem of rising health care costs. None of the options below will be unanimously approved by policymakers or citizens. Indeed, after each option is described and the rationale for seriously considering that option is presented, at least one counter-argument is also described. The description of each option is intentionally brief to make this paper more accessible to busy policymakers. In the interests of brevity, we make no attempt to be comprehensive in describing any option. For example, more policy tools could be used for combating childhood obesity than are described in Idea 3. Each section ends with a list of resources for further information. If policymakers decided to pursue a particular option, additional research and policy planning would be appropriate and recommended.

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<sup>1</sup> Thanks to Peter G. Kachavos, M.D. for his helpful comments on previous drafts.

<sup>2</sup> Douglas E. Hall, “Health Care Dollars and Health Insurance in New Hampshire,” New Hampshire Center for Public Policy Studies, September 2005 and Henry J. Aaron, “It’s Health Care Stupid! Why Control of Health-Care Spending is Vital for Long-Term Fiscal Stability,” presented at “Wanting It All: The Challenge of Reforming the U.S. Health Care System,” Federal Reserve Bank of Boston, June 15-17, 2005, [www.bos.frb.org/economic](http://www.bos.frb.org/economic).

<sup>3</sup> Public opinion polls by The Becker Institute, Inc.

Because many current efforts at cost control involve consumer-driven health plans such as health savings accounts, one option suggests ways to moderate the potential deleterious effects of these plans. Many options fall under the heading of “preventive measures” which should reduce health care costs by eliminating the need for health care. (Given that a recent study found only 3 percent of U.S. adults lead healthy lifestyles, it is not surprising that preventive medicine is high on the list of cost control ideas!<sup>4</sup>) The payoff of many preventive measures is long-term, consistent with the time frame of a foundation or think tank, but not necessarily consistent with the time frames of legislators, governors, health care providers or insurers.

The following eleven ideas for controlling private sector health care costs will be discussed in this paper.

### **State-Level Health Care Cost Control Options**

1. Piggyback on newly enacted federal database to track and reduce medical errors.
2. Maintain or increase the role of primary care physicians in the state’s health care system.
3. Implement school-based policies to combat childhood obesity.
4. Reform the state’s process for regulating the supply of health services.
5. Build on existing pay-for-performance initiatives.
6. Create a statewide public-private purchasing alliance to drive improvements in health care quality and reductions in cost.
7. Begin a pilot project in health information technology, perhaps applying for a federal grant.
8. Improve vaccination rates for senior citizens.
9. Work to reduce the potential harmful unintended consequences of the growth in consumer-driven health plans.
10. Raise tobacco taxes and target some of the resulting funds to prevention of youth smoking.
11. Mandate that adults use seat belts while driving.

### **Idea 1:**

#### **Piggyback on newly enacted federal database to track and reduce medical errors.**

**Rationale:** In 1999, the Institute of Medicine (IOM) released a ground-breaking study estimating as many as 98,000 people die in the United States each year as a result of preventable medical errors, twice as many as die in automobile accidents.<sup>5</sup> Reducing medical errors can simultaneously improve quality of health care and reduce costs.

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<sup>4</sup> A recent national study found, “just 3% of US adults followed a combination of 4 modifiable lifestyle characteristics—nonsmoking, healthy weight, adequate fruit and vegetable consumption, and regular physical activity.” (Mathew J. Reeves and Ann P. Rafferty, “Healthy Lifestyle Characteristics Among Adults in the United States, 2000,” *Archives of Internal Medicine*, April 25, 2005.)

<sup>5</sup> L.T. Kohn et al, editors, *To Err Is Human: Building a Safer Health System*, Institute of Medicine’s Committee on Quality of Health Care in America, Washington, DC: National Academy Press, 1999; U.S. Census Bureau, *Statistical Abstract of the United States: 2002*, 122nd ed. (Washington, DC, 2001) 80.

Evidence from anesthesiology indicates a concerted effort to improve patient safety can yield remarkable returns.<sup>6</sup> Anesthesiologists have seen a dramatic decrease in deaths due to anesthesia and an associated 37 percent decrease in malpractice insurance rates over the last 20 years as a result of a campaign among physicians in the field to improve patient safety. Deaths due to anesthesia have decreased from one death per 5,000 cases to one death per 200,000 to 300,000 cases over this period. Medical malpractice rates for anesthesiologists are now among the lowest in the medical field as insurers are making fewer malpractice payments. However, progress in reducing medical errors in the health care profession as a whole has been “frustratingly slow.”<sup>7</sup>

In the three years immediately following the IOM study, 23 states (not including New Hampshire) enacted medical error reporting laws.<sup>8</sup> In August 2005 President Bush signed a law establishing a national database for voluntary reporting of medical errors.<sup>9</sup> The database will be managed by patient-safety organizations who will work with providers to reduce medical errors based on analysis of the data collected. The database will not include personally identifiable information and may not be used as a basis for legal action. New Hampshire could use the federal database as a mechanism for requiring state-level reporting of medical errors. Reporting and tracking of medical errors could be used as a springboard for an effort to reduce medical errors in New Hampshire.

