Some Ideas on a Health Care Plan

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Contents

1 INTRODUCTION

HR 3200 is everything and the kitchen sink. It is a complex plan which tries to address a multitude of issues and in so doing introduces complexities which will most likely sink the bill to obscurity or create a structure which will result in more harm than benefit. That is the problem of attempting to do too much and keep too many special interest satisfied.

It would be useful to present a simple Health Care Plan and its justification in as short a presentation as possible. That is the purpose of this report. It distills the key issues of a plan, shows what it would cost, how costs could be controlled, how it is paid for and how it is implemented.

It does not include any Governmental Panels, Agencies or the like. Yes, it does include a Government Insurance Management Board, to set the minimum coverage and make certain the Insurers are following the rules, you can't trust anyone, especially Insurance Companies.

This is a brief report which follows in the following line of logic:

Step 1: We propose a set of principles for a plan. Although this generally is something that one reaches as a conclusion the work performed by many others as well ourselves let's one posit the basic principles at the outset. Basically it is a universal services plan with catastrophic coverage but also combined with cost reductions in specific areas.

Step 2: We then propose a specific plan. We start with a Core Plan that provides full catastrophic coverage and then also provides Primary coverage but includes an out of pocket on the part of the participant. It also allows choice for scaling up to more complex and extended coverage. It ensures that all people are covered for the major diseases. It also incentivizes control of usage by having some out of pocket.

Step 3: We examine the major diseases and show two things. One, using cancer we show how there has been some success in both diagnosis and treatment and that cancer rates are decreasing. Thus there is a major example of a success. Then we show the obesity pandemic and how obesity, which drives Type 2 Diabetes amongst other diseases is the primary driver for the increases in health care costs. This is a controllable effort and this is where the Government can play a critical role. We also show that cardiac problems, a mix of genetic and life style issues is a mix of the two characteristic of cancers and obesity.

Step 4: We assemble a set of Target areas of what can be done now and what it will save now and on an ongoing basis. This includes the management and reduction of obesity and the screening and management of cancers. It also looks at hospital infections and several other well known areas. If the Target Areas are achieved this is a 30% reduction

in health care costs. Thus we manage costs down. This of course must be a continuing program, driving costs out on an ongoing basis,

Step 5: We then apply the cost reductions to the current cost base and then demonstrate that with the Core Plan revenue we cover the costs after Target Area reductions.

Step 6: We then demonstrate how we can provide Universal Coverage using existing funds and only have those who can pay contribute, Namely we have a sliding scale of payments so that those with no income will be covered and those with high incomes will be taxed for the excess costs required. We utilize the existing Medicaid funds to ensure that the gap is closed. We demonstrate that the Core Plan proposed has a $30Billion excess, money back to the taxpayers, if we follow the plan. We also demonstrate the sensitivities to the assumptions for payment.

2 THE PLAN

To explain the Plan we first describe its principles, the elements required in any application of health care coverage and then second we detail how it is paid for from sources such as the individual or family, the employer, or in the case of the self employed, the individual, and finally the payments required from the Government in the event that the payer to the plan cannot afford the payments. The intent is to place every person on an equal footing, yet allowing the ability to "buy up" in a plan, and at the same time allowing this to occur in a free and open market.

Thus essential to this national and universal coverage is the need for a concomitant national and universal insurance regulator whose focus is ensuring compliance with the plans rules, ensuring the financial and operational integrity of participants, and promoting the competitiveness amongst the insurers.

2.1 Principles

The plan has the following core principles as we describe them in this section. It is a plan that covers everyone and has no exclusions and is purchased by every person and is thus portable. It is a national plan and has no state control. It is akin to life insurance but it has aspects of auto and house insurance.

The key elements of the plan appear in the following chart. Simply stated the Plan is defined as:

"A universal Health Care Plan which provides catastrophic covering as well as elements of routine medical care and the plan is national in scope and has no barriers to age, pre-existing conditions, or other delimitations, and the Plan is subscribed by individuals purchasing their insurance from competitive providers managed by a Federal oversight Insurance Regulator."

The attempt is to keep the principles simple but extensive, allowing all participants to understand the intent and scope.

Details of The Plan

The Plan has at its heart a minimum Core Plan that all citizens and legal residents must have and it permits anyone to Buy Up to other more comprehensive plans. The plan has a minimum Core Package. The Core Plan has both catastrophic coverage and has a primary care element.

Core Plan

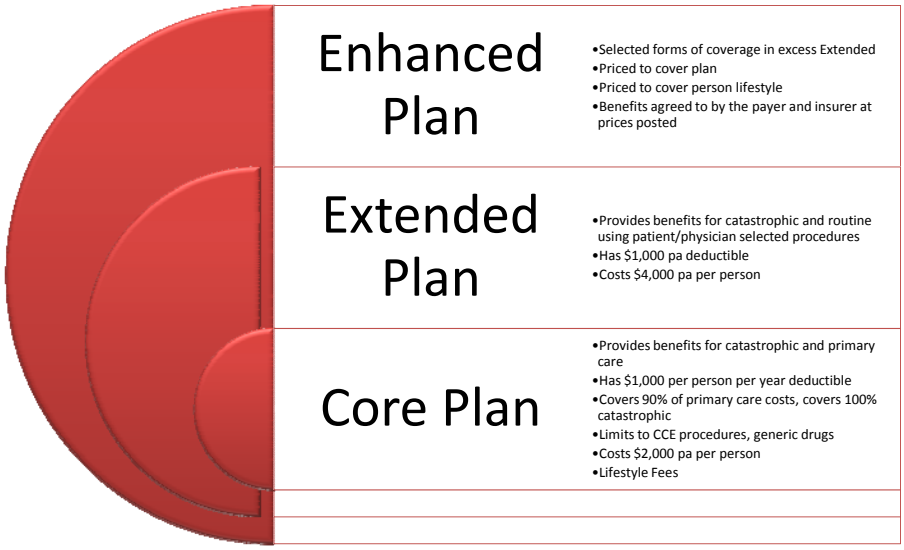
The Core Plan is as follows:

Provides benefits for catastrophic and primary care. The Plan will cover all catastrophic illness.
Has $1,000 per person per year deductible and covers 80% of all primary care expenses.
Covers 90% of primary care costs, covers 100% catastrophic
Limits procedures to CCE (Comparative Clinically Effective) approved procedures and requires use of generic drugs where possible.
Insurance Costs would be $3,000 per year per person and there would be Government based income support.
Lifestyle Fees would be applied which would add to the annual costs for those who are smokers, obese, drug users, and the like.

Maximum out of pocket costs in any one year are capped at 15% of the gross income of the individual or family.

We want to keep the costs low so this Core Plan follows a CCE, Comparative Clinical Effectiveness, set of guidelines. You sign up for this Core Package and you then have to go generic and follow CCE. This is the lowest cost option. You also have an out of pocket and a deductible. Thus there is some modicum of financial incentive. Of course if you cannot pay then it gets subsidized. Then if you want more you can buy up.

We show the overall sets of plans as below.



2.2 Extended and Enhanced Plans

Now the other two plans may look as follows (they all have benefits equal to the Core but provide additional benefits):

- Extended Plan
  - Provides benefits for catastrophic and routine using patient/physician selected procedures
  - Has $1,000 pa deductible
  - Costs $4,000 pa per person

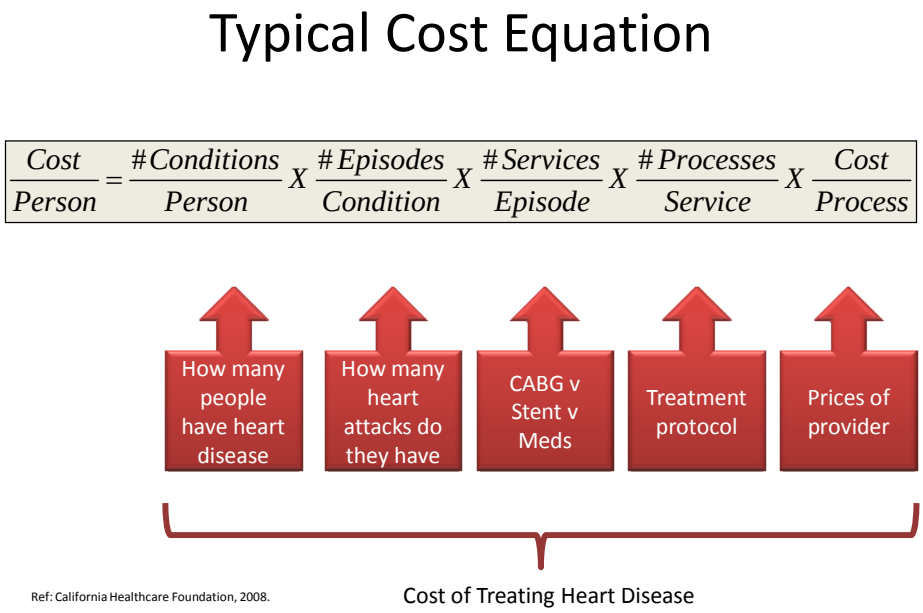
- Enhanced Plan
  - Selected forms of coverage in excess Extended

- Priced to cover plan
- Priced to cover person lifestyle
- Benefits agreed to by the payer and insurer at prices posted

The other plans may be highly variable as are many other common insurance plans.

3 MEDICAL AREAS FOR COST REDUCTION

The key to providing this Plan is the ability to attain cost reductions. To do this we use the paradigm shown in the following Figure.



