# Looking Ahead

# The Cornell Roosevelt Institute Policy Journal

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# Letter from the Director

Dear Readers,

I am very pleased to present the seventh issue of Looking Ahead: The Cornell Roosevelt Institute Policy Journal from the Center for Healthcare Policy. As the Policy Director and Editor of the Healthcare Center's journal since Spring 2014, I have had the amazing experience of producing this publication for the past two semesters, and the talent and innovation of each analyst never ceases to amaze me. I have also had the pleasure of welcoming seven new analysts to the Center for Healthcare Policy this semester and am very excited to display their work in this issue.

Each analyst has combined creativity and passion with careful research and hard work to produce the policy proposals that comprise this journal. In this issue, the policy proposal topics range from issues regarding women's reproductive rights to the Affordable Care Act to medical ethics. I have found each piece to be well researched, enjoyable to read, and incredibly thought provoking and I hope you will as well.

Best Regards,

John Lemp

Industial and Labor Relations '15

Director, Center for Healthcare Policy

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# Reducing Unintended Pregnancies: Providing Access to Long-Acting Contraception

By Anna Grosshans, Major: Development Sociology (CALS '15), Email: aog25@cornell.edu

*One in every three women in the United States becomes pregnant before the age of 20, a rate much higher than in other wealthy nations. States should provide publicly funded programs to educate women about long-acting contraceptives and provide them at little to no cost.*

## Background and Context:

Many women overestimate the effectiveness of their birth control. Even the most popular methods of contraception in the United States are prone to failure. While these methods promise high levels of effectiveness when used correctly, women do not always use their birth control consistently and correctly. These mistakes can cause contraception to fail much more often than if women used them perfectly, every time. The gap between perfect use and typical use can be substantial, and it can mean a difference between successful contraception and an unintended pregnancy.

**Key Facts:**

- One in every three women in the United States becomes pregnant before the age of 20, a rate much higher than in other wealthy nations.
- Over 40 percent of all unintended pregnancies in the United States result from inconsistent use of contraception.
- Long-acting contraception is the most effective form of birth control because it eliminates the risk of human error.

The Pill is the most common form of contraception in the United States, used by almost one third of all contraceptive users in the United States, yet it has an alarmingly high rate of failure. When 1000 women use the pill perfectly for one year, only about 3 of those women experience unintended pregnancies. With a year of typical use, however, about 9 in every 100 women experience an unintended pregnancy. The vaginal ring and the patch show similar disparities between perfect and typical use failure rates (Guttmacher, 2014).

Over 40 percent of all unintended pregnancies in the United States result from inconsistent use of contraception. Only 5 percent occur among women who use their birth control consistently and correctly. Many women occasionally forget to take their Pill or do not always take it on time. Sometimes they are unable to get to the pharmacy to start a new pack on time. There are many obstacles to perfect use, and any mistake can be enough to compromise the effectiveness of contraception.

Although these high rates of contraceptive failure are alarming, several safe methods of contraception have extremely low rates of failure, even with typical use. These methods are referred to as Long Acting Reversible Contraception, or LARC. Among the most common LARC are the Intrauterine Device, or IUD, and the Implant. These contraceptives are so effective because once they are in place, women do not have to tend to them or even think about birth control for several years. This virtually eliminates the chance of human error that causes almost half of unintended pregnancies in the U.S. When a woman does not have to take a pill every day or insert a new ring every month, there is a lower chance that she will make a mistake.

With such successful results, it is surprising that only 8 percent of contraceptive users in the United States use LARCs (Guttmacher 2014). The most significant barrier to LARCs is that many women do not know about or understand them. In addition to a lack of information, many women receive incorrect information about LARCs, especially the IUD. Some physicians also refuse to prescribe IUDs to young women based on the false perception that they can be harmful to women who have never had a child. Even when women do choose to use LARCs, they can be prohibitively expensive. For women not using insurance, an IUD can cost up to $1,000.

## The Policy Idea:

In order to promote use of long-acting contraception among young women, policymakers should provide public funding for education and access. Education will help women understand their options and choose a method that best fits their lifestyle, minimizing the chances that they will make a mistake. Funding for access will help women make these decisions based on what will work best, rather than on cost.

## Policy Analysis:

When women understand their options and receive information about all types of contraception, they are able to make healthy and informed decisions. A recent study by David Eisenberg, et al (2012) found a strong positive relationship between knowledge of contraceptive effectiveness and the likelihood of choosing LARCs. Furthermore, 71 percent of women in the study chose LARC after receiving comprehensive contraceptive counseling.

### Talking Points:

- Unintended pregnancies are part of a complex web of societal factors that magnify and perpetuate inequality
- Providing education and access to long-acting contraception drastically reduces unintended pregnancy rates
- Policy makers should embrace long-acting contraception as basic, preventive, and highly effective healthcare.

A recent effort to decrease teen pregnancy in Colorado demonstrates the effectiveness of these long-lasting contraceptives and the power of increasing their accessibility. Since 2009, when an anonymous donor contributed $23 million to a Colorado family planning initiative, the state of Colorado has provided LARC at little or no cost to over 30,000 women. At the 68 participating family planning clinics, the number of young women using LARC increased fourfold. From 2009 to 2013, the teen birth rate in Colorado dropped by 40 percent. The state attributes three quarters of this decline to the initiative to provide young women with LARCs. The drop in teen birth rates generated a ripple effect, leading to lower abortion rates, reduced enrollment in infant nutrition programs, and an overall $42.5 million decrease in spending on healthcare costs related to teen births.

Another project to provide young women with long-acting contraception produced similar results in St. Louis. The five-year project cut the teen pregnancy rate by 79 percent and the abortion rate by 77 percent. In both studies, almost 75 percent of the participants that received comprehensive information about birth control options chose long-acting methods.

LARC is covered with no copay under the Affordable Care Act for anyone with private insurance or Medicaid. A push to increase education about LARC and promote healthy reproductive choices among young women would lead to a decrease in unintended pregnancies and their social and economic costs.

## Next Steps:

The next step is to provide public funding for education and access to long-acting contraception for all women. There is currently a lot of political dialogue surrounding women's and reproductive health. Instead of using resources to block access to reproductive health care services, policy makers should direct these funds toward providing effective, preventive health care such as long-acting contraception.

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# Huntington's Disease

By Matthew Hersman, Major: Biology and Society (A&S '15), Email: mbh85@cornell.edu

*Huntington's Disease (HD) is a debilitating hereditary disorder that leads to the progressive decline of one's physical and mental capabilities. Current legislation used to determine Medicare and Social Security Disability payments are outdated and in major need of reform in order to ensure that those with HD are able to get treatment.*

## Background and Context:

Huntington's Disease is an inherited neurological disorder that impacts approximately 30,000 Americans with over 250,000 at risk for the disease. This devastating disease leads to the complete deterioration of one's physical and mental capabilities. With the onset of symptoms usually starting between the ages of 30 and 50, an individual with HD begins to find difficulty thinking, walking, and even speaking. They will begin experiencing personality swings, impaired judgment, unsteady gait, and a diminished mental capacity. The symptoms of HD patients have been described as a combination of Alzheimer's, Parkinson's disease, and amyotrophic lateral sclerosis (ALS) like symptoms. These symptoms continue to worsen until, eventually, every individual with the disease becomes entirely reliant on others for care. These symptoms persist on average for 10 to 20 years, ultimately leading to death by pneumonia, heart failure, or some other complication. There is currently no cure for HD and research has yet to find a way to slow down the onset of symptoms. Furthermore, if only one parent has Huntington's Disease, there is a 50% chance that it will be passed on to each offspring, and every person who inherits the gene will eventually contract the disease in his or her lifetime.[1]

**Key Facts:**

- HD has been described as a combination of Alzheimer's, Parkinson's Disease, and ALS.
- If one parent has HD there is a 50% chance that it will be passed onto each offspring.
- Everyone who has the gene will contract the disease at some point in their life.

## The Policy Idea:

Present eligibility guidelines to qualify for Medicare and Social Security Disability payments are outdated and harmful to those with the disease. Guidelines for Social Security eligibility only take into account the physical impairments brought by the disease. There is also a current two-year waiting period after being diagnosed with a disease before one is eligible to qualify for Medicare. New legislation is needed in order to direct the commissioner of the Social Security Administration to update the eligibility criteria for those suffering with HD to reflect the most current research on the disease. Furthermore, it is also imperative to remove barriers to accessing Medicare by eliminating the current mandatory two-year waiting period for those with HD.[2]

## Policy Analysis:

Legislative reform is needed so that all those suffering with HD are able to access the treatment they need. Current eligibility guidelines for Social Security Disability payments only take into account the physical, Parkinson's-like symptoms of the disease, when the onset of cognitive deterioration can begin up to a decade prior to any physical symptoms. This criteria is 30 years old and does not reflect the most current research on the disease. This leads to wrongful denials to people with HD and robs them of the help they need. In addition, the current two-year waiting period in order to qualify for Medicare means individuals who are diagnosed with the disease must wait two years before being considered eligible to qualify for Medicare assistance. During these two years of waiting, the individual will find his or her mental and physical capacity steadily decline with no way to treat the symptoms.

Restructuring the guidelines for Social Security Disability is necessary so that those who have been diagnosed with the disease are not wrongfully denied the care they need. Social Security guidelines should be accurate and reflect the fact the most current research on the disease in order to ensure that those with HD are not wrongfully denied from assistance. In addition, providing a waiver to the two-year Medicare waiting period will allow those suffering with HD to receive the treatment when they need it. By waiving the waiting period, indi-

viduals with HD will be able to access the neurologists, psychologists, and prescription drug coverage they need.