**Counter-arguments:** Although New Hampshire does not require reporting or tracking of medical errors, providers are already participating in less prescriptive efforts designed to reduce medical errors.<sup>10</sup> Perhaps any serious consideration of the idea of piggybacking on the new federal medical error database should be postponed until the results of these other initiatives can be analyzed.

In 2005 the New Hampshire legislature established a five-year health care quality assurance commission, designed to include representatives from each hospital and freestanding ambulatory surgical center, to review and analyze information about medical errors.<sup>11</sup> A second initiative organized by the nonprofit Institute for Healthcare Improvement is the “100,000 Lives Campaign.” The objective of this campaign, which a number of New Hampshire hospitals are participating in, is to save 100,000 lives over 18 months by implementing six proven safety measures (e.g., one measure aims to prevent ventilator-associated pneumonia).<sup>12</sup> A third initiative designed to reduce medical errors which began in 2003 is the Performance Improvement Project. All of the state’s acute care hospitals have been participating in this

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<sup>6</sup> Hallinan, Joseph T., “Once seen as risky, one group of doctors changes its ways,” *Wall Street Journal*. June 21, 2005

<sup>7</sup> Lucian L. Leape, M.D., and Donald M. Berwick, M.D., “Five Years After *To Err is Human*: What Have We Learned?” *JAMA*, May 18, 2005, Vol. 293, No. 19: 2385.

<sup>8</sup> Gilbert M. Gaul, “Plan Would Compile, Analyze Medical Errors,” *Washington Post*, July 29, 2005, A06.

<sup>9</sup> “Bush Signs Law Creating National Database on Medical Errors,” *Medical News Today*, August 2, 2005, [www.medicalnewstoday.com](http://www.medicalnewstoday.com).

<sup>10</sup> For some information on each of these see the Foundation for Healthy Communities web site at [www.healthynh.com](http://www.healthynh.com).

<sup>11</sup> HB514.

<sup>12</sup> “LRGH Joins 100,000 Lives Campaign,” *Laconia Citizen*, July 4, 2005 and Institute for Healthcare Improvement web site at [www.ihl.org](http://www.ihl.org).

project which focuses on quality improvement with respect to acute myocardial infarction, heart failure, and community acquired pneumonia.

**Resources for more information:** L.T. Kohn et al, editors, *To Err Is Human: Building a Safer Health System*, Institute of Medicine's Committee on Quality of Health Care in America, Washington, DC: National Academy Press, 1999; Lynda Flowers, *State Responses to the Problem of Medical Errors: An Analysis of Recent State Legislative Proposals*. Portland, ME: National Academy for State Health Policy. February 2002.

## Idea 2:

### **Maintain or increase the role of primary care physicians in the state's health care system.**

**Rationale:** Recent research has shown that, "states with relatively more general practitioners have both higher rates of use of effective care and lower spending."<sup>13</sup> Primary care physicians have an opportunity to get to know the "whole patient" over many years. This provides an incentive for the physician to promote preventive care, provides continuity of care, and reduces the extent of redundant testing that takes place when people visit many doctors for the same complaint. However, in recent years fewer medical students have gone into primary care and more have chosen to become specialists.<sup>14</sup>

New Hampshire could increase the emphasis on primary care (or try to stem the decline) in at least two ways. First, the public and non-profit sectors could work together to attract primary care physicians to areas of the state designated as Primary Care Health Professional Shortage Areas. In 2002, all but three New Hampshire counties contained such shortage areas.<sup>15</sup> For example, state government could work with the Dartmouth Medical School to increase the incentives for New Hampshire-trained physicians to practice medicine in the state. Second, it may be wise to examine the current trend toward use of hospitalists<sup>16</sup> instead of primary care physicians to care for patients in hospitals. Does the increased use of hospitalists tend to fragment care and increase the cost of medical care? Or do hospitalists improve quality of care despite higher costs because of their around-the-clock availability and special training?