The above really shows three drivers for health care costs:

1. Disease States, Prevalence and Incidence: This is the number of people getting ill and then seeking service.

2. The Services Provided: This is where the CCE limitations and the generic drug usage comes to play.

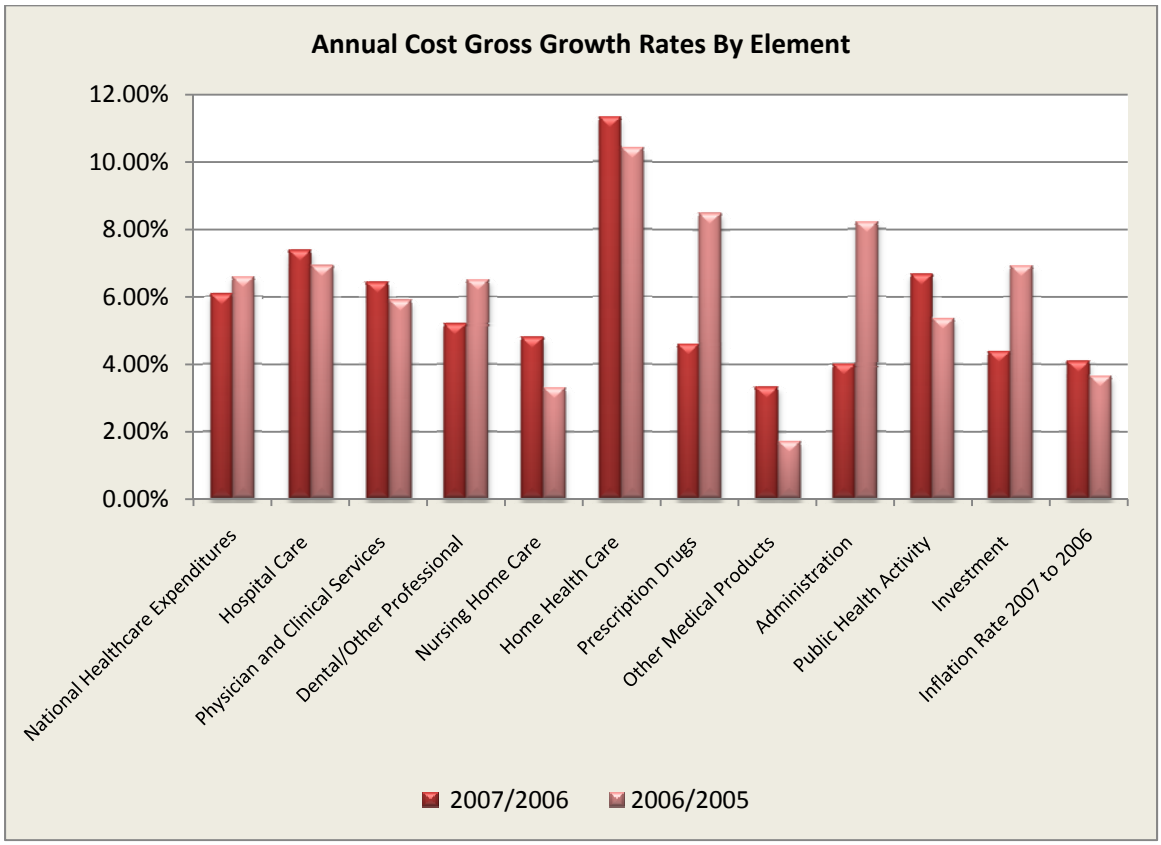
3. The Costs of unit service Delivered: This is the cost of a physicians time, a drug, or a medical procedure.

This allows us to have a structure to ask why the costs are so high. Do we have some increasing disease state, higher incidence and prevalence, or do we have an increased use of more procedures for existing disease states, such as more MRIs and the like, or is it the fact that the cost of doing this are just increasing, and that we are doing the same things to the same people but it just costs more. In reality is a combination of all of

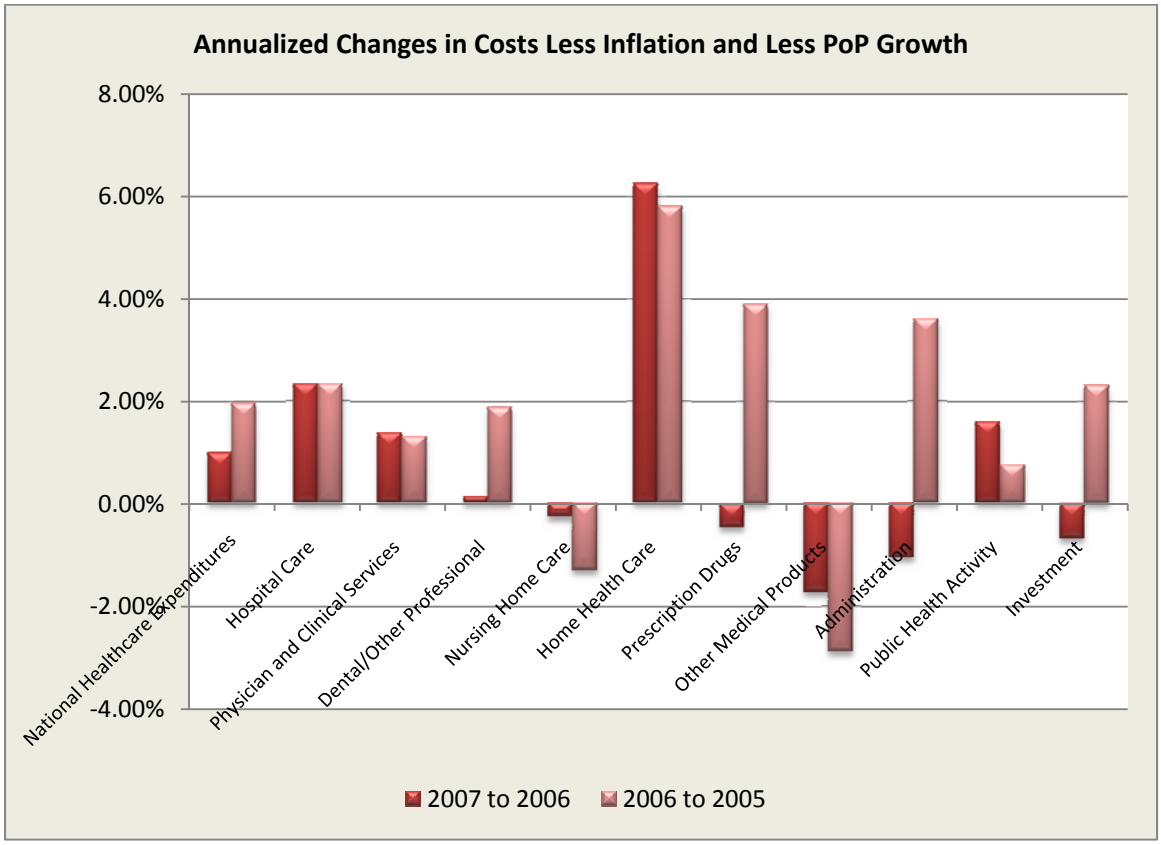
these elements. Yet in many areas these elements may have more emphasis on one element than another and that element can be targeted for reduction.

3.1 Costs

The first issue will be costs. We show the annualized cost increase by element below. It is clear that there are certain elements where the costs are increasing at an extremely high rate.



If we now subtract inflation and the population growth from these numbers we obtain the following. Still the rates of increase are for the most part positive. The question is why? Are these salary increases or are they something else? As we have shown at the beginning of this section we see that total costs which these represent are driven by the three elements. We will argue that it is not salaries or unit costs increases nor increased procedures but actual increases in disease states, driven especially by one in particular, those driven by obesity.



The difficulty with the above cost is that it looks at the total costs and does not provide for an examination of the elements as we presented at the outset. This analysis clearly shows the increases in the total costs by area but it is necessary to look at the incidence of diseases, the increase in procedures and the increases in individual costs. We do so as follows.

3.2 Disease States and Reductions

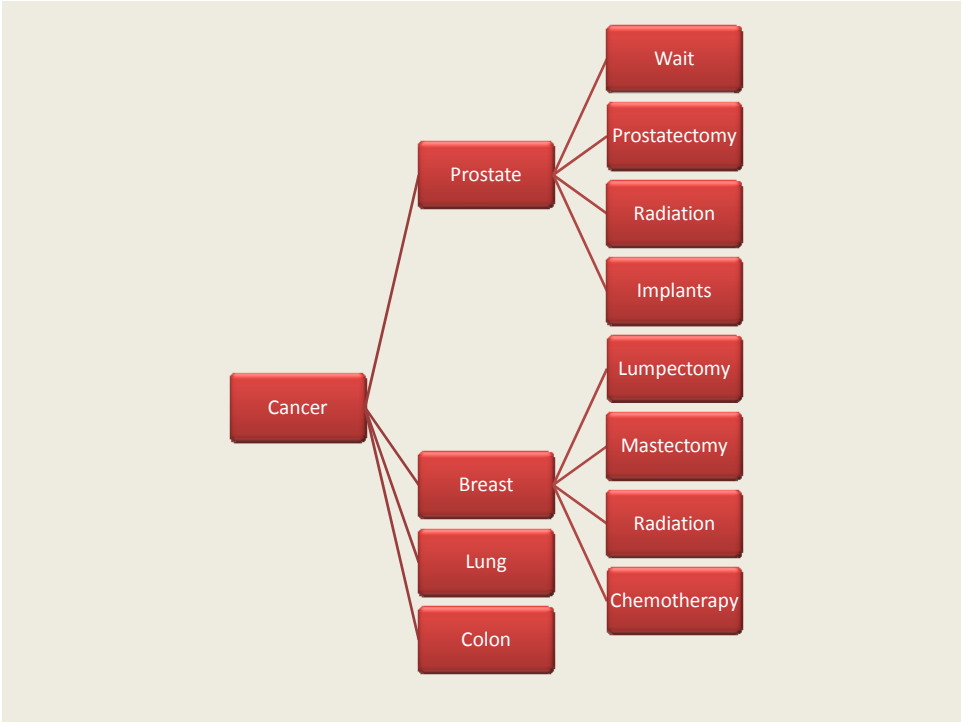
We now briefly look at several of the major disease states. The ones we have selected show the general trends. First cancers show that the diligence in detection has paid off with decreasing incidences of many and longer lifetimes through decreased mortalities. The second is the obesity pandemic which results in the explosion of Type 2 Diabetes and the ancillary diseases. The third is cardiac diseases which have become a chronic disease state management problem.