The Congressional Budget Office has estimated the costs of these measures to range from $10.5 million to $13 million annually.[3] The United States currently spends roughly $2.8 trillion on healthcare per year[4], meaning approving this legislation would increase healthcare expenditures by a paltry 0.00046%. Overall, this is a low cost legislative reform with the potential for incredible benefits for those affected. These symptoms regularly occur during an individual's working years when disability benefits are most needed. By treating these patients early and effectively, this will allow these individuals to work longer and more productively and will also offset costs due to treating patients in the later stages of the disease. Robbing those of the medical care they need inflicts incredible harm on individuals with HD as well as their loved ones.

## Next Steps:

There is current legislation to help reform the problems with HD eligibility guidelines. While The Huntington's Disease Parity Act is a crucial piece of legislation that has received widespread bipartisan congressional support, the bill has yet to pass. Without widespread advocacy and support this bill is likely to remain untouched. Urging local congressmen and senators to cosponsor and advocate for this bill is the only way it will receive attention.

### Talking Points:

- The HD eligibility criteria for receiving Social Security payments is outdated.
- The two-year waiting period to receive Medicare payments robs HD victims of the care they need.
- Estimated costs total to $10.5 million to $13 million.

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# Wherever, Whenever: Health in the Palm of Your Hand

By Angelica Cullo, Major: Biological Sciences (CALS '16), Email: afc46@cornell.edu

*Access to virtual mental health services has the potential to improve healthcare access, efficiency, and outcomes, however professionals in the field remain in short supply. While a number of states have passed full telemedicine parity laws, many have yet to pass any such legislation, or have passed legislation that significantly limits the viability of telehealth services. States should pass full parity laws for private insurance coverage of telemedicine services.*

## Background and Context:

Even if there were enough psychiatrists to treat all these patients, other obstacles to treatment remain, including travel time and costs, convenience, and stigmas associated with seeking care.[1] Telemedicine (with a particular emphasis here on telepsychiatry) -a method of providing healthcare services through the use of real-time audio-visual technology- has the potential to address these challenges. Since the early 1990's, telepsychiatry has grown significantly in popularity. Insurers, government agencies, and healthcare providers are realizing the attractiveness of telemedicine to improve healthcare access, efficiency, and outcomes. Studies by the U.S. Department of Veterans Affairs have shown telepsychiatry to be as effective as face-to-face treatment and sometimes more efficient in monitoring medications and symptoms due to ease of scheduling, reduction of no-show appointments, and involvement of other caregivers or family members.[2] A number of studies have also showed the same or higher satisfaction rates among patients of telemedicine as compared to traditional face-to-face services.[3]

**Key Facts:**

- There are about 50,000 psychiatrists in the United States. According to the American Psychiatric Association, this is too few to meet the demands for mental health services, particularly in rural areas.[5]
- 57% percent of states received a failing score when the quality of their state-wide telemedical services coverage was assessed.[6]

## The Policy Idea:

State legislatures should pass full parity laws that regulate coverage provided by private insurers. 19 states and the District of Columbia have already enacted full state parity legislation, the remaining states should follow suit. Parity legislation recognizes telemedicine as a viable form of delivering healthcare services that are already covered by insurers and does not expand the services covered. Parity laws mean a consumer and provider can expect comparable coverage and reimbursement for telemedicine and in-person services.

## Policy Analysis:

Sustainable solutions to our nation's healthcare challenges require uniformity in access and quality of care. Often the patients who are at the greatest risk of developing severe or chronic illnesses are the least likely to seek care, in addition to having the least access to care.[4] Access to healthcare services in regions with provider shortages, particularly rural, low-income, minority and elderly and disabled communities are important areas to target healthcare improvement efforts. Traveling time and costs, convenience, emergency situations, and stigmas associated with seeking many healthcare services inhibit these and other populations from seeking adequate care. Although a number of states have partial parity laws which limit insurance coverage telemedicine to certain geographic areas or a pre-determined list of services, full parity laws are an effective way to reach populations that could benefit the most from improved access to services, particularly preventive services. Preventive services like those enabled by telemedicine have been shown to reduce inpatient care stays and high costs associated with hospital care. Maryland estimates net savings of $0.9 million in avoided transportation cost ad $1.6 million in avoided emergency department admissions

Some claim privacy is endangered with expansion of telemedicine services, however, on a secure network, providers and patients can use a standard, built-in webcam on their device or computer. Providers would not use FaceTime or Skype because they do not meet HIPAA standards. That said, in the future FaceTime may be a viable option if WPA2 (Wifi protected access) Enterprise and 128-bit encryption is used over a Wifi connection.

## Next Steps:

State policymakers should introduce the telemedicine parity bill to the state legislature and campaign to pass it into law. Federal politicians and other lawmakers need to advocate for these parity laws in the upcoming presidential election campaigns.

## Taking Points:

- Full legal parity for telemedical insurance coverage will help improve uniformity in access and quality of healthcare.
- Full parity has already been achieved in 19 states and the District of Columbia.
- Nine states and the District of Columbia have laws mandating statewide coverage and reimbursement for telemedicine-provided services under their medicaid programs.
- With the recent changes under the ACA, now is the time to reach audiences that may have not had coverage previously.

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# Tackling the Perennial Paradox: Streamlining Healthcare in the United States

By Frank Sun, Major: Policy Analysis and Management (HumEc '16), Email: fs334@cornell.edu

*As the already steep healthcare costs in the U.S. become steeper without much improvement in quality, it is important to find ways to reduce costs while improving the efficiency and quality of our system. Streamlining healthcare procedures and goods using intensive cost-benefit analysis could be the solution the country needs as it moves forward and tackles the healthcare cost conundrum.*

## Background and Context:

Historically, the United States has been notorious for spending significantly more on healthcare than other western, industrialized countries around the world. Between 2009 and 2010, the United States spent around $8,300 per person on healthcare (both private and public spending), whereas Norway who is ranked second, spent only about $5,300.[4] Japan and New Zealand both spent around one-third as much and countries like Switzerland spent about two-thirds as much. In terms of GDP, healthcare spending in the United States takes up 17.6%, which is nearly twice as much as the OECD percentage and at least one and half times as much as other countries.[4]

**Key Facts:**

- U.S. spends more on healthcare than any other modern, westernized nation (17.6% of GDP).
- Between 2009 and 2010, U.S. spent $8,300 per person on healthcare while second-ranked Norway only spent about $5,300.
- U.S. does worst in many healthcare quality categories than other countries.

At first glance, this seems really great for the United States. More spending must lead to better healthcare outcomes and higher quality treatments. The disturbing truth, however, is that the United States actually does worse in many healthcare quality categories when compared to other western, industrialized countries. Apart from the treatment of cancer, the United States pales in comparison to other countries in areas such as life-expectancy, infant-mortality rates, and primary care. It ranks close to the bottom in these categories. This is the biggest paradox of the United States healthcare system. Why are we spending so much on healthcare when the outcomes are less than favorable compared to countries that spend much less?

The answer cannot be found simply by looking at quantity of services offered. Other countries may offer just as many procedures as the United States, but in this country these healthcare goods and services may be overused and end up costing considerably more. Overuse is a big issue as many physicians and hospitals embrace procedures that do not provide the most cost-effective outcomes. For example, studies have shown that many types of surgical procedures and apparatuses do not actually lead to better outcomes for patients. Many "positive" health outcomes are the result of a placebo effect and could actually be hurting the patient in the long run.[1] A 2002 study done on 180 knee osteoarthritis patients revealed that procedures such as lavage and arthroscopic surgical performed no better than a fake or "sham" surgical procedure.[5] However, procedures such as these are still prevalent in the United States healthcare system and physicians continue to utilize them regardless of their effectiveness.

## The Policy Idea:

As the Patient Protection and Affordable Care Act attempts to tackle the iron triangle of healthcare (cost, quality, access), policy reform needs to look towards streamlining medical goods and procedures. Using cost-benefit analysis and comparing procedures here to those of other western, industrialized countries, the United States must eliminate the subpar procedures and incentivize hospitals and doctors to adapt to utilizing only procedures that have been shown to truly help patients. They need to acknowledge the placebo effect and realize that wasteful overspending becomes an issue when many of these procedures do not actually lead to better outcomes and have patients coming back to hospitals with more costly, follow-up issues. The goal is efficiency and this type of policy reform would get rid of the cycle of wasteful spending that plagues the United States healthcare system today.

## Policy Analysis:

This policy could effectively cut wasteful spending by getting rid of wasteful procedures. For example, even though the 2002 study proved arthroscopic procedures and lavage were not very effective, insurance companies still spent over $3 billion dollars on those procedures in that year.[1] Other less-than-stellar procedures such

as meniscus cartilage repair cost the government and insurance companies about $4 billion dollars per year.[1] These costs do not include the additional follow-up costs that are incurred by patients, hospitals, and insurance companies due to lack of actual health benefits and re-hospitalization of patients. Using a cost-benefit analysis to eradicate weak procedures such as these while retaining the effective procedures could save billions of dollars in costs to patients, insurance companies, and healthcare providers because they would no longer be paying for these faulty procedures and the consequences that follow. A Massachusetts hospital has begun to use one type of knee-implant 75% of the time which has given the hospital bargaining power on pricing and also cut their knee-implant costs in half.[2] This is a prime example of streamlined, effective healthcare at work. In fact, the patients who had knee surgery at this hospital were able to walk much earlier, got off narcotics earlier, and also were able to leave the hospital earlier – this cut costs in many departments other than just the price of the knee implants.