**Counter-arguments:** Over time it has been difficult to forecast physician supply into the future. Some forecasts of shortages have been reversed in later years (and likewise for some forecasts of physician surpluses).<sup>17</sup> Furthermore, the most important reason fewer doctors have been choosing primary care over medical specialties involves relative pay scales, which in turn depend

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<sup>13</sup> Katherine Baicker and Amitabh Chandra, "Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care," *Health Affairs Web Exclusive*, April 7, 2004: W4-193.

<sup>14</sup> Mark D. Schwartz, MD, et al, "Rekindling Student Interest in Generalist Careers," *Annals of Internal Medicine*, April 19, 2005.

<sup>15</sup> Those counties were Carroll, Cheshire, and Strafford. See Daphne A. Kenyon, "Assessing New Hampshire North Country Health Data," Josiah Bartlett Center for Public Policy, May 2003 at [www.jbartlett.org/pdf/northbook0303.pdf](http://www.jbartlett.org/pdf/northbook0303.pdf).

<sup>16</sup> A hospitalist is a physician who cares only for hospitalized patients. If a primary care physician has privileges at a hospital that employs hospitalists, that primary care physician does not necessarily need to visit his/her patients when he/she is on call—he/she can have the hospitalist take care of it.

<sup>17</sup> David Blumenthal, "New Steam from an Old Cauldron—The Physician-Supply Debate," *New England Journal of Medicine*, April 22, 2004.

on reimbursement rates set by Medicare. The federal government, not state governments, controls these rates.

**Resources for more information:** “Is This What We Want?” by Jonathan M. Ross, M.D., *Dartmouth Medicine*, Vol. 29, No. 3, Spring 2005: 55; Barbara Starfield, Leiyu Shi, Atul Grover, and James Macinko, “The Effects of Specialist Supply on Populations’ Health: Assessing the Evidence,” *Health Affairs Web Exclusive*, 15 March 2005.

### Idea 3:

#### **Implement school-based policies to combat childhood obesity.**

**Rationale:** According to a recent report, the rate of childhood obesity more than doubled from 1980 to 2000.<sup>18</sup> Being overweight or obese increases an individual’s risk for developing diabetes, heart disease, and cancer, among other diseases.<sup>19</sup> Medical researchers studying the effects of obesity on longevity recently concluded: “Unless effective population-level interventions to reduce obesity are developed, the steady rise in life expectancy observed in the modern era may soon come to an end and the youth of today may, on average, live less healthy and possibly even shorter lives than their parents.”<sup>20</sup>

Schools play a special role in promoting good nutrition and exercise habits for children. In New Hampshire in 2003, 20 percent of New Hampshire adults were obese and 10 percent of high school students were overweight.<sup>21</sup> The New Hampshire legislature could enact laws prohibiting the sale of soda and candy during school days or increasing physical education requirements, among other policy options.

**Counter-arguments:** If legislation is not well-crafted, it could impose an unfunded mandate on local governments or unnecessarily interfere with local control. In its 2005 session, the New Hampshire Senate rejected a bill to restrict what food and drink items school cafeterias could sell to students.<sup>22</sup>

**Resources for more information:** S. Jay Olshansky, et al, “A Potential Decline in Life Expectancy in the United States in the 21<sup>st</sup> Century,” *New England Journal of Medicine*, March 17, 2005; Trust for America’s Health, *F as in Fat: 2005: How Obesity Policies are Failing in America*, August 2005.

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<sup>18</sup> Trust for America’s Health, *F as in Fat: 2005: How Obesity Policies are Failing in America*, August 2005, <http://healthyamericans.org/reports/obesity2005/Obesity2005Report.pdf>.

<sup>19</sup> *F as in Fat: 2005*.

<sup>20</sup> S. Jay Olshansky, et al, “A Potential Decline in Life Expectancy in the United States in the 21<sup>st</sup> Century,” *The New England Journal of Medicine*, March 17, 2005.

<sup>21</sup> Trust for America’s Health, <http://healthyamericans.org>. Adults with a body mass index (BMI) of 25 to 29.9 are considered overweight; those with a BMI of 30 or more are considered obese. Trust for America’s Health web site reports obesity rates for adults but overweight rates for adolescents.

<sup>22</sup> SB177 prohibited the sale of any individual food item that derived more than 35 percent of its calories from fat or 10 percent of its calories from saturated fat, as well as any food item, other than fruit or vegetables, which was more than 35 percent sugar by weight.