3.2.1 Cancers

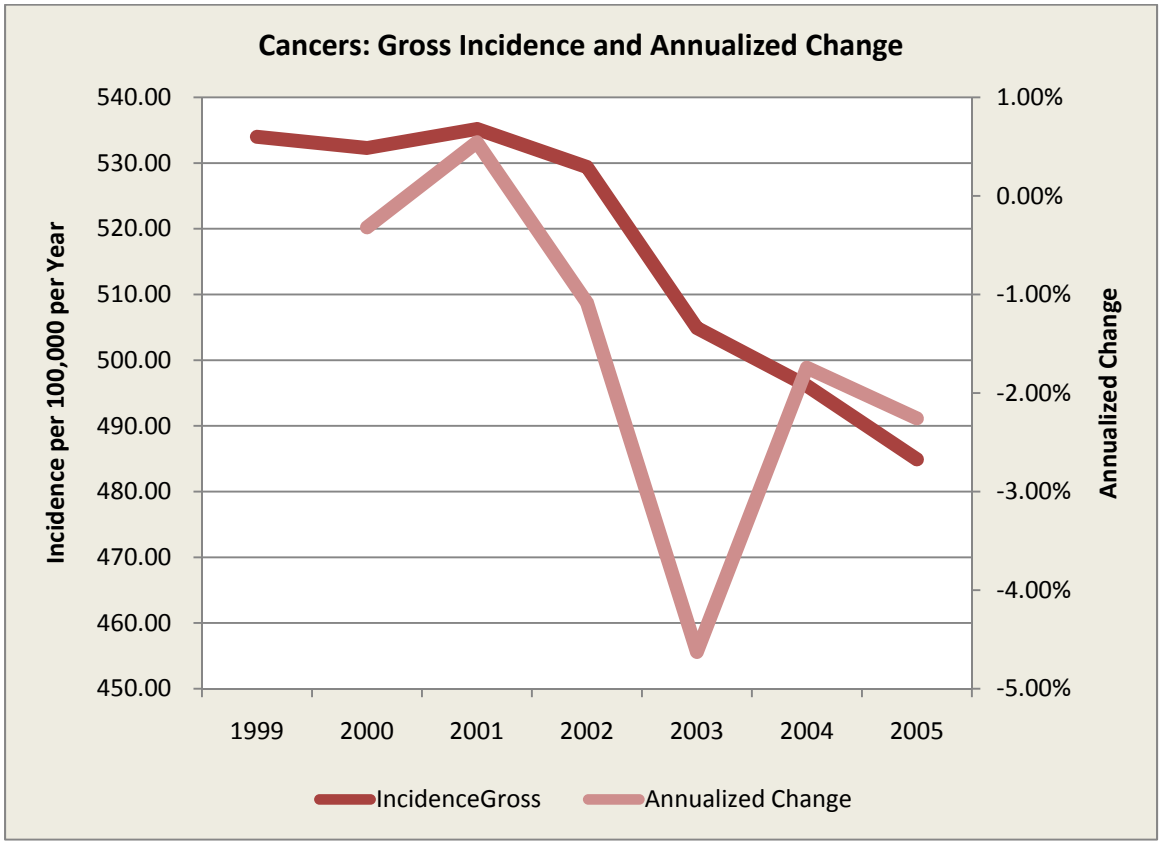
Cancers are often the most dreaded of diseases. They are clearly all catastrophic and must be treated with the utmost care. The good news is that the incidence and mortality rates are declining. In fact they are being detected earlier and as such can be

treated in many cases as if they were chronic diseases. We have discussed this in detail in our earlier report.

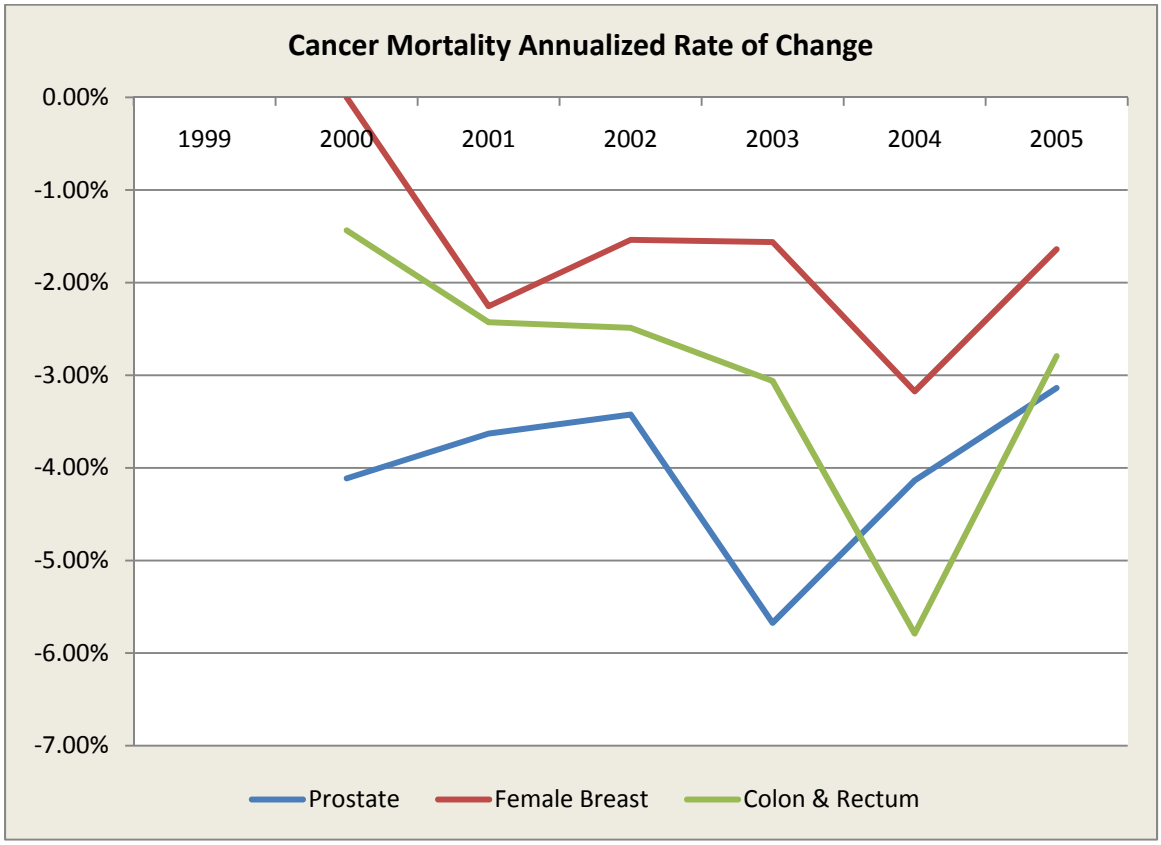
The following is an example of several of the major cancers and their treatments. As we have written earlier such cancers as prostate can in most cases be treated with just waiting. However as we have also indicated there are also a small set which are very aggressive. The ability to determine this is a genetic issue still poorly understood.



The following depicts the incidence and the annualized rate of change. This is for all cancers. Note that we are seeing a 4% annualized decline.



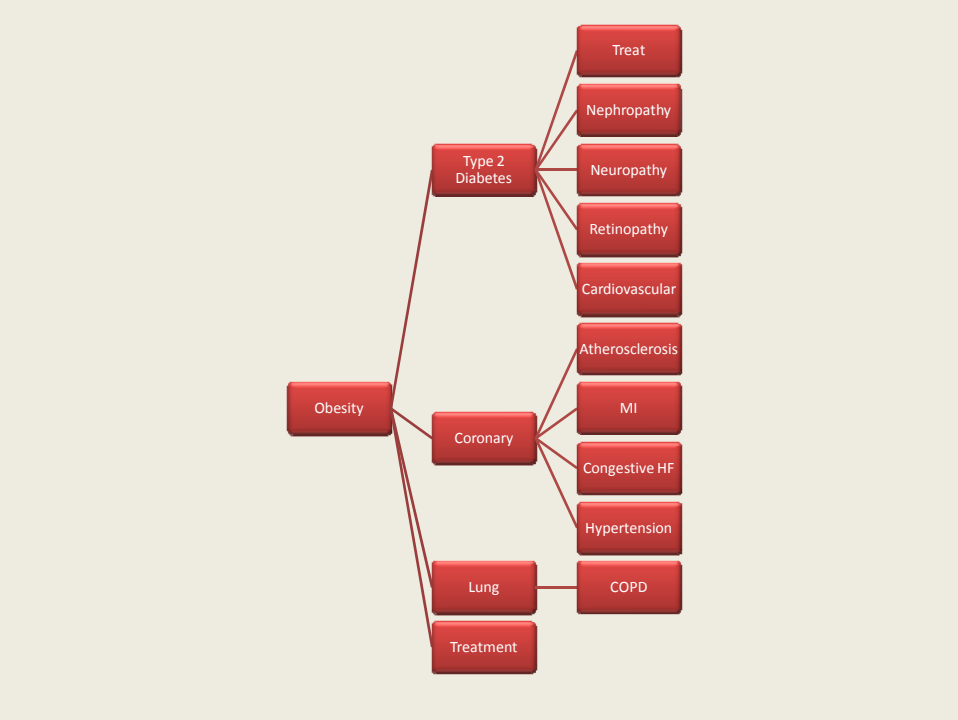
The following shows the changes for the top three cancers. Both prostate and colon have the greatest decline. The reason for this is the use of colonoscopies and PSA tests. Many medical commentators say we waste money on PSA testing but ironically they all seem to be women and one wonders what their motives are since the data clearly decries their assertions. This is one of the problems regarding the CCE approach of the current Administration since data may really invalidate a recommendation