**Talking Points:**

- Cost-effectiveness research is ignored or lacking and overuse of ineffective procedures is rampant.
- Many "positive" health outcomes are the result of a placebo effect and could actually be hurting the patient in the long-run.
- Healthcare providers need to be incentivized to adopt streamlined procedures – malpractice and physician training need to be taken into account.
- Clustering hospital under the same jurisdiction in production-line style healthcare systems could cut costs and increase efficiency and health outcomes.

It is important to take into account the externalities that occur in the other areas of healthcare costs due to cutting wasteful spending and only adopting effective procedures. The increase in hospital bargaining power can help lower costs of medical devices because the hospital and company can enter a relationship where the hospital supplies increased demand only if the company agrees to lower costs. This saves insurance companies, hospitals, and patients money and could lower healthcare costs overtime. Selling more medical devices also helps the government bring in more revenue to fund the ACA through the Medical Device Excise Tax to offset costs of the law and reduce the federal deficit. Streamlining and adapting more cost-effective procedures can strengthen patient-physician relationships and shift liability from physicians to the government. Patients that get better earlier for a lower price will likely see their physician as more trustworthy. This will reduce incentive for physicians to order extra medical tests and procedures and wastefully spend – shifting liability from physicians to a larger entity/authority also incentivizes physicians to not overspend.

## Next Steps:

Next steps that need to be taken center mostly on incentivizing healthcare providers to adapt to streamlined healthcare procedures. This could be done through alleviating growing pains about malpractice so that physicians do not feel they need to always use to most expensive technologies for the best results to avoid getting sued, or designating cost-benefit/cost-effectiveness analysis research to government agencies to study the best medical procedures and medical apparatuses for various conditions. Different liability decisions need to be made so that physicians feel they can trust the procedures they are using with minimal risk. Also, if studies are published in renowned medical journals, physicians are more likely to trust them and adopt the streamlined procedures and technologies – studies should also show evidence of cost deductions.

Another step that could cut costs through streamlining procedures would be the creation of widespread production-line style healthcare. It would cut wasteful spending by putting certain clusters of hospitals under the same jurisdiction so that they can adopt the same types of technology, treatments, and medical devices that deliver the best results at a modest cost. Training programs need to be offered for physicians so they can work together and adapt to the new healthcare system requirements and quality variables for the systems should be monitored for all hospitals under the jurisdiction of the healthcare system in order to a create a dynamic system that aims for continued improvement. Hospitals in some areas of the country have already adopted a system similar to this and results have been positive overall.[3] The creation of these production-line style healthcare systems should aim to deliver the best quality care at the lowest cost – it reduces the amount of spread out hospitals with hundreds of physicians using their own expensive procedures and medical devices which many not even deliver the best outcomes.

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# A Solution to Uncompensated Care in Emergency Rooms

By Phil Susser, Major: Policy Analysis and Management (HumEc '16), Email: pss226@cornell.edu

*A significant portion of the inefficiencies of today's healthcare delivery system can be attributed to uncompensated care. Because of the high volume of emergency room visits by homeless individuals — that goes unpaid — increased responsibility for social workers in managing the chronic homeless upon emergency room admission could diminish these costs.*

## Background and Context:

Uncompensated care is healthcare provided by physicians or hospitals that does not get reimbursed. Often times due to lack of insurance and inability to pay, uncompensated care is an issue that has been targeted by the Affordable Care Act (ACA); an aspect of the legislation has created incentives for individuals to insure themselves through the individual mandate. In 2013, the cost of uncompensated care was $84.9 billion. Much of the funding for uncompensated care comes from Medicaid, Medicare and other government programs. Often times, the emergency room is the first place the uninsured go to for care. The 1986 Emergency Medical Treatment and Active Labor (EMTALA) Act made it illegal to deny healthcare in the emergency room based on ability to pay, making it a safety net for the uninsured. This bill intended to eliminate "patient dumping" or the relocation of undesirable patients based on ability to pay, citizenship, and other characteristics. But, it has simultaneously had the effect of increasing the load of patients that emergency rooms face, and arguably created moral hazard — the phenomenon of making riskier health decisions when insured — for the uninsured. In 2010, there were 129.8 million emergency room visits, up from the 90 million visits in 1990. The homeless on average visit the emergency room five times a year.

**Key Facts:**

- In 2013, the cost of uncompensated care was $84.9 billion.
- In 2010, there were 129.8 million emergency room visits, up from the 90 million visits in 1990.
- The homeless on average visit the emergency room five times a year.
- The most chronic users of the emergency department are costing hospitals as much as $44,400 per year.

## The Policy Idea:

The EMTALA has made the emergency room a safety net for not only hospital care, but shelter as well. A more integrated approach, between social workers and doctors in the treatment of the homeless, would shoulder some of the costs of treating this population and help in discouraging the use of the hospital emergency room as a form of shelter. Mandated protocol in the treatment of homeless individuals repeatedly using the emergency room should require physicians to collaborate with social workers in helping to provide shelter, drug and alcohol abuse treatment, and mental health treatment if applicable.

## Policy Analysis:

Integrated care for the homeless could be beneficial considering that homelessness is as much a health issue as it is a personal issue and a social issue. Therefore, in treating a homeless patient who is seemingly overusing emergency room care, hospitals can both reduce costs and improve the long-term well being of the individual. The most chronic users of the emergency department are costing hospitals as much as $44,400 per year; on average a homeless individual will use the emergency room four times as often as a non-homeless individual; there is significant room for cost savings. Since alcohol usage is a strong predictor of emergency room usage for homeless individuals, targeting this preventable source of admission through an increased role of social workers could diminish costs. 11% of the $223.5 billion in costs associated with excessive alcohol consumption comes from hospital costs, so targeting the alcohol consumption of the chronic homeless is a step towards reducing this staggering statistic. Because the homeless are more likely to utilize ambulance services, as they often do not have other forms of transportation to the emergency room, divorcing the alcohol dependent chronic homeless with the emergency room and redirecting them to alcohol treatment centers with an increased role for social workers could be advantageous.

## Next Steps:

Local hospitals should identify the most frequent users of the emergency department. In the future, hospital social workers should make increased efforts to motivate these individuals to seek treatment for preventable health issues, such as alcohol dependency. With great incentives for healthcare providers and hospitals to utilize electronic health records, the medical history of these patients can be tracked across hospitals. A coordinated effort then, between social workers, as a "case manager" of sorts, would add a new, beneficial dimension to the treatment of the homeless.

## Talking Points:

- Hospital treatment for excessive alcohol consumption is costing significant sums of money.
- Because the homeless are often chronic users of the emergency department, addressing their usage of such services is important to solve a public health issue and reduce costs.
- If social workers had a more integrated role within the hospital in managing the cases of homeless patients, or any chronic emergency room patients, then greater well being for these individuals can be achieved and certain costs can be avoided.

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# Showing Mercy to the Terminally Ill: Legalizing Physician-Assisted Suicide

By Emma Sahn, Major: Economics (A&S '17), Email: ebs94@cornell.edu

*Physician-assisted suicide and euthanasia are two intertwined and sensitive topics that generate much attention. Physician-assisted suicide is legal in very few places around the world, and euthanasia even less so. New York State should implement a policy that legalizes both end-of-life methods to cease the suffering of terminally ill patients.*

## Background and Context:

The ethicality and legality of physician-assisted suicide has long been debated, with incidents surrounding the issue still occurring today. The case of Karen Ann Quinlan in 1975 marked the beginning of the debate: Karen fell into a coma after drinking large amounts of alcohol along with taking prescription drugs and there was no hope for her recovery. Her parents requested to remove the ventilator that was allowing Karen to breathe, but the doctors treating her refused. After taking the matter to the New Jersey Supreme Court, Karen's parents won their fight and were allowed to take their daughter off of life-support.[1]

Currently, only five states in the U.S. claim physician-assisted suicide to be legal[2], and for many living in other states where it is not legal, this law can cause a great deal of pain and suffering for those who are terminally ill or unresponsive (i.e., in a coma). This issue is very difficult to address because of the amount of legal, ethical, and moral complexities surrounding it: some believe it is unethical to end someone's life while others believe that it is wrong to let someone suffer when you could easily put them out of their misery. Although most states do proclaim physician-assisted suicide to be illegal, New York State should change its policy on the matter to be more like Oregon, Montana, Vermont, New Mexico, and Washington, the five states who have legalized it.

**Key Facts:**

- 73% of physicians working in a cancer center said that physician-assisted suicide should be legal.[6]
- 65% of physicians working in a cancer center said that physician assisted-suicide should be legal.[6]
- Euthanasia is only legal in the Netherlands, Belgium, and Luxembourg.[7]

## The Policy Idea:

My policy addresses the issues of competency and passive versus active assisted suicide in New York State. It will allow people to end their lives if they wish to be put out of misery, and will help the families of loved ones move on and say goodbye in a better state. This policy will also allow those who are incompetent to have an approved and trusted substitute person to make their end-of -life decisions for them. As for the line between passive and active assisted suicide, this policy will make euthanasia legal, but not without serious qualifications, rules, and consequences for breaking these rules.