## Idea 4:

### Reform the state's process for regulating the supply of health services.

**Rationale:** New Hampshire government officials have fewer powers to regulate the supply of health services than officials in many states. The only regulatory process currently in place with a potential for major impact on health care spending is the certificate of need (CON) process.

“The CON regulatory approach is predicated on ‘Roemer’s Law’ which implies that a built bed is a filled bed—alternatively, ‘if you build it, they will come.’”<sup>23</sup> Recent research has found that about 41 percent of the variation in health care spending around the country “is driven by hospital resources and the number of doctors. In other words, it is the supply of medical services, rather than the demand for them that determines the amount of care delivered.”<sup>24</sup> Furthermore, other evidence indicates that more spending does not always lead to better health outcomes.<sup>25</sup> In theory state-level constraints on the supply of health services, including constraints on major capital expenditures, appear to be a potentially attractive policy lever for holding down health care costs.

However, across the country CON has fallen into disfavor in recent years. A recent review of experience with CON laws across the U.S. concluded that, “there is little data to support the notion that CON helps curb costs.” On the plus side, this review concluded that CON regulation can be used to persuade hospitals to expand indigent care (i.e., in order to get permission to construct an addition, a hospital might be required to expand its dental clinic for Medicaid clients), or to encourage patients to go to high-volume, high-quality centers for certain surgical procedures.<sup>26</sup>

Certificate-of-need was introduced in New Hampshire in 1979 and is implemented through the Health Services Planning and Review Board (HSPRB). Projects exceeding the following thresholds must be reviewed by the HSPRB:

- Acute care facility projects over \$2.1 million.
- Nursing home, ambulatory and specialty hospital projects exceeding \$1.4 million.
- Equipment purchases exceeding \$400,000.<sup>27</sup>

A review of CON in New Hampshire from 1982 to 1991 concluded that, “Without a constraint on overall capital expenditures...the HSPRB’s performance in controlling capital expenditures

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<sup>23</sup> Ellen Jane Schneider, Trish Riley and Jill Rosenthal, *Rising Health Care Costs: State Cost Containment Approaches*, National Academy for State Health Policy, June 2002, p. 7.

<sup>24</sup> Shannon Brownlee, “The Overtreated American,” *The Atlantic Monthly*, February 1, 2003. Brownlee was reviewing research done elsewhere including some by John Wennberg, Elliot Fisher and Jonathan Skinner of Dartmouth College.

<sup>25</sup> John E. Wennberg, Elliott S. Fisher, and Jonathan S. Skinner, “Geography and the Debate Over Medicare Reform,” *Health Affairs Web Exclusive*, February 13, 2002.

<sup>26</sup> *Rising Health Care Costs: State Health Cost Containment Approaches*, p. 11. Such regionalization of health services could be more difficult to achieve in New Hampshire, with what appears to be an implicit assumption that all health care consumers should have the right to obtain health care nearby.

<sup>27</sup> <http://www.dhhs.state.nh.us/DHHS/HSPR>.

over the past decade has been lackluster.”<sup>28</sup> Furthermore, the web page of the HSPRB shows that of 16 CON applications from 2002 to 2005, only one has been denied. On the other hand several of the recent CON applications concern MRI services, and private health insurers are targeting MRIs and other medical imaging services as some of the fastest growing medical expenditures.<sup>29</sup>

On balance, it seems sensible to review New Hampshire’s CON process in order to determine whether a reformed or expanded process for regulating health care services could be effective in holding down health care costs (or, at minimum, achieving other worthy goals such as expansion of indigent care).

**Counter-arguments:** A number of other states have repealed their CON laws as these laws have fallen into disfavor, due to the lack of evidence that CON regulations reduce health care costs. Another argument against CON is that it can be used by providers already in the market to prevent others from entering the market. When this happens, CON may actually increase health care costs.

**Resources for more information:** “New Hampshire: Private Solutions for Public Problems,” in Robert B. Hackey, *Rethinking Health Care Policy: The New Politics of State Regulation*, Washington, DC: Georgetown University Press, 1998; and Ellen Jane Schneider, Trish Riley and Jill Rosenthal, “Rising Health Care Costs: State Health Cost Containment Approaches,” National Academy for State Health Policy, June 2002.