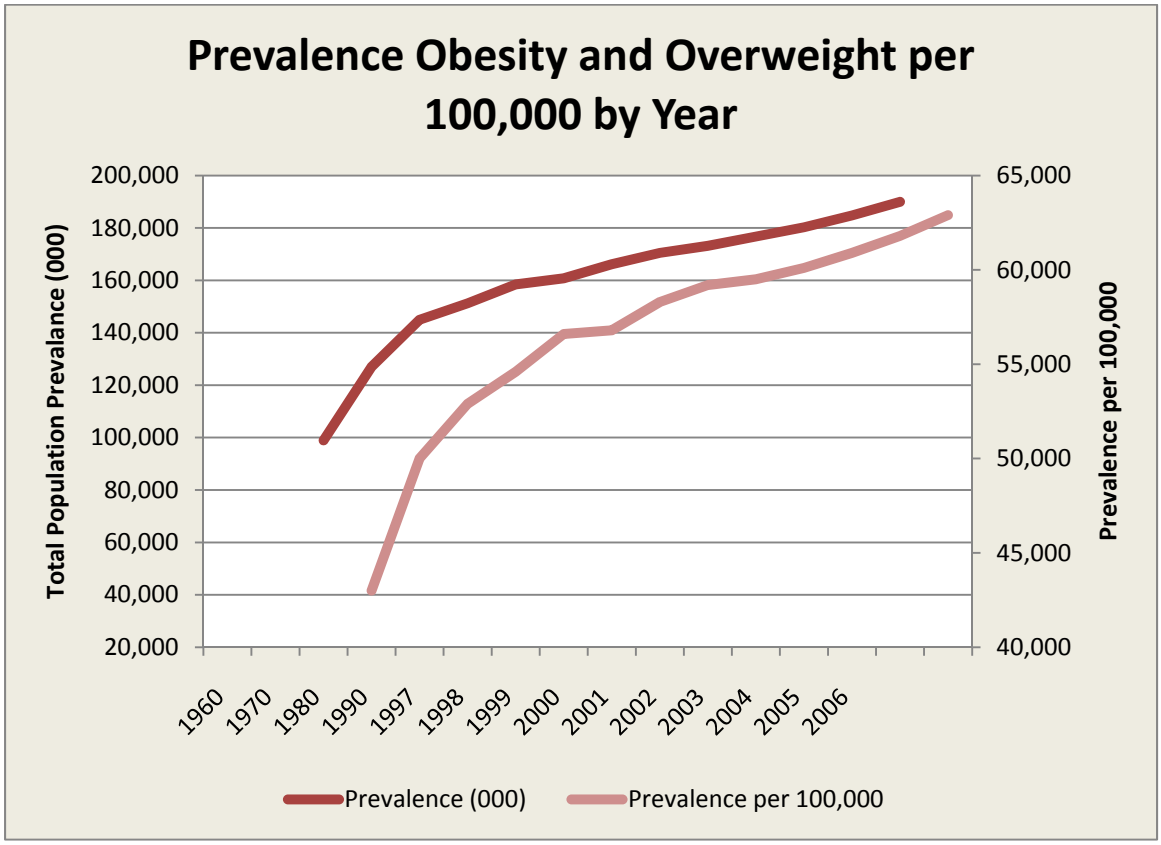
The slower rate of decreases in breast cancer is not fully explainable since there are more women seeking mammograms, the purported gold standard of detection, yet there decrease in mortality is half that of colon cancer where much fewer individuals are receiving colonoscopies, again the gold standard.

3.2.2 Obesity Related Disorders

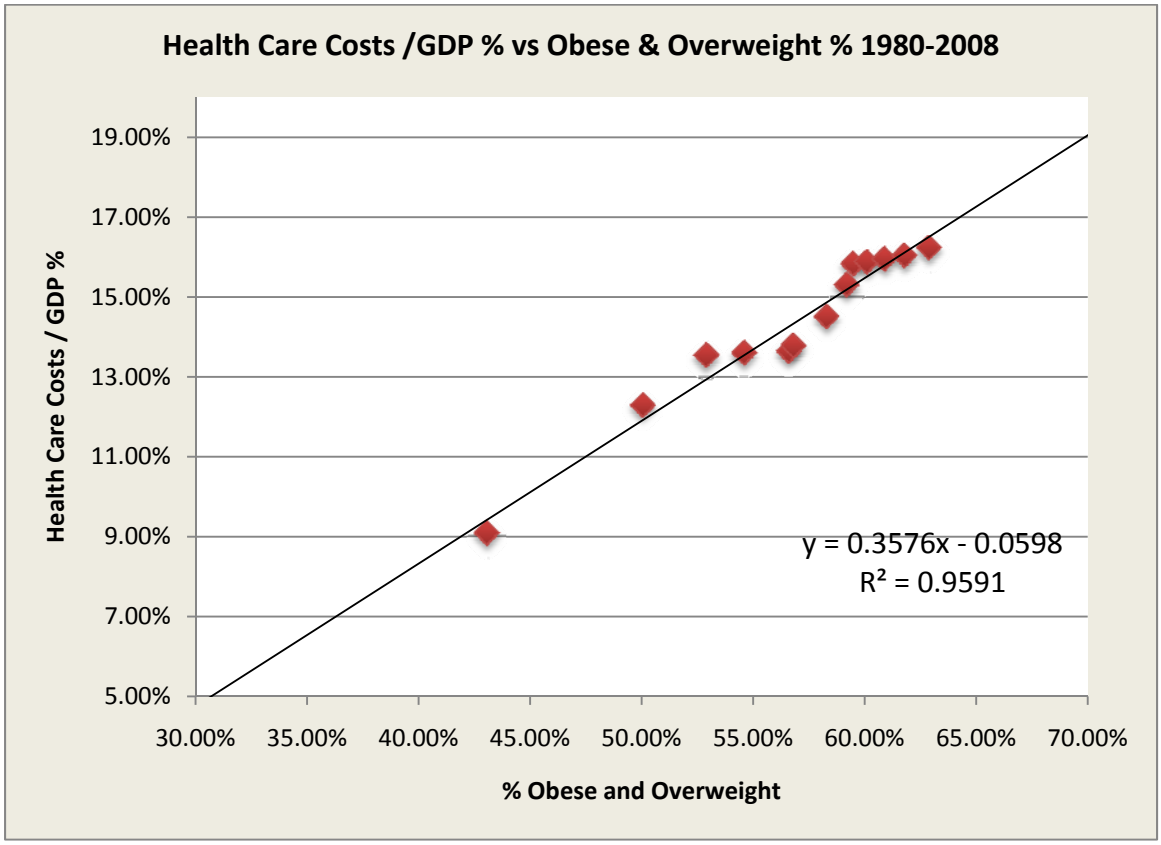
Obesity and overweight has become a pandemic in the US. Obesity is the major driver for Type 2 Diabetes and its sequellae. In turn obesity also drive cardiovascular disorders and many others. The following Figure depicts the explosive number of disorders resulting from obesity. Obesity is essentially a state where the body had been burdened by the excess fats and thus attacks occur o the liver and immune system since obesity has a body reaction akin to many inflammatory states. The chronic and increasing nature of this inflammatory pressure appears to be the cause for many of the sequellae. The following Figure is simple a sample of what can result and it is not a complete statement.