## Policy Analysis:

In New York State, it is currently illegal to assist someone in committing suicide. In fact, it is considered a statutory offense to commit physician-assisted suicide, and assisted suicide falls under second-degree manslaughter, while administering euthanasia is considered second-degree murder.[3] New York and Missouri are also the only two states that require evidence directly from the patient about their wishes to withdraw treatment – in other states, this responsibility is given to the healthcare proxy, whose judgment is trusted, especially when the patient is unresponsive.[3]

While New York has a very strict and limiting set of laws, there are some states in the U.S. that provide the option of physician-assisted suicide. Currently, Vermont, Washington and Oregon all have Death With Dignity laws, which involve a strict set of requirements for qualifying for assisted suicide. However, it is possible that the rules are not taken seriously enough – one study suggests that the mental health evaluations of the patients are insufficient, the assessment of other options is weak, and the concerns that the six-month prognosis for the patient is inaccurate.[4]

In the Netherlands, where euthanasia is legal, a study was done to monitor the effects of the legalization

of euthanasia. The results showed that, whereas before only 18% of cases of euthanasia were reported, 80% were reported after euthanasia became legal. This shows that physicians trust the system and are being more honest. More importantly, the study found no evidence of the legalization resulting in an abuse of euthanasia.[5] Therefore, enacting a similar policy in New York and improving upon other states' current policies could make a huge difference for those wishing to end their life for medical reasons.

**Talking Points:**

- Many people suffering from painful illnesses are unable to be granted a peaceful death.
- Current legislation concerning physician-assisted suicide in a few states is inadequate and needs to expand to other states.
- Euthanasia is shown to have positive effects – it is important to spread awareness about the benefits of euthanasia.[5]

## Next Steps:

The next step is to get in touch with the Death With Dignity organization to begin the process of enacting legislation in New York to ultimately allow terminally ill patients to request prescriptions if they wish to end their life more quickly and peacefully. Beyond that, legislative action must be taken to legalize euthanasia in New York State. Because people are generally less inclined to allow euthanasia than they are more passive measures of assisted suicide, a lot of the work will have to be in convincing people with evidence of the benefits of euthanasia.

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# Nationwide Soda Taxes: The 50-State Battle Against the Obesity Epidemic

By Madison Cripps, Major: Policy Analysis and Management (HumEc '17), Email: mac499@cornell.edu

*In order to fully counter the continuation of the obesity epidemic, a nationwide soda tax must be implemented – a difficult task, exacerbated by citizens' lacking knowledge and the soft drink industry's well-funded and oppositional agenda.*

## Background and Context:

Obesity has rapidly become the leading cause of death in the United States, with two in three adults and one in three children considered overweight or obese.[1,2] In addition, childhood obesity has tripled over the last four decades. With such a large proportion of the population suffering from obesity related illnesses, the U.S. federal government – which has an annual expenditure of $190 billion towards treatment of these conditions – is burdened by these costly (and largely preventable) medical expenses.[1]

**Key Facts:**

- Sugar-sweetened beverages account for 15% of all children's caloric intake.[4]
- The U.S. spends $190 billion annually treating obesity related conditions.[1]
- Researchers estimate that an SSB tax would decrease soda consumption by about 10% – thus, decreasing government healthcare spending on obesity.[6]

As obesity rates rise, so does consumption of sugar-sweetened beverages (SSBs). Research examining beverage consumption trends in the mid-2000s suggests that SSBs are a top source of calories for many Americans – nearly 25% of adults and 70% of children consume at least one SSB per day.[3] Consequently, the New England Journal of Medicine deemed soda consumption the single, biggest contributor to the obesity epidemic.[4] Thus, soda taxes are often considered an economically sound, potential solution to this dire public health dilemma.[5]

The controversy surrounding taxes on SSBs received much attention following former New York City Mayor Michael Bloomberg's attempt to ban soft drinks which were 16 ounces or larger.[6] In spite of numerous potential health benefits, Mr. Bloomberg's plan was both harshly criticized by enraged New Yorkers, who feared that the tax infringed upon their freedom of choice, and strongly opposed by the beverage industry, which aimed to protect itself against profit loss by allocating millions of dollars towards anti-tax lobbyists.[7] Ultimately – in a manner reflective of nearly all soda tax proposals across the country – Bloomberg's plan failed as a result of this forceful and well-funded resistance.

Nonetheless, Berkeley, California recently became the first U.S. city to adopt a soda tax. With support and a hefty financial contribution from Bloomberg, the Berkeley soda tax initiative successfully defeated the beverage industry's tax opposition, as more than 75 percent of Berkeley voters approved "Measure D" – a one-cent tax-per-ounce on sugary drinks.[8] Still, the lack of uniformity in tax acceptance throughout the U.S. is cause for concern, considering the extent to which American citizens throughout all 50 states continue to suffer from obesity.

## The Policy Idea:

The policy addresses the impact SSBs have on the already high and quickly rising obesity rate in the US. A one-cent tax per-ounce on sodas, sports drinks, and sugary juices will help to greatly reduce the consumption of these beverages. The policy will also incentivize both healthy eating and the purchase of fresh produce, as opposed to unhealthy and fattening foods.

## Policy Analysis:

A total of 34 states and Washington, D.C. currently include soft drinks among the items for which normal sales taxes apply.[3] Under this system, however, high obesity rates persist, as soda consumption remains unaffected by these marginal sales taxes. Instead, SSBs should face separate, per-ounce tax rates, similar to those enacted in Berkeley.

A number of studies have been conducted analyzing the efficacy of soda tax implementation, and the resulting data serves as undeniable support for the positive outcomes these taxes provide. Using Berkeley's one-cent tax-per-ounce model, a group of researchers and scientists from San Francisco General Hospital (SFGH), the University of California, San Francisco (UCSF), and Columbia University designed a study measuring the

estimated effect of a nationwide tax on SSBs. The results suggested large gains in the realm of public health, including the prevention of 240,000 cases of diabetes per year.[9] Along with decreased occurrences of obesity-related conditions, a nationwide soda tax would also increase tax revenue. In their study of a 3-cent per 12-ounce national tax, the Congressional Budget Office estimated an increase of $24 billion over the course of four years, which could ultimately go towards Medicaid funding.[3,4] Considering these facts, implementing a tax on SSBs will result in improvements in public health as well as increases in government funding, both of which are imperative gains in the fight against obesity.

## Next Steps:

A data analysis generated by the Bureau of Labor Statistics examines the ways in which shifts in the relative prices of healthy and unhealthy foods contribute to the America's obesity epidemic. Over the past 30 years, the cost of fresh produce has increased by 50%, while soda and fattening foods have become increasingly inexpensive. In reality, the proposed soda tax would strike back against this price gap and incentivize healthy eating, leaving those previously unable to afford fresh produce better off.[4] In spite of this clear health benefit for lower-income individuals, the beverage industry strives to maintain its customer base by funding ads meant to scare less well-educated and lower income families into the false belief that the soda tax's "regressive" nature will ultimately harm them.[6]

**Talking Points:**

- Legislation must be enacted nationwide in order to stop the public health declines and government health care spending increases resulting from the obesity epidemic.
- Research provides remarkable evidence and support for the benefits of taxing SSBs.
- The beverage industry has spent $117 million opposing taxes nationally since 2009, wrongfully convincing individuals that they are better off without a soda tax. So, despite the clear health benefits soda taxes provide, it will be difficult to gain SSB tax support.[6]

In order to make substantial strides in decreasing the obesity rate through soda taxes, such a tax must be implemented in each of the 50 states and Washington, D.C. SSB tax proposals must first receive majority support, which is difficult considering the persuasive, multibillion-dollar soft drink industry's agenda. With the urgent need to enact a policy that effectively curbs the obesity epidemic, public health officials and tax advocates need to organize a pro-tax campaign, which would efficiently spread information regarding the taxes' positive health and financial benefits to misinformed American citizens.

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# Redefining Health Interventions: Applying Social Impact Bonds to Diabetes

By Charles Paton, Major: Policy Analysis and Management (HumEc '17), Email: cap294@cornell.edu

*Preventative healthcare has received bipartisan support as a cost effective alternative to improve health outcomes. Social improvement bonds, a form of preventative healthcare, harness the benefits of the competitive market as a way to create innovative interventions for preventable diseases. The federal government should pass legislation to provide stability and money guarantees to social entrepreneurs who partake in the development of health interventions, specifically with regard to obesity and diabetes.*

## Background and Context:

Obesity and diabetes are two public health issues that have been gaining significant attention, both domestically and internationally, over the past few decades. Obesity is a condition caused by various genetic and environmental factors and is typically associated with excess fat accumulation.[1] Obesity increases risks of developing other risky health conditions, such as atherosclerosis and diabetes. Diabetes is a metabolic condition in which the body is unable to produce adequate levels of insulin.[2] Similarly, diabetes can lead to more serious complications such as kidney failure and vision problems.

Over the last 30 years, obesity has more than doubled in children and quadrupled in adolescents.[3] Diabetes on the other hand has increased six-fold from 1958 to 2010.[4] Aside from the individual risks associated with these two diseases, the healthcare costs associated with treating the increasing number of people with the two diseases has skyrocketed. The labor-intensive surgeries that have been developed as alternatives to exercise and diet have generated substantial moral hazard among individuals. National health expenditures totaled $2,915 billion in 2013, roughly a $500 billion increase from 2008, and are projected to continue to grow at an average rate of 5.8% through 2022.[5] Although not the only contributor to these cost increases, obesity-related costs have caused a modest spike in these costs. These expenditure increases are especially noteworthy among the elderly, whose healthcare costs are covered by Medicare, a publicly funded health insurance program. Despite the economic recession, Medicare spending increased at a rate of 9.4% from 2000 to 2009.[6] Experts now estimate that the average recipient will take more money out of the program than he/she ever paid in, creating the current unsustainable nature of the program. Without immediate reform to these programs, Medicare especially, we will continue to see unreasonable spikes in expenditures and, eventually, insolvency.