## Idea 5:

### **Build on existing pay-for-performance initiatives.**

**Rationale:** Under discounted fee-for-service, the predominant financial arrangement for compensating health care providers, providers are paid more for more intensive care (i.e., more visits and more tests) but are not paid more for higher quality care. Evidence has been accumulating that pay-for-performance initiatives can induce providers to provide better care. For example, according to accepted medical guidelines, drugs called ACE-inhibitors should be prescribed for heart-failure patients. When the Hawaii Medical Service Association adopted a bonus program to reward doctors for prescribing ACE inhibitors for such patients, the percentage receiving ACE-inhibitors increased from 41 percent to 64 percent.<sup>30</sup>

New Hampshire has two pay-for-performance initiatives that could be expanded to reduce health care costs in the state. (Higher quality health care may not reduce health care costs for the individual provider, but is more likely to reduce health costs for the state as a whole.)

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<sup>28</sup> “New Hampshire: Private Solutions for Public Problems,” in Robert B. Hackey, *Rethinking Health Care Policy: The New Politics of State Regulation*, Washington, DC: Georgetown University Press, 1998.

<sup>29</sup> “Medical Imaging Services: Efforts to Reduce Spending Examined” in American Health Line, April 26, 2005 reports that use of outpatient medical imaging services increased by 44 % from 1999 to 2001 and that Medicare reimbursements to physicians for medical imaging services increased by more than 60% from 1999 to 2003.

<sup>30</sup> Laura Landro, “To Get Doctors to Do Better, Health Plans Try Cash Bonuses,” *The Wall Street Journal*, September 17, 2004.

Anthem Blue Cross Blue Shield of New Hampshire operates a pay-for-performance program that provides bonuses to primary care physicians who provide certain preventive services for their patients.<sup>31</sup> This program could be expanded to other health plans, with partial compensation from state government or nonprofits.

The Centers for Medicare and Medicaid Services (CMS) has just begun a pay-for-performance demonstration project and a Dartmouth-Hitchcock clinic is one of the sites. The Dartmouth-Hitchcock project pays bonuses to physicians for quality and cost-effectiveness in care of patients with congestive heart failure or diabetes.<sup>32</sup> Although this demonstration project has just begun, the State of New Hampshire could get ready to “tag on” to the program and expand it if it turns out to be successful.

**Counter-arguments:** Since the CMS project just began in April 2005, it may be too soon to think about expanding the program. Also, in setting up a pay-for-performance program, challenges arise in measuring quality: what measures to use, how to collect the data, and how to make appropriate risk adjustments. In addition, physicians may resist pay-for-performance projects if they believe hitting performance targets is out of their control because of noncompliant patients (e.g., the emergency room physician who has no control over whether a patient sees his primary care doctor for follow up) or that performance bonus funds are obtained by reducing base-level physician compensation.

**Resources for more information:** Patricia Seliger Keenan and Janet Kline, “Paying for Performance,” The Commonwealth Fund Issue Brief, November 2004; “Developing Pay-for-Performance Programs,” Hot Topic, Changes in Health Care Financing & Organization, August 2005, [www.hcfo.net/topic0805.htm](http://www.hcfo.net/topic0805.htm).

## **Idea 6:**

**Create a statewide public-private purchasing alliance to drive improvements in health care quality and reductions in cost.**

**Rationale:** In order to improve health care quality and lower costs, the state of Minnesota created a “Smart-Buy Alliance” in 2004. This option suggests New Hampshire follow Minnesota’s example.<sup>33</sup>

Minnesota’s Alliance includes state government, large employers and labor groups that together purchase health insurance for 70 percent of the state’s residents. Alliance members still purchase health care individually, but agree on four separate strategies to achieve their goals. The first strategy involves identifying the best health care providers for certain types of care (e.g., cardiac

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<sup>31</sup> This program is slated for modifications in 2006 and the kind of incentives the revised program provides remains to be seen. “Quality Improvement Incentive Program,” <http://ir.leapfroggroup.org/compendium/compendiumdetail.cfm?recid=7>.

<sup>32</sup> “Medicare: CMS Launches Pay-for-Performance Demonstration Project,” American Health Line, February 2, 2005.

<sup>33</sup> “Minnesota’s Smart-Buy Alliance: A Coalition of Public and Private Purchasers Demands Quality and Efficiency in Health Care,” *States in Action: A Quarterly Look at Innovations in Health Policy*, The Commonwealth Fund, [www.cmf.org](http://www.cmf.org).

care), and encouraging Alliance members and patients employed by Alliance members to consider this information when choosing providers. Other strategies involve adopting uniform measures of quality of care, providing additional health information to consumers, and requiring the use of certain forms of health information technology.