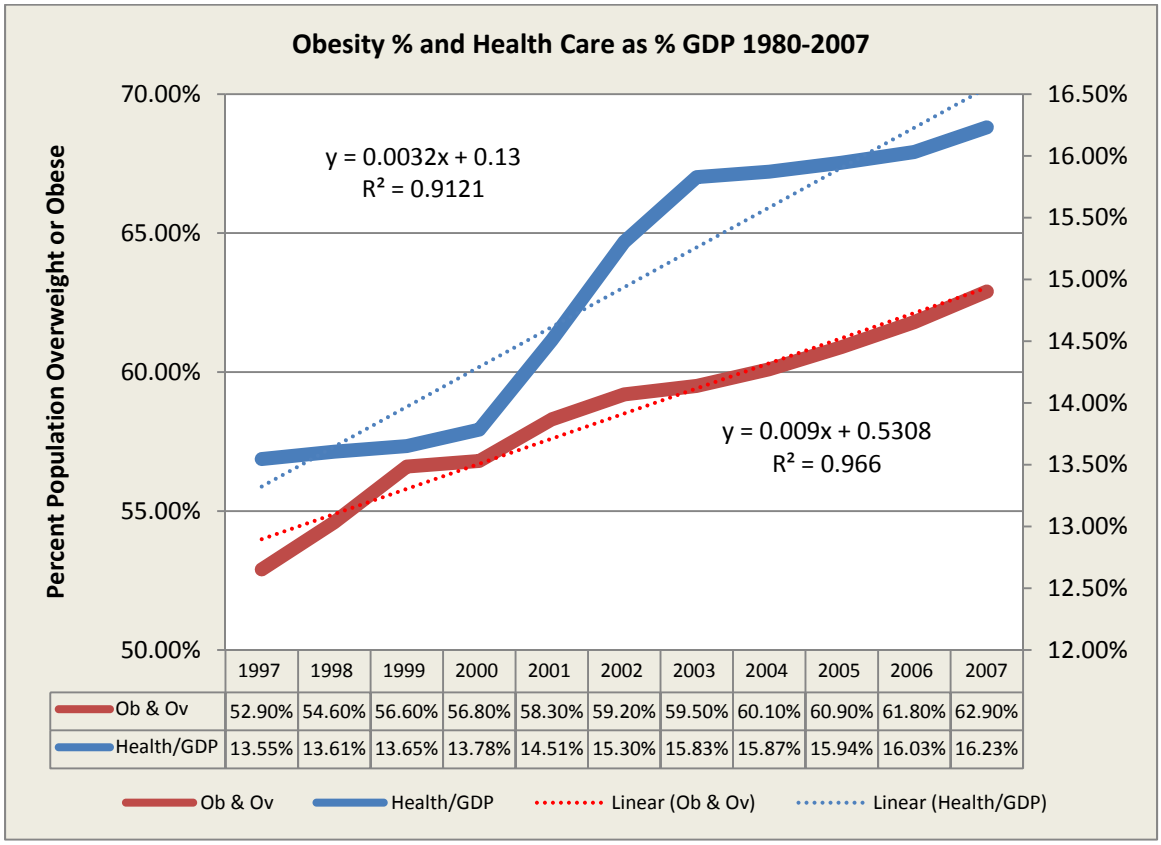
The following chart displays the prevalence of obesity in the past fifty years. The growth is almost uncontrolled. There are two curves, the total prevalence I the total population and the prevalence per 100,000. The curve shows that the total number of people who are obese or overweight grows with the population growth but the prevalence per 100,000 also shows a remarkable3 growth as well. It has grown from 42,000 per 100,000 to over 63,000 per 100,000 or 63% of the total population. The most disturbing fact is a great deal of that growth is amongst younger people who will come down with chronic diseases and have these diseases for a longer period thus raising the costs while also taking them from the workforce and thus as taxpayers. It is a deadly cycle.



We depict below the relationship between the health care as a percent of GDP and the percent obesity in the US. As we have indicated obesity drives a plethora of diseases. It is the driver that we have estimated which dominates the growth in health care costs. It is a controllable driver however. If there is any interest in controlling and reducing health care costs then is essential to reduce this factor.



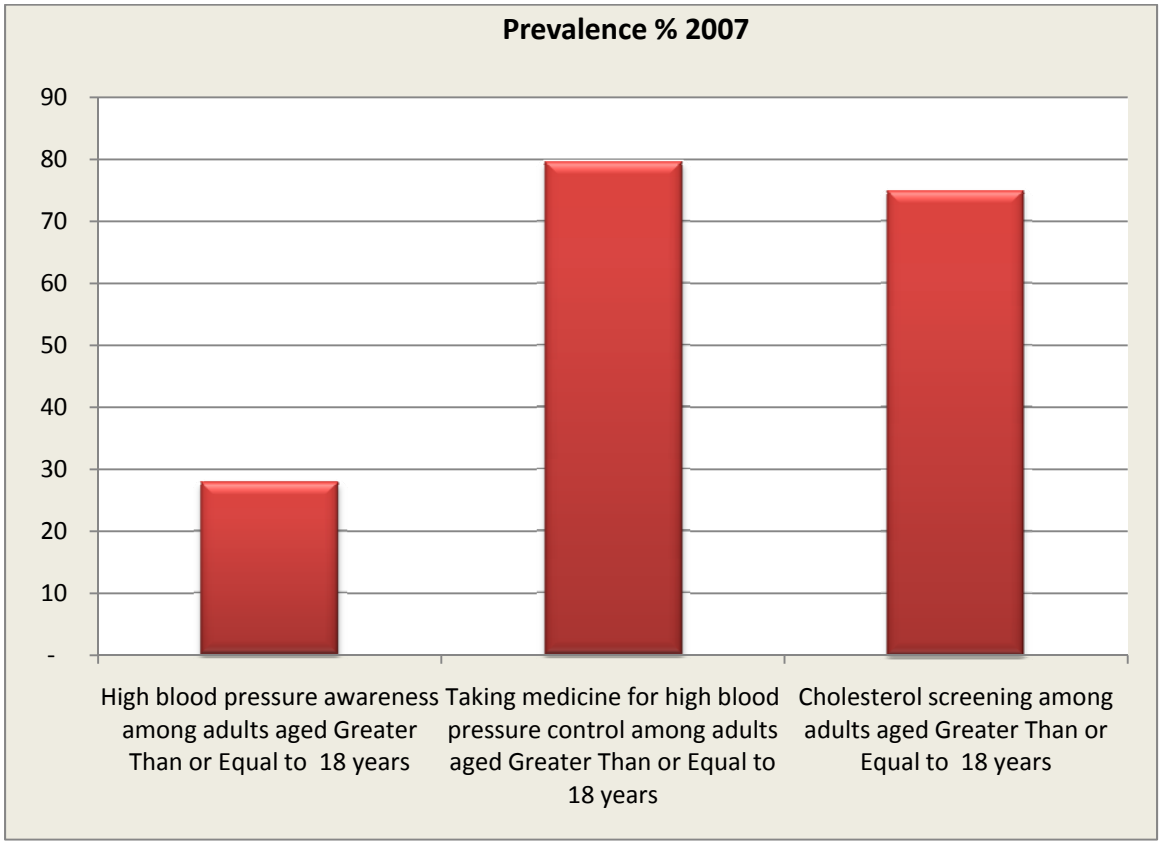
In the following we show the rates of increase. We show the above data but over time. There is a strong correlation but even more importantly a well know causal relationship.



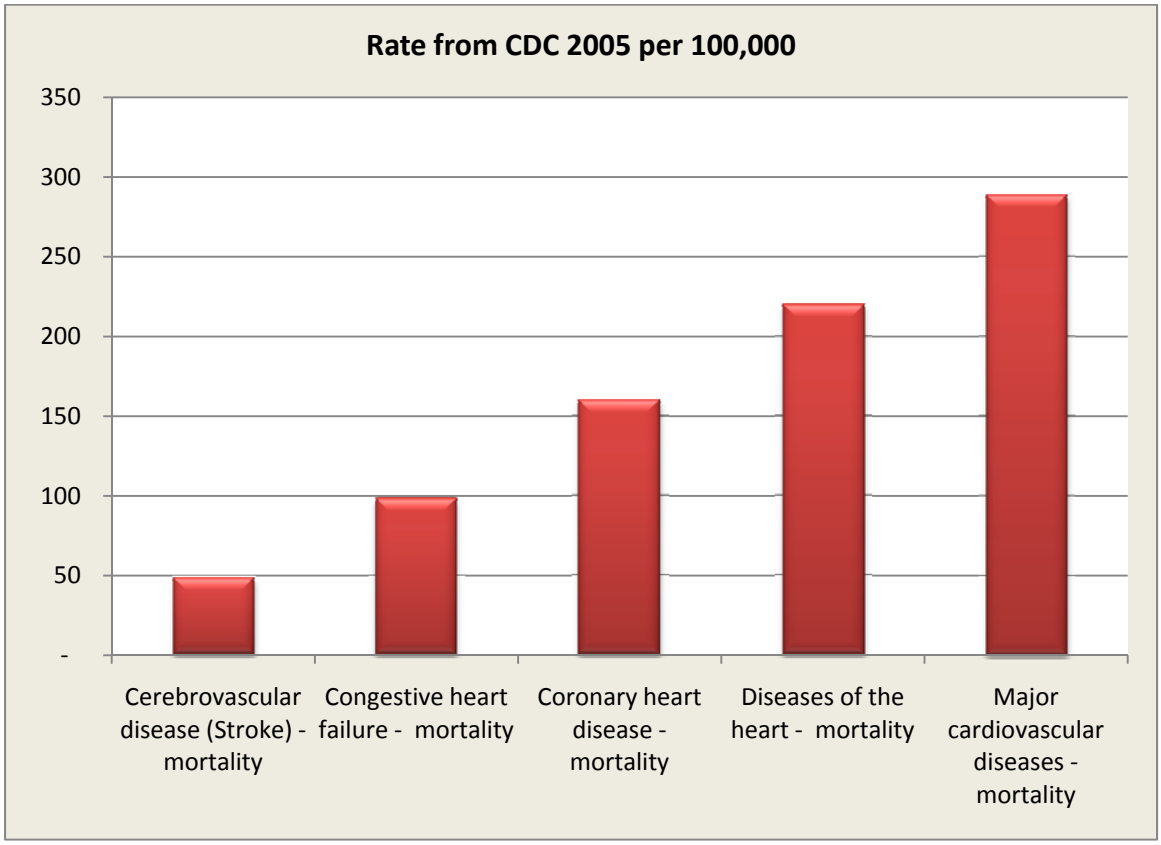
Thus unlike cancers which are all too often a genetic predisposition, albeit with some environmental drivers, the obesity driven diseases are fully controllable and are the dominant life style disease set.

3.2.3 Cardiac Disorders

The other major category is the set of cardiac disorders. The following shows some typical statistics. These are prevalence data for three major areas which are monitoring areas for attempting to mitigate the cardiac disease sets..



The mortality rates are shown below. They have been decreasing over time as we have been able to manage the disease in the early states and as we have been able to mitigate surgically many pending problems with stents and the like but they still dominant the health care budget. There is a correlation between obesity and the cardiac diseases as well.