Although a lot of public attention has focused on direct reform to the programs in question, various preventative solutions also exist to combat the underlying conditions before they develop. Preventative healthcare consists of the steps to keep a patient healthy, rather than caring for them once they are sick. The Patient Protection and Affordable Care Act took one step toward preventative healthcare by putting in place the individual mandate, a requirement that everyone purchase health insurance. Individuals with health insurance are much more likely to engage in check-up visits, physical examinations, and preventative screening than individuals who do not. Thus, costs are front loaded and tend to be reduced over the long-run. Cost savings usually increase with the length of time the program is in place. Recent success by various pilot programs around the world has raised much question about the efficacy of preventative programs for health outcomes, specifically diabetes. This paper proposes the use of social improvement bonds, a type of preventative program, to reduce the incidence of obesity and diabetes.

## The Policy Idea:

A Social Improvement Bond (SIB) is a contract between the private and public sectors in order to improve a social issue. The goal of the SIB is to save the public sector money by reducing spending on an issue through an intervention program. The savings realized by the government are then shared with the firm that implemented the successful program. If no savings are realized as a result of the intervention, then the private firm must cover all the costs of the intervention. In this way, SIBs encourage innovative solutions to some of the nations pressing issues but also require research and evaluation of the proposed intervention. The risk associated with the SIB forces firms to be realistic in their analysis of the program, because if it fails, they might have to cover all the costs on their own. Although the risks of the interventions could be quite large, the profits for the firm could be even larger. The interventions also exhibit economies of scale; in that, companies with successful

interventions could easily expand their programs to new regions with less risk and capital. The federal government would be able to capitalize on the cost savings as a result of the monetary difference between the expected payoffs with and without the intervention.

Applied to healthcare, SIBs should be used to improve health outcomes by incentivizing programs to reduce the incidence of obesity and diabetes, particularly among youth. The specifications of these programs would be left up to the private companies to determine; however, the federal government would need to establish a set of procedures and criteria for determining which programs would qualify for bonds, how much funding they would qualify for, how the program will be evaluated, how long the program will be evaluated, and how much a firm will receive for a successful program. The federal government should also consider leveraging some of the risk for the company. Since SIBs are new and somewhat risky, government support could encourage weary investors to implement a potentially highly effective program. After a few successful programs are implemented and investors are comfortable applying for SIBs, the government can downsize its role in the process, leaving all the risks and rewards to the entrepreneurs.

## Policy Analysis:

The first consideration in the implementation of this policy is the political environment. Even the best policy idea would be lost if it was submitted to a hostile legislative house or, taking into consideration our current administration, a house with strong partisan gridlock. However, a cursory analysis of some of the advocates of SIBs indicates that it may be politically viable. Senator Ted Cruz (R-TX) and Senator Al Franken (D-MN) are two unlikely colleagues in the promotion of the idea. Many other representatives from the two major political parties join them in support of preventative health interventions. Private firms, such as Goldman Sachs, have even gone so far as to implement recidivism SIBs in states with legislation. It appears other firms, both non-profit and for-profit, would be interested in expanded opportunities for investment. To conclude, both the political environment and availability of a target market suggest that the implementation of SIBs to reduce diabetes and obesity is feasible.

The next consideration is the cost-effectiveness of SIB's for healthcare interventions. A major benefit for SIB legislation is that it poses very little risk to the government. Private firms that are not successful in meeting the criteria specified by the proposal will not receive any return on their investment. Therefore, the government will not lose any money from the endeavor. Alternatively, the outlays from the federal government for programs that are successful would be slightly less than the savings on healthcare spending further down the road. Thus, regardless of the outcome, the federal government benefits from the implementation of the policy. The most difficult part of the whole procedure would be establishing a fair but sustainable protocol for dealing with proposals and outcomes. The federal government would need to establish a department that would evaluate the efficacy of each intervention to determine whether it will qualify for a bond.

## Next Steps:

Given the turnover as a result of the most recent election and the limited time before recess, it is unlikely that comprehensive and effective legislation for obesity and diabetes SIBs will be passed before the end of 2014. However, immediate conversations about important components of the legislation are critical. This will enable government officials and special interest groups to ponder and investigate various elements they would like to see incorporated.

**Talking Points:**

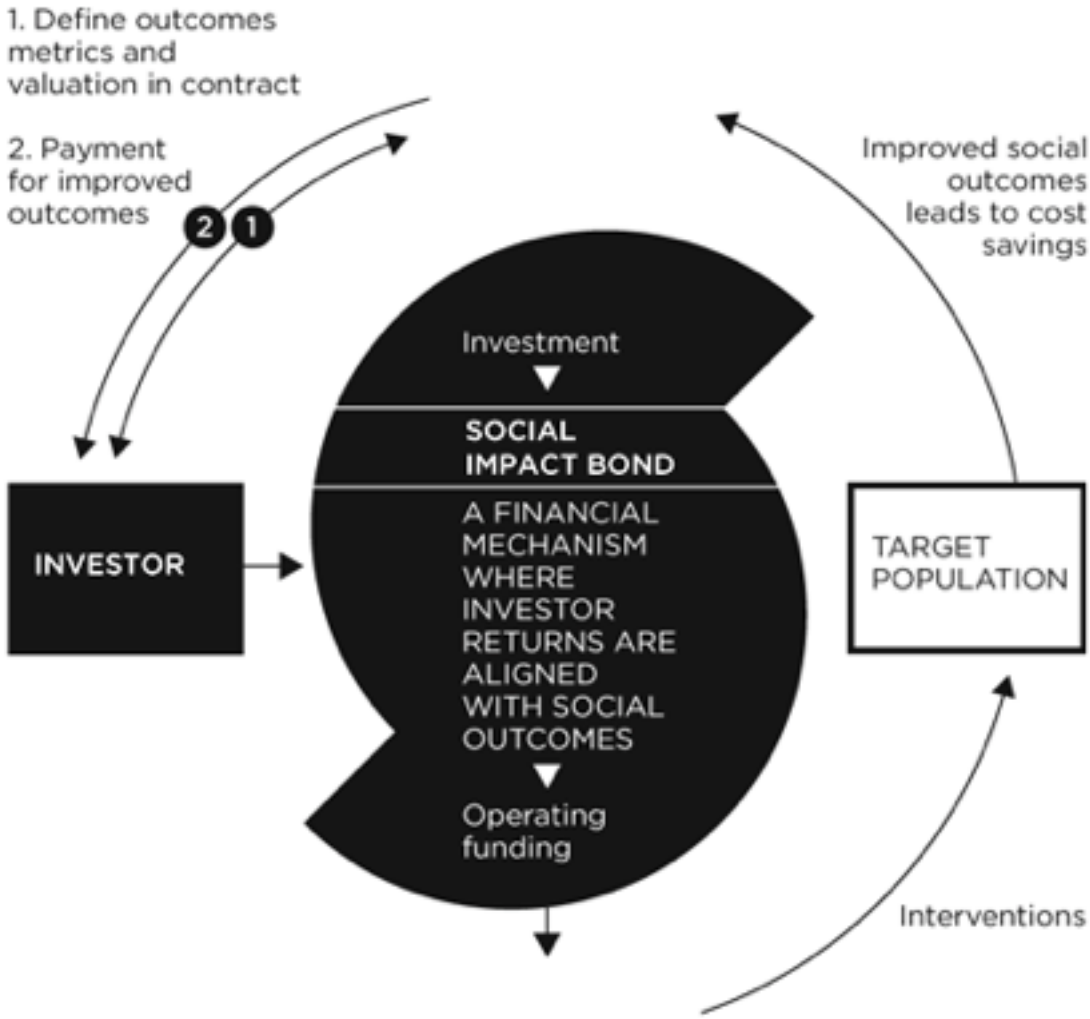
- Healthcare spending is growing at an unsustainable rate – part of the problem is the emphasis on novel but expensive curative procedures.
- Social improvement bonds shift the focus from treatment to prevention.
- SIBs, and their subsequent interventions, provide direct benefits in the form of healthcare cost savings as well as substantial positive externalities.
- SIBs have bipartisan support in Congress.
- SIBs present very little risk for the federal government; they only cover the cost of successful programs and share a portion of the cost savings with the firm – therefore, there are no real expenditures.
- SIBs encourage innovation and competition among firms to garner profits from the current inefficiencies in the prevention market.

Congress should also look to its laboratories of democracy to determine which factors have proven most

effective in crafting successful legislation. It should also look to other countries, such as the United Kingdom where SIBs originated, to see how they structured their legislation. Although this will provide a good foundation for a bill, Congress should tailor its findings to meet the geographic and demographic demands of our current population as well as the financial demands of our strained health systems.

**Key Facts:**

- In 2012, more than one third of all children and adolescents were obese.
- Roughly 33% of adults in 2012 had pre-diabetes conditions.
- National health expenditures in 2012 totaled $2,807 billion.
- 75% of spending in the U.S. goes to treatment of chronic conditions.
- For every dollar spent on healthcare, only about 4 cents goes toward public health and prevention.