This purchasing alliance is a voluntary measure, not a state-imposed mandate. It harnesses the market power of large purchasers of health care in order to press for improvements in quality and reductions in cost. This initiative is similar to the national effort of the Leapfrog group, which includes major employers across the U.S.<sup>34</sup>

**Counter-arguments:** It may be better to wait to seriously consider this option until Minnesota's innovation has had more time to demonstrate its success. The Minnesota experience does not provide enough history to judge whether this approach is likely to be successful.

**Resources for more information:** "Minnesota's Smart-Buy Alliance: A Coalition of Public and Private Purchasers Demands Quality and Efficiency in Health Care," *States in Action: A Quarterly Look at Innovations in Health Policy*, The Commonwealth Fund, [www.cmf.org](http://www.cmf.org).

## **Idea 7:**

**Begin a pilot project in health information technology, perhaps applying for a federal grant.**

**Rationale:** It is widely recognized that the state of information technology (IT) in health care is behind that in many other fields. It is further recognized that improvements in health IT could both improve health care quality and reduce costs. However, providers typically have neither the funds nor the incentive to invest in IT projects. The health field is fragmented, with numerous small providers, many of whom do not have large capital budgets to facilitate investment in IT. Furthermore, health care providers typically lack an incentive to invest in IT since savings in global health care costs benefit the populace as a whole, but not the provider. For example, increases in the efficiency of health care that lead to fewer surgical procedures will reduce provider payments.

The State of New Hampshire could initiate a project that encourages investment in health IT. This could take several forms. Select providers could be encouraged to adopt electronic medical records (EMR), computerized provider order entry (CPOE), or e-prescribing. Electronic medical records have more capability than traditional paper records as the computer screen can provide reminders of necessary clinical tests or alert the provider to drug allergies. CPOE allows providers to enter orders electronically to avoid errors due to poor handwriting or verbal transmission. E-prescribing not only avoids errors due to poor handwriting, but saves patients' time by automatically sending prescriptions to a pharmacy.

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<sup>34</sup> [www.leapfroggroup.org](http://www.leapfroggroup.org).

Financial incentives to providers could be provided through grants or loans. Given the considerable activity in health IT at the federal level, the state may be eligible for federal grants for this initiative.

A group of businesses, health care providers, and associations in Massachusetts has come together to promote advances in technology to lower health care costs and improve quality. A recent report issued by the group estimated the annual savings in Massachusetts if 75 percent of providers adopted the following technologies would be: \$141 million for e-prescribing, \$290 million for ambulatory CPOE, \$966 million for inpatient CPOE.<sup>35</sup>

**Counter-arguments:** It may be a few years too early to begin this type of initiative. It may be sensible to wait for more progress at the federal level (such as the setting of standards for electronic medical records) and to follow the example of leading health care systems in metropolitan areas such as Boston. It may also be sensible to wait to pursue such an initiative until IT makes more progress in protecting patient privacy and ensuring security of electronic records.

**Resources for more information:** Karen A. Wager, Frances Wickham Lee, and John P. Glaser, “Current and Emerging Use of Clinical Information Systems,” Chapter 5 in *Managing Health Care Information Systems*, San Francisco: John Wiley & Sons, 2005.

## Idea 8:

### **Improve vaccination rates for senior citizens.**

**Rationale:** Flu and pneumonia vaccinations are recommended for senior citizens (flu vaccinations annually, pneumonia vaccinations once). A study in the *Journal of the American Medical Association* found regular annual flu vaccinations reduced seniors’ risk of death by 24 percent compared with seniors who did not receive annual vaccinations.<sup>36</sup>

A recent study by the federal Agency for Healthcare Research and Quality found New Hampshire is below average among the states for the percentage of hospitalized Medicare patients who received either flu or pneumonia vaccinations. In fact, New Hampshire’s rankings on both criteria fell from the previous year.

A variety of means could improve vaccination rates for seniors. The state could run a public information campaign targeted either at seniors, physicians, or both. Alternatively, this measure could become part of a pay-for-performance initiative.

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<sup>35</sup> Massachusetts Technology Collaborative with New England Healthcare Institute, “Advanced Technologies to Lower Health Care Costs and Improve Quality,” 2003. The estimated cost savings accrue for a number of reasons and benefit a number of entities. For example, e-prescribing is estimated to provide savings to physicians because of improvements in office efficiency, savings to consumers because e-prescribing systems can prompt physicians to substitute generic for name-brand drugs, and savings to providers in general from decreasing malpractice claims and malpractice insurance costs.

<sup>36</sup> “Flu Vaccine: Annual Vaccination Improves Seniors’ Survival Rate,” American Health Line, November 3, 2004.