3.3 Target Areas for Cost Reduction

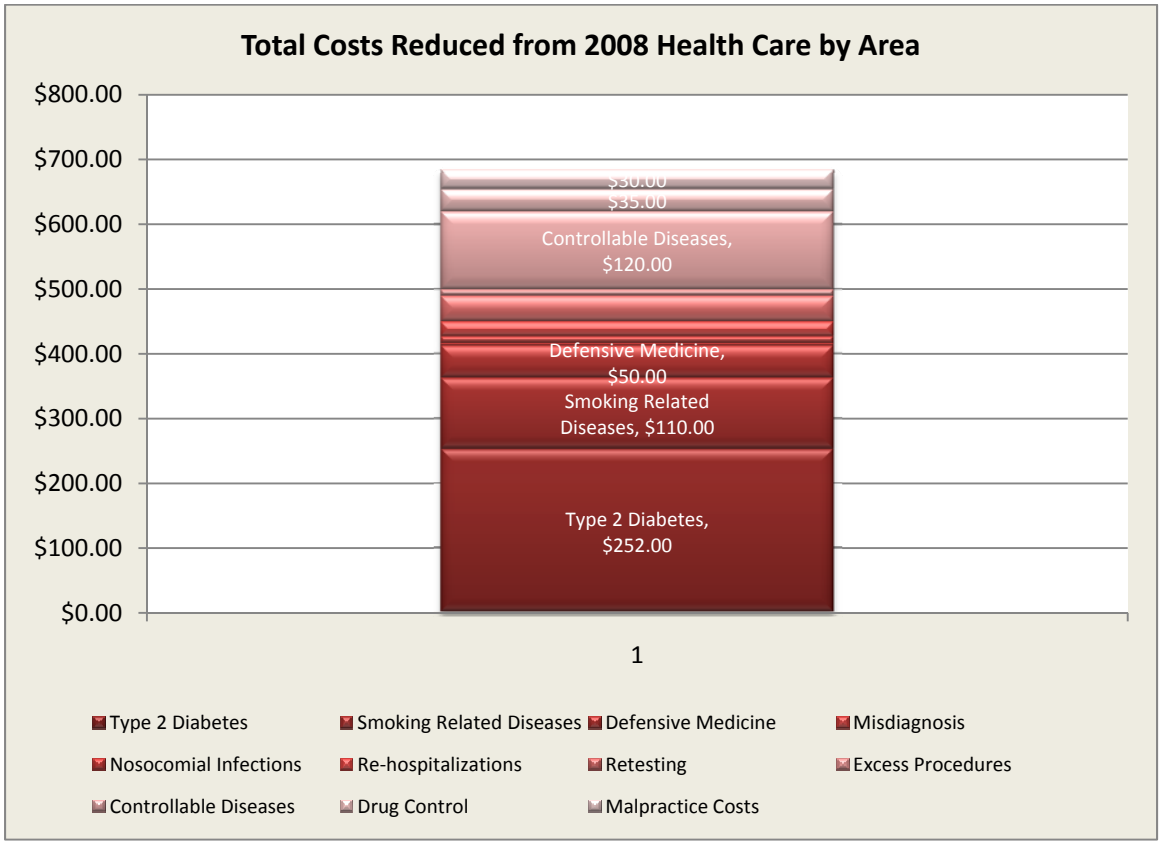
The next question is given some of the above areas what can we do to target reduction across the spectrum of diseases. The following Figure graphically depicts the major areas.

We now show how we can deal with each of these and then project using 2007 health care costs what the reduction is in each area. Then we also show how we can take action to effect the reductions.

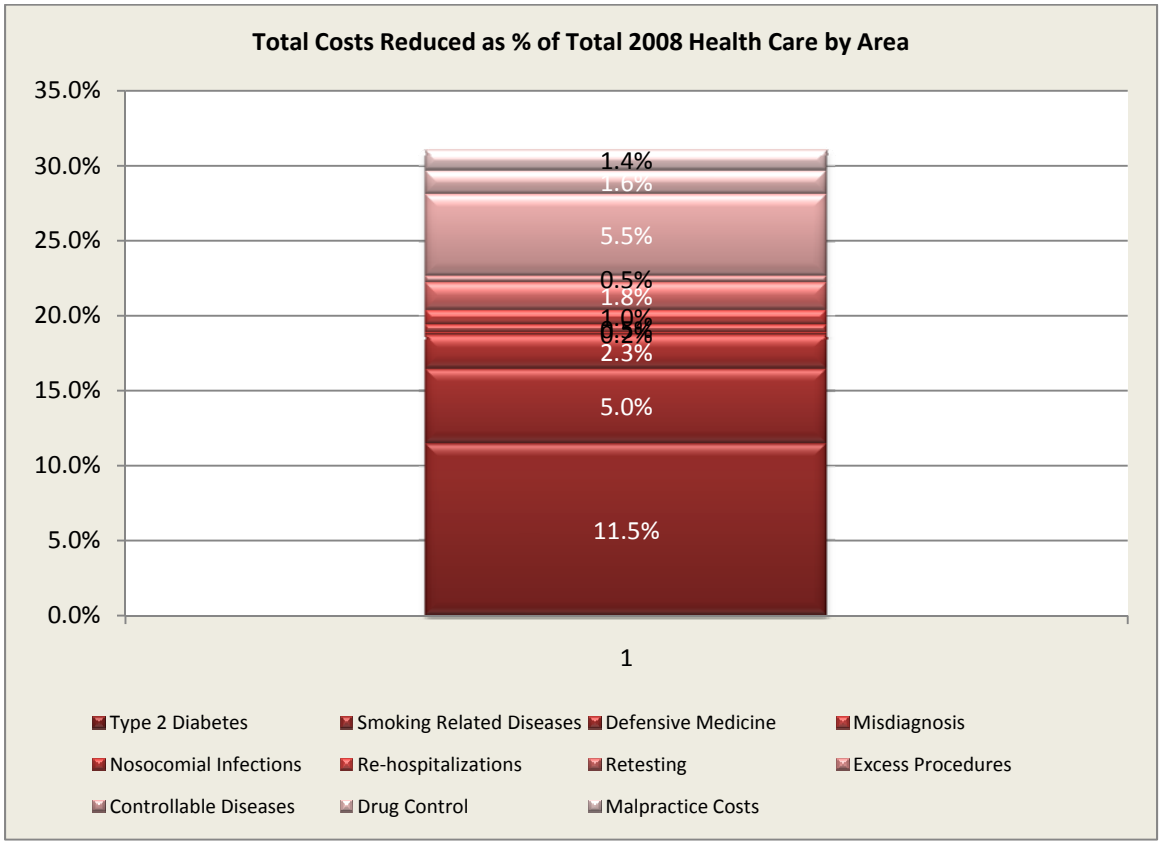
Cost Element	*Issue*	*Cost $000,000,000*	*Percent Total*	*Controls*
Type 2 Diabetes	This is all Type 2 Diabetes related costs.	$252.00	11.5%	Take remedial steps to reduce consumption of carbohydrates via actions at point of purchase and/or point of consumption
Smoking Related Diseases	This relates to all smoking related diseases.	$110.00	5.0%	Take remedial steps to reduce consumption of carbohydrates via actions at point of purchase and/or point of consumption. This has been successful with taxes directly on tobacco.
Defensive Medicine	This is the issue of performing excess tests, procedures and referrals in order to defensively avoid malpractice claims	$50.00	2.3%	This has been a difficult area to quantify. It could be mitigated via some form of tort reform. It is known that actions are taken but it is difficult to assess whether the actions are within clinically acceptable guidelines.
Misdiagnosis	This is the cost associated with misdiagnosis of what would otherwise be a remediable disease.	$3.50	0.2%	This is driven by concerns for Tort liability. To reduce the number of such misdiagnoses it is necessary to recognize them and in turn address why the occurred and how to remedy them. This is problematic in a Tort environment.
Nosocomial Infections	This is the cost of hospital acquired infections	$11.20	0.5%	This is simply remedied by the application of readily known procedures of medical hygiene and reinforcement.
Re-hospitalizations	This is the costs of re-hospitalizations of patients who should have been treated in their first stay.	$22.00	1.0%	This can be remedied by a multiple set of procedures regarding the patient release and the education of the patient before release, as well as follow up upon release.
Retesting	This relates to the EMR ability to have on line test results which are shareable	$40.00	1.8%	This can be dramatically mediated via EMR patient record sharing as well as identifying incremental costs associated with repeat procedures.
Excess Procedures	This is the cost of excess procedures that physicians perform for purposes other than determining diagnosis and care or as a defensive mechanism against litigation. Frequently these are also referred to as added revenue procedures.	$10.00	0.5%	Placing cost data and alternatives at the point of prescription using EMR technology

Cost Element	*Issue*	*Cost $000,000,000*	*Percent Total*	*Controls*
Controllable Diseases	These are the costs associated with the care and treatment of patients with controllable diseases who can be less expensively treated if they are screened and monitored more effectively. Example would be prostate, colon, and breast cancers.	$120.00	5.5%	Screening of patients can dramatically reduce incidence and mortality rates as well as reduce costs of advanced states.
Drug Control	This is the amount which could be saved if physicians had access to costs on prescriptions at the point of issuance to the patient.	$35.00	1.6%	Placing cost data and alternatives at the point of prescription using EMR technology
Malpractice Costs	This is the current total out of pocket costs of malpractice insurance and claims related thereto	$30.00	1.4%	This is a cost which can be reduced via tort reform.
Total		$683.70	31.08%	