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# How Do We Get The Most Bang For Our Buck? The PCMH Mandate

By Adrian Jones, Major: Policy Analysis and Management (HumEc '17), Email: atj25@cornell.edu

*Rising healthcare costs have initiated healthcare reform in the U.S through the largest piece of legislation in recent years, the Affordable Care Act (ACA). As a nation, we spend the most on healthcare, yet access to it is not widespread. The Patient-Centered Medical Home is becoming a more popular option for cost-effectively delivering care, and a similar model is being used for Medicare recipients. Further, a Patient-Centered Medical Home mandate for all healthcare recipients would decrease overall costs and provide the quality healthcare the ACA aims to provide.*[1]

## Background and Context:

**Key Facts:**

- Reports find that if every American had a medical home, healthcare costs would decrease by 5.6%, which approximately saves the U.S government $67 billion per year in healthcare.[6]
- A survey of 28,230 adults around the country found that minority patients receive better managed care of chronic diseases and critical preventative care when they are in a PCMH.[6]
- The number of PCMHs around the country is growing. Each month about 150 practices apply for NCQA recognition.
- About 27,000 clinicians and 5,700 sites have NCQA recognition.

While the U.S currently spends more than $2.9 trillion on healthcare annually, 54 million Americans are uninsured. These rising costs of healthcare sparked the nation's need for healthcare reform. The 2010 Patient Protection and Affordable Care Act (ACA) primarily sought to solve this issue by expanding healthcare coverage to all U.S citizens by providing quality, affordable healthcare to all Americans hoping that more insured individuals would result in less costs overall.[2] So, how do we get the most bang for our buck? One way is the Patient-Centered Medical Home (PCMH), a "team-based" model of delivering care throughout a patient's life as one method for reform. The PCMH is led by a personal physician that is responsible for providing continuous and coordinated care to patients by working with a team of professionals (a nurse, medical assistant, health educator, specialist, etc.) for personalized healthcare delivery.1 This coordination will maximize health outcomes by reducing errors (false-positives, over-provision, duplicate testing, conflicting medication, etc.) caused by fragmented care. The ACA includes PCMH programs as a part of authorized primary care extension programs but does not fund it.

The ACA uses a similar, centralized approach for Medicare recipients through Accountability Cost Organizations (ACO) and Clinical Integration (CI).[2] The major difference is that ACO's providers are eligible for financial incentives to treat patients.[3] However, I propose that patient-centered medical homes be mandated for all healthcare recipients. This way coordinated and personalized care is aimed at all citizens receiving care rather than the elderly Medicare recipients. ACO and CI techniques have been tested and proven through the Medicare program, but now it's time to expand coordinate care to all patients. A PCMH would give the continuous care the ACO's and CI's provides but also would create a personalized component of the home.[4]

Patient-centered medical homes already have a method of evaluation through a national clearinghouse system called the National Committee for Quality Assurance (NCQA). The NCQA sets national standards for ensuring the quality of each PCMH based on the latest data.

Not only has recent literature shown that PCMH's better health outcomes and are cost-effective, but reports are finding that PCMH can reduce racial and ethnic disparities.[5] With new medical school goals changing to ensure socially aware and culturally sensitive healthcare providers, the PCMH can facilitate better patient-provider relationships.

## The Policy Idea:

My idea is the PCMH mandate will completely reshape the delivery of healthcare in the U.S because it will require all Americans to have one center, a patient-centered medical home, that coordinates care from all their service providers. The research around patient-centered medical homes proves that care can be succinct, patients can have a closer relationship with their doctors, and at the same time reduce overall healthcare costs. Being that we spend so much money on healthcare, the PCMH mandate will go along with the Affordable Care Act's goals of increasing quality, and reducing over costs.

## Policy Analysis:

A PCMH mandate would require that all citizens receiving healthcare be a part of a patient-centered medical home for coordinated and personalized care. This mandate would effectively increase the workflow of healthcare professionals and maximize healthcare outcomes. It is unique because it empowers patients to make healthcare decisions alongside their providers.

The PCMH mandate would require a patient's healthcare providers to work together in a succinct manner and would still give patients the flexibility of provider choice in their PCMH. Legislation mandating PCMH's for primary care health recipients is needed in order to get a head start on improving care and decreasing costs in healthcare in the long-term. Research points that cooperation amongst healthcare providers and communication with patients will yield the best care possible. We can assure the quality of PCMH's with NCQA standards and recognition given to patient-medical homes based on their quality.

Although, patient-centered medical homes are still relatively new, Mega-analysis studies have even shown improved overall experiences for patients. Results of these studies show promise for improving the way healthcare is delivered in the U.S, decreasing the total healthcare spending, and still provide top-notch care to consumers.

**Talking Points:**

- The ACA's individual mandate means that there will be more insured patients needing the attention of primary care physicians. PCMH's provide a "team" of providers that include nurses, specialists, etc., so a patient's care will be coordinated amongst all players, including the patient.
- Patients will have personalized care and the opportunity to make healthcare decisions alongside their doctors, making PCMH's more unique than ACOs and CIs.

## Next Steps:

Moving forward with the PCMH mandate will not be easy because it would require federal legislation in order to be effective. The PCMH will need initial federal funding to get started.

However, the political environment in Congress after this year's midterm election is now majority Republican in both chambers. Republicans opposed many parts of the Affordable Care Act, including the "individual mandate" that requires all Americans to enroll in a health insurance plan or otherwise pay a penalty fee. GOP members are actually still in the process of repealing parts of the ACA, will unlikely vote to add additional "mandates" to the healthcare reform law.

With that being said, the PCMH mandate will require President Obama to use executive action and may require him to use his bully pulpit in order to shape public opinion to favor the PCMH mandate.

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# Healthcare Improvements: Electronic Health Records

By Alexander Gomez, Major: Policy Analysis and Management (HumEc '17), Email: akg67@cornell.edu

*The United States has yet to successfully implement widespread electronic health record systems. Government incentives have improved the situation, but more must be done to ensure widespread coverage and sustainability.*

## Background and Context:

In a country that prides itself in medical and technological advancement, certain components of the United States' healthcare system are blatantly archaic. One such component is medical records. Paper-based records are the norm in the United States. Medical professionals create record by hand and store them locally. This creates a disconnect between medical services; emergency medical technicians on an ambulance do not have direct access to records and have to base their procedures on minimal information and doctors at other hospitals and thus must wait for the record to be sent to them before they can get a patient's full medical history.[1] Despite recording systems with computerized provider order entry being available for more that thirty years, less than 10% of hospitals use a completely electronic integrated system.[2] This is due largely in part to privacy concerns, additional costs, and technological worries. Although there have been security breaches, they are associated with the transition to new technology and are comparable to the exposure that current record systems have.[3] In fact, on average, approximately 600,000 people have access to individual paper-based records (such as medical professionals, insurers, etc.).[4] Other factors such as costs for training and implementation are inherent aspects of an evolving system and are necessary to bring about future technology. However, the benefits of electronic health records, namely complete and accurate information that allows for better care, outweigh the costs. Experts realize this, and in many places, such as New Jersey, the government is encouraging the implementation of electronic medical records through incentive programs created by the American Recovery and Reinvestment Act of 2009.[5]

## The Policy Idea:

The American Recovery and Reinvestment Act of 2009 offers incentives to healthcare providers to begin the use of electronic health records. However, the policy does not reach enough providers to create a national, collaborative network. In order to achieve this, an economically efficient policy must be created that is cost-efficient, sustainable, and far reaching. All healthcare facilities, including nursing homes, must be included and government funding must be allocated to helping them to implement electronic health records.

## Policy Analysis:

The American Recovery and Reinvestment Act of 2009 also included The Health Information Technology for Economic and Clinical Health Act (HITECH). The purpose of the HITCH Act is to provide the U.S Department of Health and Human Services with the power to create programs that improve healthcare, quality, safety, and efficiency through information technology.[5] The act allows healthcare professionals and hospitals to receive incentive payments when they implement HER technology and meet a set of "Meaningful Use" objectives. Since the adoption of the law in 2009, the number of hospitals with a basic electronic health record system increased from 9% to 44%. However, there are worries about whether or not hospitals are using these systems to actively exchange data. In order for the full benefits of the system to come to fruition, peer-to-peer interaction must increase. The issue of funding also comes into question. Many systems are not sustainable and dependent on the money that comes from the incentive system. Finally, coverage to a wider range of healthcare centers is necessary. Nursing homes, rehabilitation centers, and mental health providers and facilities are left out from funding and do not have the means to provide their own systems.[1]

**Key Facts:**

- In 2012, 44% of U.S. hospitals had at least a basic electronic health record.
- Nearly 30% of U.S. hospitals are exchanging clinical data with non-affiliated providers using these HIEs.
- Approximately 10% of ambulatory care practices in the U.S. are exchanging clinical data using these HIEs.

## Next Steps:

Despite gains made under the original Health Information Technology for Economic and Clinical Health Act, more work has to be done in order to achieve the national network of health records that would allow for better care. The types of healthcare practices offered subsidies/incentives must be increased, funding must be improved, and collaboration must be encouraged. In order to do this, legislation would have to be revised. In the current political climate, asking for an increase in funding may be unfeasible. However, to be successful, the separate parties must mobilize and bipartisan support must be achieved. To do this, informational campaigns with emphasis on successful centralized electronic health records in other countries should be conducted. With increased education, constituents may begin to see the merit of these systems and convince their representation to pursue the allocation of funds. As time progresses and technology improves, electronic health records will also become more intuitive and hopefully more sustainable. Decreases in cost may occur, as the system becomes more of a staple. Alternatively, the government could seek to contract out the design of a federal system, which could be built on freeware.