**Counter-arguments:** This, like a number of cost-control ideas, increases costs in the short run in order to decrease costs in the long run.

**Resources for more information:** “Report Finds Gaps in Health Care,” *New Hampshire Business Review*, April 15-28, 2005: 26.

## Idea 9:

**Work to reduce the potential harmful unintended consequences of the growth in consumer-driven health plans.**

**Rationale:** In the last couple of years, there has been an increasing interest in consumer-driven health plans. These plans take a variety of forms, but all involve linking consumer health care choices to cost with the aim of decreasing the growth in health expenditures, and cutting costs for employers. Health savings accounts coupled with high deductible catastrophic insurance are probably the best known form of consumer-driven health plan. In tiered health plans, another type of consumer-driven health plan, individual’s co-payments vary with the provider’s tier, and the classification of the provider’s tier is based in turn on cost and quality information. According to a report in April 2005, “seven out of 10 employers expect to offer “consumer-driven” health plans, such as health savings accounts (HSAs), by next year...”<sup>37</sup>

Consumer-driven health plans present a number of potential dangers. One concern is consumers may skimp on preventive care, thereby reducing health care costs in the short term, but incurring greater costs in the long run. Another concern is high income and healthy individuals are most likely to choose consumer-driven plans, leaving lower income and less healthy individuals in traditional discounted fee for service plans. Over time this adverse selection could drive the traditional plans out of business, leaving only healthy and high income individuals with health insurance coverage.

One suggestion is to reduce the potential harmful effects of these consumer-driven health plans by refining how they work. Refined consumer-driven health plans can take a number of forms. Employers can cap the potential dollar amount of cost-sharing for low-income employees to reduce the negative impact on this segment of the population. Alternatively, the degree of consumer cost-sharing could vary in order to encourage consumers to make more effective health care purchases. For example, the share of costs paid by individuals for more cost-effective providers could be lower than for less cost-effective providers. As other examples, individuals might make a higher co-payment for emergency room treatment than for treatment in a physician’s office or receive financial rewards for engaging in health maintenance or preventive care.

**Counter-arguments:** Some argue the current growth in health care expenditures has no reason to slow unless provider incentives change. As long as providers are paid by volume, not effectiveness of care, they argue, they will tend to overuse some procedures, treatments, and technology.

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<sup>37</sup> “The Pros, Cons of HSAs,” *Washington Health Policy Week in Review*, Commonwealth Fund, April 25, 2005.

**Resources for more information:** Sally Trude and Joy M. Grossman, “Patient Cost-Sharing Innovations: Promises and Pitfalls,” Issue Brief, No. 75, January 2004, Center for Studying Health System Change; “The Pros, Cons of HSAs,” *Washington Health Policy Week in Review*, Commonwealth Fund, April 25, 2005.

*The following ideas are not new, but are ones that may bear reconsidering. For example, although the New Hampshire legislature already raised tobacco taxes recently (Idea 10), tobacco taxes in New Hampshire are still low relative to neighboring states.*

## **Idea 10:**

**Raise tobacco taxes and target some of the resulting funds to prevention of youth smoking.**

**Rationale:** Tobacco use is the leading cause of preventable premature death in the United States.<sup>38</sup> About 3,500 people in New Hampshire died from lung cancer from 1993 to 1997.<sup>39</sup> In 1999, 34 percent of New Hampshire youth surveyed indicated that they had used tobacco in the past 30 days. The state’s *Healthy New Hampshire* target is to reduce that rate to 24 percent.<sup>40</sup> New Hampshire youth are twice as likely to smoke cigarettes as middle aged adults.<sup>41</sup>

Even with a 28-cent-per-pack increase in 2005, New Hampshire’s 80 cents per pack rate is well below those of other New England states (Connecticut \$1.51, Maine \$2.00, Massachusetts \$1.51, Rhode Island \$2.46, and Vermont \$1.19). Beginning in 2005 loose tobacco joins cigarettes and smokeless tobacco as a taxable tobacco product, but cigars are still not subject to the tobacco tax. Raising cigarette taxes further and extending tobacco taxation to cigars would raise significant revenue, some of which could be used for smoking prevention programs.<sup>42</sup> Higher cigarette taxes and smoking prevention programs would reduce the rate of smoking, especially among young people, who are more responsive to cigarette prices than adults.<sup>43</sup>

**Counter-arguments:** Because the legislature just enacted a cigarette tax increase in its 2005 session it is unlikely to enact another cigarette tax increase soon.