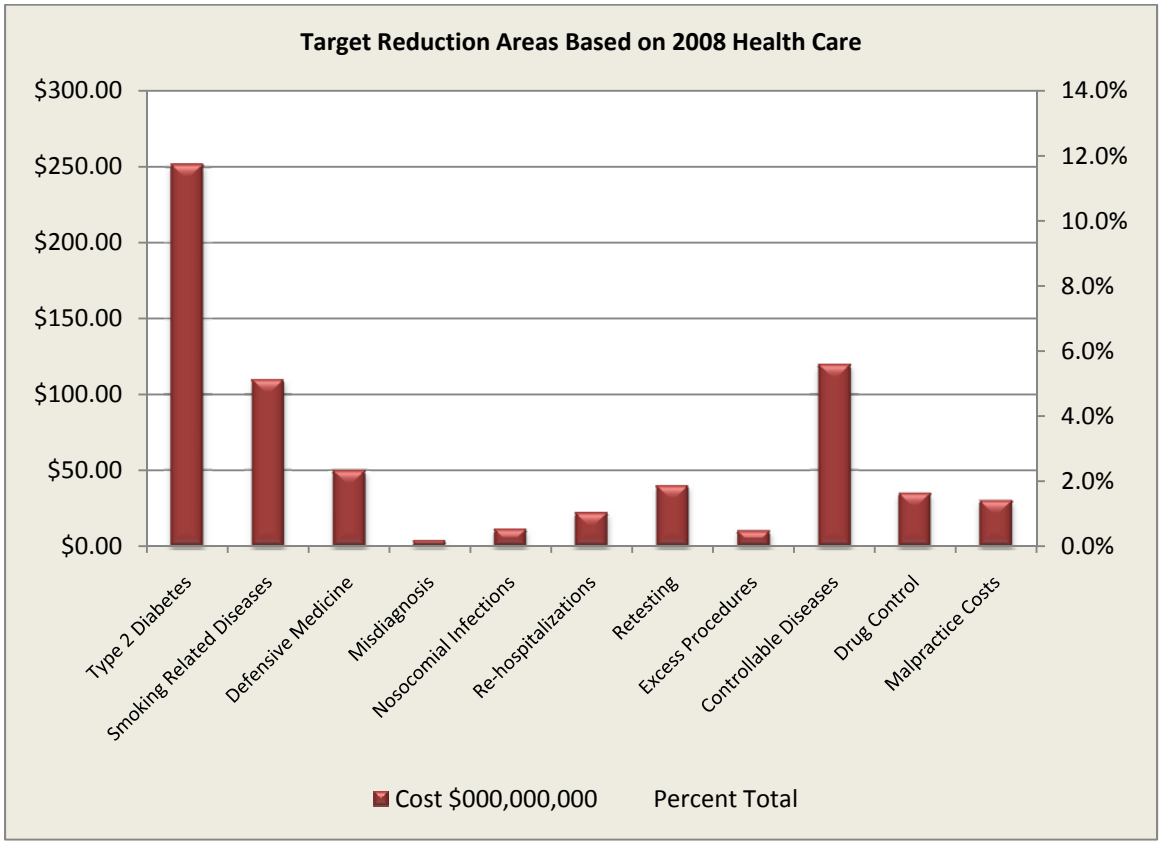
The costs reductions can be displayed as follows, first in terms of overall dollars in a 2007 scenario.



Then we show below the percent and we suggest that since that they are scalable they can be integrated in a going forward plan.

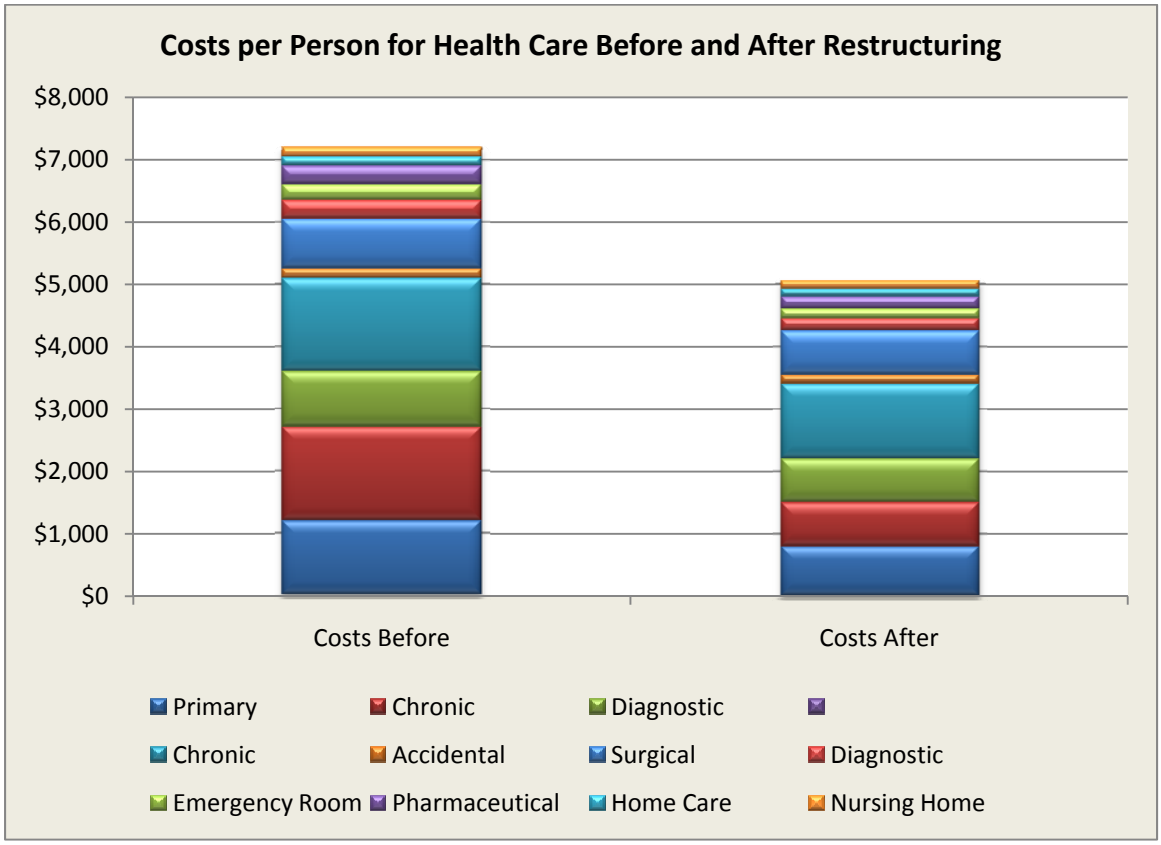


This is a 30% cost reduction. The view below assist in seeing it by target area.



3.4 Target Cost Reductions

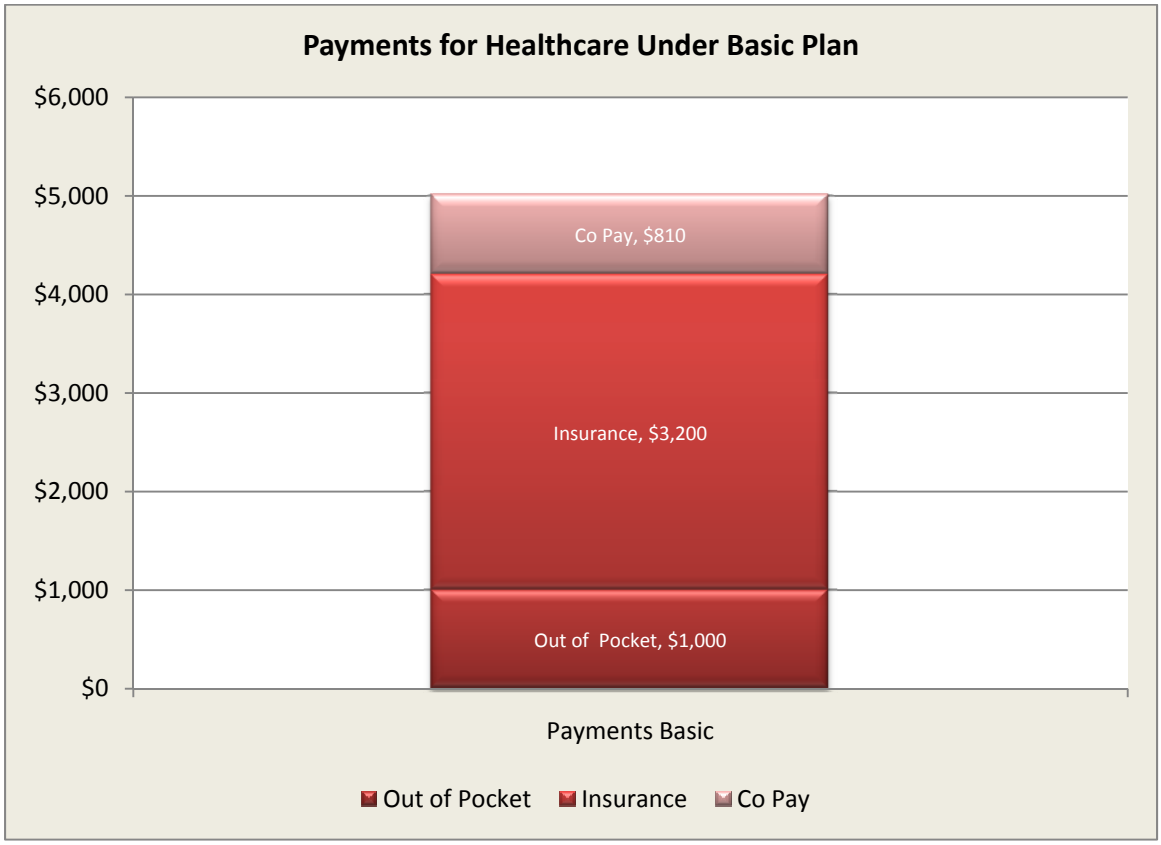
Applying the Target Cost Reductions we see we can reduce the cost per person from what it is today of some $7,200 per year to just over $5,100 which is a 30% cost reduction. This we show below by cost area.



We have applied our plan to the costs as they were in 2008 and we have achieved the cost reductions by areas as shown.