**Talking Points:**

- Although slowly improving, the current state of electronic health record systems is unacceptable for a 21st Century approach to medicine.
- Government incentives are helping to transition medical professionals into modern day record keeping. However, incentives do not cover the all professionals in the industry.
- In order to improve sustainable design must be implemented and funding increased, as well as emphasizing collaborative interaction.

## Endnotes:


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# Increasing the Role of Free Clinics: Liability in High-Risk Judgment

By Allen Chen, Major: Policy Analysis and Management (HumEc '18), Email: azc5@cornell.edu

*Nationally, free clinics suffer from the inability to fully serve their patients due to the potential for liability coupled with the increase in lawsuits against medical practitioners. The federal government should implement a safety net that will shoulder the costs of potential lawsuits against free clinics so that free clinics can increase their scope and quality of care. Please specify what you mean by the term "safety net." Will it be in the form of guaranteed legal protections? Subsidies? Other incentives?*

## Background and Context:

An estimated 31 million Americans will be uninsured by 2024 despite the passing of the Affordable Care Act, due to barriers such as language, citizenship status, income, and uncooperative physicians. Cite sources. A free clinic is a healthcare facility in the United States offering services to economically disadvantaged individuals for free or at a nominal cost.

Free clinics face the constant problem of shortage of funds and overflow of patients that sometimes have conditions or diseases that free clinics are unable to treat because of the aforementioned factors and liability. The average settlement for a malpractice suit is between $400,000 and $800,000. The average budget for a free clinic in Michigan is $190,000. One mistake, misdiagnosis, or wrongful prescription can lead to the closure of a free clinic due to legal costs. As a result, free clinics have began to shy away from providing comprehensive care and closing its doors on patients with serious conditions that require risky assessment. Most users of free clinics are homeless, low income, new immigrants, and/or physically, mentally, language impaired individuals.

## The Policy Idea:

The U.S. federal government should implement discounted or subsidized malpractice insurance for free clinics. Free clinics will receive assurance from state and federal governments that they will be protected if they need to engage in risky practices.

## Policy Analysis:

**Key Facts:**

- 31 million Americans will still be uninsured by 2024.
- Average malpractice settlement is between $400,000 and $800,000.
- Average budget of a free clinic in Michigan is $190,000.

While the Affordable Care Act has increased access to high quality medical care for millions of Americans, millions more are still uninsured because of barriers to entry. Free clinics receive funding from local governments as well as pharmaceutical and lab companies through subsidized medication. It is now time for the federal and state governments to provide support through the provision of malpractice insurance.

Other than the implementation of malpractice insurance for free clinics, there must be outreach campaigns for hospitals to attract doctors that had been deterred from volunteering due to the fear of losing their licenses. Additionally, lobbyists must make an effort to convince legislatures to support this policy because it is an admittance of defeat for the Affordable Care Act and other healthcare reform bills. The continual lack of support for free clinics means that uninsured individuals will continue to use the nation's most expensive form of treatment -- emergency rooms -- instead of seeking preventative care and treatment before it is too late.

## Next Steps:

**Talking Points:**

- As the number of uninsured individuals continues to persist, the time is now for the federal and state governments to look at alternatives to the Affordable Care Act.
- Public health officials, researchers and professors, and pharmaceutical companies support free clinics.
- Free clinic care is substantially cheaper than emergency room care.

Create a student organization that partners with neighboring free clinics to promote awareness of the issues free clinics face. Eventually work with city and local officials to influence state elected officials to introduce legislation to improve free clinics. Ultimately, introduce federal legislation providing subsidized or free malpractice insurance for free clinics.

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# Preventing Abortion Clinics from Closing: Alternate Ways of Ensuring Patient Safety

By Ellie Politi, Major: Human Biology, Health, and Society (HumEc '18), Email: emp225@cornell.edu

*Texas recently passed a law mandating all abortion clinics meet the same standards of surgical centers, forcing thirteen abortion facilities to shut down and preventing access to women across the state. The state should instead institute a change in the curriculum of nurse practitioners and physicians' assistants to include in-clinic abortions and mandate that all procedures are overseen virtually by physicians.*

## Background and Context:

Earlier this month, Texas passed a state law mandating that all abortion clinics meet the same building, equipment, and staffing codes as surgical centers and that all clinic doctors have admitting privileges at a local hospital within 30 miles from the clinic. This new law forced thirteen abortion clinics to shut down over night across the state, leaving only eight open, and questions concerning the constitutionality of the law, which affects a population of 5.4 million women able to reproduce have surfaced.[1]

State proponents of the law have made the claim that this legislation will ensure patient safety and improve quality of care while abortion providers have responded that these new standards are unnecessary and expensive, making it difficult for these clinics to stay open. This law is purely political, enacted to gain the support of certain parties, as there is no medical evidence in favor of patient care and safety. Abortion is a medical procedure, and the Texas law has made it a political procedure. Impeding access to abortion facilities results in delays in abortion. Also, the inaccessibility of abortion clinics not only poses a physical obstacle to many women but also violates these women's constitutional rights by doing so. In 1973, the Supreme Court ruled that every woman maintains the right to a pre-viability abortion in the case Roe v. Wade.

If the proposed laws were to take effect, almost one million women of reproductive age would live more than 150 miles away from the nearest clinic, which in some cases, would make access to these facilities nearly impossible.[2] Eighty percent of the population lives far from licensed ambulatory surgery centers located in major cities in Texas, and this population will be the most effected. Almost 74,000 women in East Texas are of reproductive age and would no longer be able to go to the Beaumont abortion clinic and would have to travel to Houston, which is 90 miles from Beaumont. More than 91,000 women in South Texas are of reproductive age and would no longer be able to go to the abortion provider in Corpus Christi and would have to travel to San Antonio, which is 140 miles from Corpus Christi. 182,399 women in West Texas are of reproductive age and would no longer be able to go to either abortion clinics in El Paso and would have to travel to San Antonio, which is 560 miles from El Paso. 275,672 women are of reproductive age in the Lower Rio Grande Valley, and they would no longer be able to go to the abortion clinics in McAllen or Harlingen and would have to travel to San Antonio, which is 235 miles away from McAllen and 250 miles from Harlingen. 56,853 women in Midland Texas are of reproductive age and would have to travel to Dallas, which is 340 miles from Midland.[3]

In 2012, only 21% of all abortions were performed in licensed ambulatory surgery centers (ASCs) in Texas. This figure has not increased in the past two years, suggesting that ASCs will not be able to accommodate the high demand for abortion services.[4]

The Supreme Court has overruled the law while it is being appealed, so the thirteen clinics have since been reopened, at least temporarily. This law should not be enacted, for there is no medical backing for the implementation. In addition to preventing abortions, this law has other implications. If an abortion clinic cannot afford to operate, its other services, such as cancer screening, HIV screening, counseling, and contraception would no longer be provided. Some of these services provide an imperative resource while others, such as contraception, would just exacerbate the problem of abortion if no longer provided.

## The Policy Idea:

Instead of instituting this new law that would shut down abortion clinics across the state, Texas should institute a change in the curriculum of nurse practitioners to include in-clinic abortions and mandate that all procedures are overseen virtually by physicians. Nurse practitioners and physicians' assistants of the abortion clinics should become certified to perform in-clinic abortions as part of their education and training. To ensure patient safety, a physician must oversee all abortion procedures via web camera.

## Policy Analysis:

Pairing the mandate that nurse practitioners and physicians' assistants become certified to perform first trimester in-clinic abortions as part of their education and training with the oversight of physicians both guarantees the safety of the procedure and increases the accessibility of abortions to women while allowing abortion clinics across the state to remain open.

The University of California San Francisco conducted a six-year study that concluded that first trimester abortions (92% of abortions occur in the first trimester) are just as safe when performed by nurse practitioners and physicians' assistants as when they are performed by physicians themselves. About ten states across the country allow non-physicians to perform medication abortions only, while only four states (Montana, Oregon, New Hampshire, and Vermont) allow non-physicians to perform both medication and aspiration abortions. In the study, physicians and nurse practitioners and physicians' assistants performed abortions, with the conclusion that outpatient abortion is safe (complications limited to 2%), and complication rates between the physicians and non-physicians were statistically insignificant. In addition, because second-term abortion is expensive, groups such as minority, uninsured, and low-income women remain marginalized and underserved in health care. Increasing accessibility by allowing non-physicians to perform in-clinic, early aspiration abortions would reduce healthcare disparities, as it would increase availability of first-trimester aspiration abortions.[5]

**Key Facts:**

- There is no medical evidence to limit abortion clinics to licensed ASCs, and only five in the state are licensed.[8]
- Complication rates in abortion procedures between the physicians and non-physicians are statistically insignificant.[9]
- 92% of abortions occur in the first trimester.[10]

This policy affects all 5.4 million[6] women of reproductive age living in Texas, and the number of women of reproductive age who will be affected by an increased distance from abortion clinics will also rise dramatically. "The number of women of reproductive age in Texas living more than 50 miles from a clinic providing abortion in Texas increased from 816,000 in May 2013 to 1,680,000 by April 2014. When the ASC requirement goes into effect this will increase to 1,960,000. The number of women of reproductive age in Texas living more than 100 miles from a clinic providing abortion in Texas increased from 417,000 in May 2013 to 1,020,000 by April 2014. When the ASC requirement goes into effect this will increase to 1,335,000. The number of women of reproductive age in Texas living more than 200 miles from a clinic providing abortion in Texas increased from 10,000 in May 2013 to 290,000 by April 2014. When the ASC requirement goes into effect this will increase to 752,000."[7]

**Talking Points:**

- Texas recently passed a law mandating all abortion clinics meet the same standards of surgical centers, forcing thirteen abortion facilities to shut down and preventing access to women across the state.
  - There is no medical evidence to support this law.
  - It breaches women's constitutional right to an abortion (Roe v. Wade).
  - The other services provided by abortion clinics will no longer be provided.
  - ASCs will not be able to accommodate the high demand for abortion services.[11]
- Nurse practitioners and physicians assistants of the abortion clinics should become certified to perform in-clinic abortions as part of their education and training. To ensure patient safety, a physician must oversee all abortion procedures via web camera.
  - Guarantees the safety of the procedure.
  - Increases the accessibility of abortions to women.
  - Allows abortion clinics across the state to remain open.