**Resources for more information:** Daphne A. Kenyon, “Saving Lives While Raising Revenue,” *State Tax Notes*, March 3, 2003.

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<sup>38</sup> Thomas M. Habermann, M.D., editor-in-chief, *Mayo Clinic Internal Medicine Board Review 2002-2003*. Lippincott, Williams & Wilkins: Philadelphia, 2002, p. 382.

<sup>39</sup> Office of Planning and Research, New Hampshire Department of Health and Human Services, July 2001. *New Hampshire Regional Health Profiles*.

<sup>40</sup> New Hampshire Department of Health and Human Services, March 2001, *Healthy New Hampshire 2010*.

<sup>41</sup> Findings from the Behavioral Risk Factor Surveillance System in NH, 2000.

<sup>42</sup> The fact that the tobacco tax excludes cigars while taxing cigarettes and smokeless tobacco is arguably unconstitutional given the state’s requirement for “proportional and reasonable” taxation in Part 2, Article 5 of the state’s constitution.

<sup>43</sup> Frank J. Chaloupka and Michael Grossman, “Price, Tobacco Control Policies and Youth Smoking,” September 1996, National Bureau of Economic Research Paper No. 5740, p. 22.

**Idea 11:****Mandate that adults use seat-belts while driving.**

**Rationale:** In 2000, the National Highway Traffic Safety Administration estimated that, “the failure of a substantial portion of the driving population to buckle up caused 9,200 unnecessary fatalities, 143,000 serious injuries, and cost society \$26 billion in easily preventable injury related costs.”<sup>44</sup> Twenty years of research shows seat-belt use reduces fatality risk by 45 to 73 percent depending on the type of vehicle, type of seat-belt, and position in the vehicle. Seat-belts also decrease a person’s chance of suffering a moderate to critical injury by 44 to 78 percent, according to the same study.<sup>45</sup>

In a separate study published in 2004, federal highway officials found seat-belt use rates tend to increase with the presence of seat-belt laws and the ability of authorities to enforce them. New Hampshire, the only state with no adult seat-belt law,<sup>46</sup> had the lowest estimated use rate of any state. The federal study, which rated seat-belt use by drivers and front-seat passengers, put New Hampshire’s seat-belt use rate at 50 percent for 2003.

Seat-belt laws are generally classified as either primary or secondary. Under primary enforcement seat-belt laws police can stop drivers specifically for failing to wear seat-belts. Under secondary enforcement laws, fines for failing to wear a seat-belt can be levied if a driver is stopped for some other offense. Studies have found primary seat-belt laws have the greatest impact on seat-belt usage.<sup>47</sup>

**Counter-arguments:** Opponents of a mandatory seat-belt law for adults argue such laws interfere with individual liberty. Peter Thomson, chief of the New Hampshire Highway Safety Agency, argued against legislation before the House in 2005 to require adults to buckle up. He criticized the bill as intrusive and put emphasis on a voluntary increase in seat-belt use prompted by a public education campaign as a better approach.<sup>48</sup>

**Resources for more information:** Blincoe, L., Seay, A., Zaloshnja, E., Miller, T., Romano, E., Luchter, S., and Spicer, R. *The Economic Impact of Motor Vehicle Crashes, 2000*. Washington DC: National Highway Traffic Safety Administration, U.S. Department of Transportation; 2002; and Glassbrenner, Donna. *Safety Belt Use in 2003 – Use Rates in the States and Territories*. Washington, DC: National Center for Statistics and Analysis, National Highway Traffic Safety Administration, U.S. Department of Transportation, March 2004.

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<sup>44</sup> Blincoe, L., Seay A., Zaloshnja, E., Miller, T., Romano, E. Luchter, S. and Spicer, R. *The Economic Impact of Motor Vehicle Crashes, 2000*. Washington, DC: National Highway Traffic Safety Administration, U.S. Department of Transportation, 2002.

<sup>45</sup> *Economic Impact of Motor Vehicle Crashes*.

<sup>46</sup> Glassbrenner, Donna. *Safety Belt Use in 2003: Use Rates in the States and Territories*. National Center for Statistics and Analysis, National Highway Traffic Safety Administration, U.S. Department of Transportation, March 2004. No seat-belt usage rate was reported for Maine or Wyoming.

<sup>47</sup> *Safety Belt Use in 2003*.

<sup>48</sup> Kepple, Benjamin. “Safety Chief Opposes Law Mandating Seat-Belt Use,” *The Union Leader Sunday News*, February 23, 2005, B1.

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