## Next Steps:

The first step is to establish medically based procedures and standards for certification and training of nurse practitioners and physicians' assistants. These standards could be developed by the American Medical Association (AMA), whose first priority is patient safety. The AMA has a long history of proposing standards and training programs for its members and offers extensive resources in continuing education programs on an on-going basis.

The next step is for individual clinics or larger organizations, such as Planned Parenthood, to commit the resources required to implement the certification and training of physicians' assistants and nurse practitioners and the establishment of remote monitoring by

physicians. The benefit of having a national organization, such as Planned Parenthood, as a participating provider is its ability to implement this program on a statewide, or even national, level.

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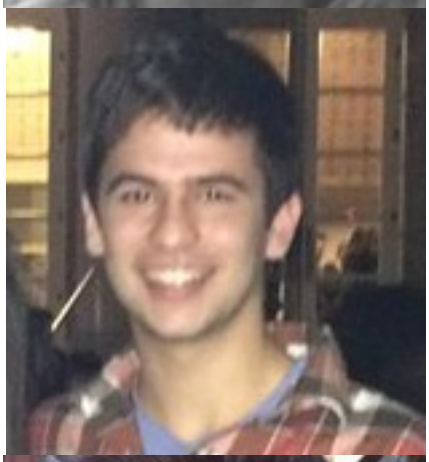
# Meet the Center for Healthcare Policy

**Anna Grosshans**

Anna is a senior majoring in Development Sociology. She is a women's health and reproductive rights activist and has worked with organizations such as Planned Parenthood and the American Civil Liberties Union during her time at Cornell. After graduation, she hopes to pursue a career in health policy and women's rights.



**Matthew Hersman**

Matthew is a senior in the College of Arts and Sciences, majoring in Biology and Society with minors in Health Policy and Business. He is a Health Policy Analyst for the Cornell Roosevelt Institute. Aside from the Roosevelt Institute, he is also the Vice President of the Drug Information Association and a Planning Board Member for the Cornell Undergraduate Health Cooperative. Last summer, he worked as a Legislative Intern at Strategic Health Care, where he was able to experience healthcare lobbying first hand in the nation's capital. He hopes to work one day in consulting or healthcare management.

**Frank Sun**

Frank is a junior in the College of Human Ecology majoring in Policy Analysis and Management with minors in Business and Law and Society. He joined Roosevelt in Spring 2014 as an analyst in the Healthcare Policy Center. Frank does research on pharmaceutical markets in the Policy Analysis and Management department and walks backwards around campus as a Cornell tour guide.

**Angelica Cullo**

Angelica is a junior in the College of Agricultural and Life Sciences studying Biological Sciences with a concentration in Nutrition. This is Angelica's second year with Roosevelt, and she is interested in increasing access and quality of healthcare, particularly mental and psychiatric healthcare services. She has always been interested in mental and public health and feels that effective public policy should be guided by research and data.

**Phil Susser**

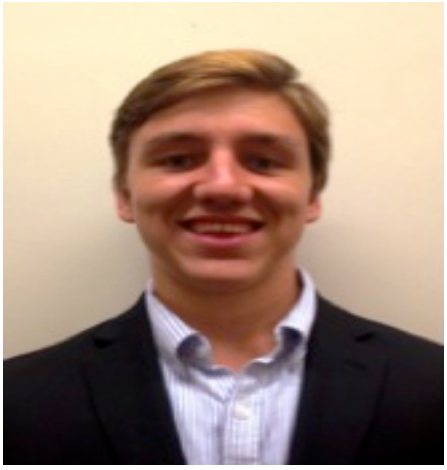
Phil is a Junior in the College of Human Ecology, majoring in Policy Analysis and Management. He joined the Roosevelt Institute in the Spring of 2013 and has focused on how healthcare systems will change with the enactment of the Affordable Care Act. He spent last summer volunteering at an emergency department of a New York City public hospital. After college, he plans to enter a career in medicine.

**Emma Sahn**

Emma is a sophomore majoring in Economics in the College of Arts and Sciences. She joined the Cornell Roosevelt Institute in the Fall of 2014 as a Policy Analyst in the Center for Healthcare Policy. Emma's main policy interests include healthcare and global health issues. She has interned at New York Methodist Hospital and would like to work in healthcare consulting in the U.S. or abroad trying to address global health issues. Contact her at ebs94@cornell.edu.

**Madison Cripps**

Madison Cripps is a sophomore in the College of Human Ecology studying Policy Analysis and Management, with possible minors in Business and Education. She is interested in health policy as well as education policy, specifically pertaining to the academic achievement gap. After college, Maddie hopes to attend law school.



**Charles Paton**

Charles is a sophomore in the College of Human Ecology studying Policy Analysis and Management and minoring in Business and Law and Society. He joined the Roosevelt Institute in the Fall of 2014 as a Policy Analyst in the Center for Healthcare Policy. Outside of the Roosevelt Institute, Charles works as a research assistant in the Pharmaceutical and Health Advertising Research Lab and is a resident advisor in Clara Dickson Hall. Upon graduation, he aspires to work in the consulting or finance industries before attending law school. Contact him at cap294@cornell.edu.

## Adrian Jones

Adrian is a sophomore in the College of Human Ecology, majoring in Policy Analysis and Management and minoring in Urban and Regional Studies. She joined the Roosevelt Institute in the Fall of 2014 as a Policy Analyst in the Center for Healthcare Policy. Adrian's academic interests revolve around structural factors and environmental influences that lead to social inequalities and disparities in areas such as health, homelessness, and education. She is currently on a research team in the Department of Design and Environmental Analysis, where she studies how a students' perception of their physical environment contributes to their socio-emotional development. She is also a member of Cornell's Varsity Track & Field team. After college, she hopes to pursue a career in public service, and also plans to attend medical school. Contact her at atj25@cornell.edu.


## Alexander Gomez

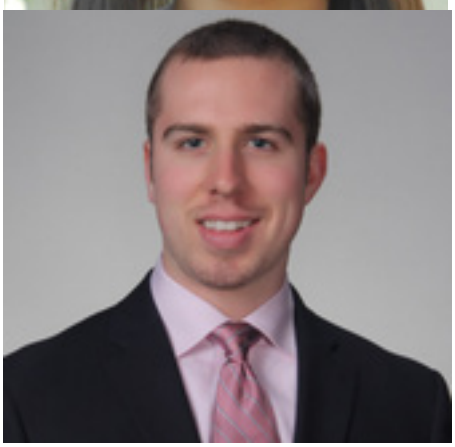
Alexander Gomez is a sophomore majoring in Policy Analysis and Management at Cornell University. He loves keeping up with new technology and watching soccer, and is also an avid outdoorsman.

## Allen Chen

Allen is a freshman majoring in Policy Analysis and Management. He joined the Cornell Roosevelt Institute in the Fall of 2014 as a Policy Analyst in the Center for Healthcare Policy. Allen's main policy interests include healthcare, education, and poverty. He is eager to share his passion for healthcare as a Policy Analyst. Allen is a Brother of a service fraternity, Alpha Phi Omega, DJ of WVBR, Cornell's student radio station, Rock Climbing Instructor at Cornell Outdoor Education, and an administrative assistant of Cornell's Alumni Affairs and Development Volunteer Department. He has interned at San Gabriel Habitat for Humanity, is a 2013 Bank of America Student Leader and would like to work in consulting, education, or public service. Contact him at azc5@cornell.edu.

## Ellie Politi

Ellie is a freshman in the College of Human Ecology, majoring in Human Biology, Health, and Society. She joined the Roosevelt Institute in the Fall of 2014 as a Policy Analyst in the Center for Healthcare Policy.



## John Lemp

John is a senior majoring in Industrial and Labor Relations and minoring in Business and Law and Society. He joined the Cornell Roosevelt Institute in the Spring of 2013 as a Policy Analyst in the Center for Healthcare Policy and as a Policy Advocate in the Center for Economic Policy and Development. John's main policy interests include healthcare, international relations, and political economy. He is eager to work with analysts on publishing blog posts and policy proposals as the current Healthcare Policy Director. John serves as the IFC Representative and Alumni Relations Chairman of his social fraternity, Pi Kappa Alpha, and the Vice President of Operations for the Student Cryptocurrency Initiative. He has interned at the Franklin D. Roosevelt Presidential Library and Museum as well as a boutique investment banking firm and would like to work in consulting, insurance, or finance before going into public service or working for the government. Contact him at jrl264@cornell.edu.

"We have always held to the hope, the belief, the conviction that there is a better life, a better world, beyond the horizon."

- Franklin D. Roosevelt