3.5 Payments, Balance and Control

First we look at the pro forma payments required under the Core Plan. If we take the pro forma sources of funding from the subscribers as shown below we show that it matches penny for penny what the costs are. This chart does not address the issue of how someone will actually get the funds for this payment, we address that in the next subsection. What this shows is that the pro forma payment do cover the costs after we have achieved the deductions from the Target Areas.



Thus we have a simple straightforward plan which has no overt costs other than what the Government decides its wants to reimburse people for. The plan costs total out of pocket what it costs for auto insurance per car in New Jersey. Since every person has a car the costs per person out of pocket is that amount. The other amounts for the insurance payments are additional and would have to come from their own resources and that may mean from their employer. I have avoided the tax issue but frankly the money should be taxable based solely on a fairness principle, but we avoid the discussion here.

4 FINANCING HEALTH CARE REFORM

Now we address where the subscriber will get the Financing Health Care Reform as we have presented it herein is the key determinant to it enactment. The problem is that although we can set the rates as in the previous subsection the question is who can afford such a payment. This has always been the crux of a universal coverage plan and even with the Medicare and Medicaid Plans. In this section we show how using existing funding and a modification in certain Medicare/Medicaid taxation plans that the plan as specified in the Core Plan with action taken in the Target areas that the proposal require no new Government funding. The current Administration proposes trillions of dollars in addition to what is already being spent. With the proposal we have made herein this added expense is no longer required.

We begin this discussion by making several key assumptions:

1. Medicare and Medicaid spending remains fixed at current levels as may be adjusted by inflation and population growth.

2. The Core Plan is adopted.

3. The costs savings we have proposed are adopted as well.

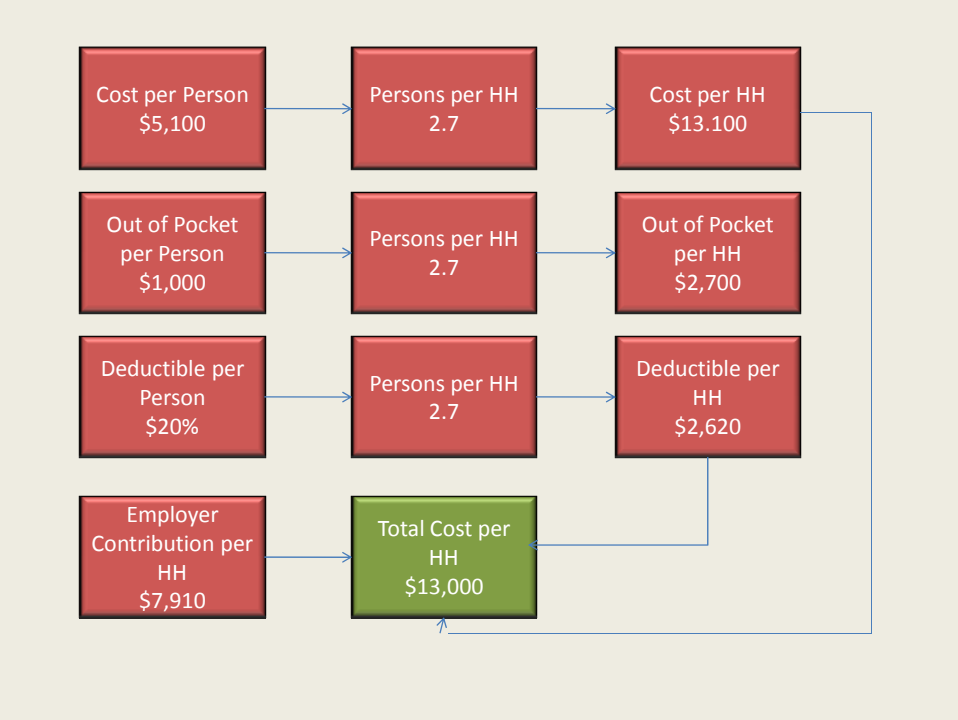
4. Universal coverage is implemented.

5. A set of constraints are applied regarding contributions to health care.

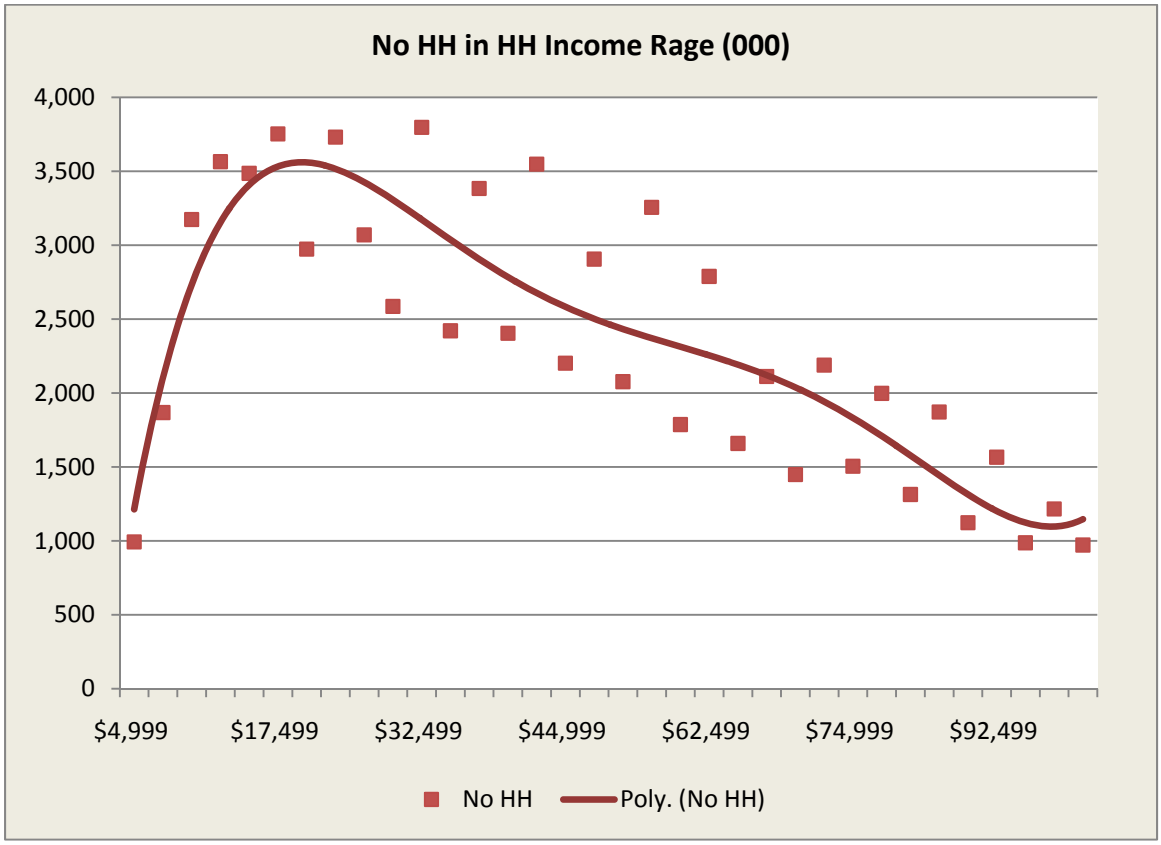
Let us begin with the constraints. We depict the details of our assumptions in the following Table below:

Element	*Value*	*Description*
Target Percent of Health Care per Family Gross Income	10%	No family should spend more than 10% of their gross income on health care. This may be changed but the selection of 10% is consistent with total exposure.
Maximum Out of Pocket per Person	$ 1,000	The Core Plan has a maximum out of pocket of $1,000 per person.
Persons per HH	2.57	The US has this number of persons per HH
Annual Costs per Person	$ 5,189	This is the cost per person in the US in 2008 if we were to implement the cost reduction procedures,
Annual Costs per HH	$ 13,101	This is the cost per HH for all health care from all sources.
Out of Pocket per HH	$ 2,569	This is the out of pocket per HH
Deductible Percent	20%	This is the deductible of non out of pocket expenses.
Deductible per HH	$ 2,620	This is the deductible per year.
Employer Contribution per HH per year	$ 7,912	This is the employer contribution per year.
Maximum Employee Contribution as % Income	15.0%	The employer contribution is maxed out at this percent of salary and the Government would pay the excess.
Minimum Employee Contribution as % Income	8.5%	This is the minimum employee or HH contribution. If the health care expenses are less than this then there is a tax on the difference and this tax is used as an offset.

We diagrammatically depict this below:



Now the primary problem is that there are many HH whose income is well below what is needed to pay for the Core Plan. Thus they must be subsidized for there is no other way to ensure universal coverage. We show below the distribution of HH incomes in 2007. Even if the Median Incomes are almost $70,000 we have many people well below that level.



Now we seek a way to pay for this plan. This is demonstrated in the Table below. Simply we use the existing Medicaid funds, we then show a gap, which we fill by taxing those whose incomes are above a certain level on the principle that they must have a minimum percent of their income spent on health care and if the minimum is above what they pay in their plan it is then considered a support tax to close the gap. In this example we actually show an excess of $30 Billion. Thus the proposal actually pays for itself.

Financial Element	Amount	Comments
Total Subsidy Costs	$266,487	These are the total Subsidy costs that must be covered in a year. We use 2007 as the baseline year.
Medicaid	$192,322	This is the current 2007 Medicaid costs. Since we are replacing Medicaid with this plan we can use this as an offset.
Excess	$74,165	This is the difference which must be made up.
Tax on Remainder	$104,350	This is the tax on higher income HH whose health care expenditures fall below the minimum amount.
Net Excess Tax	-$30,185	This is the excess tax which must be raised. In this example there is no excess and in fact the monies are returned to the taxpayers.

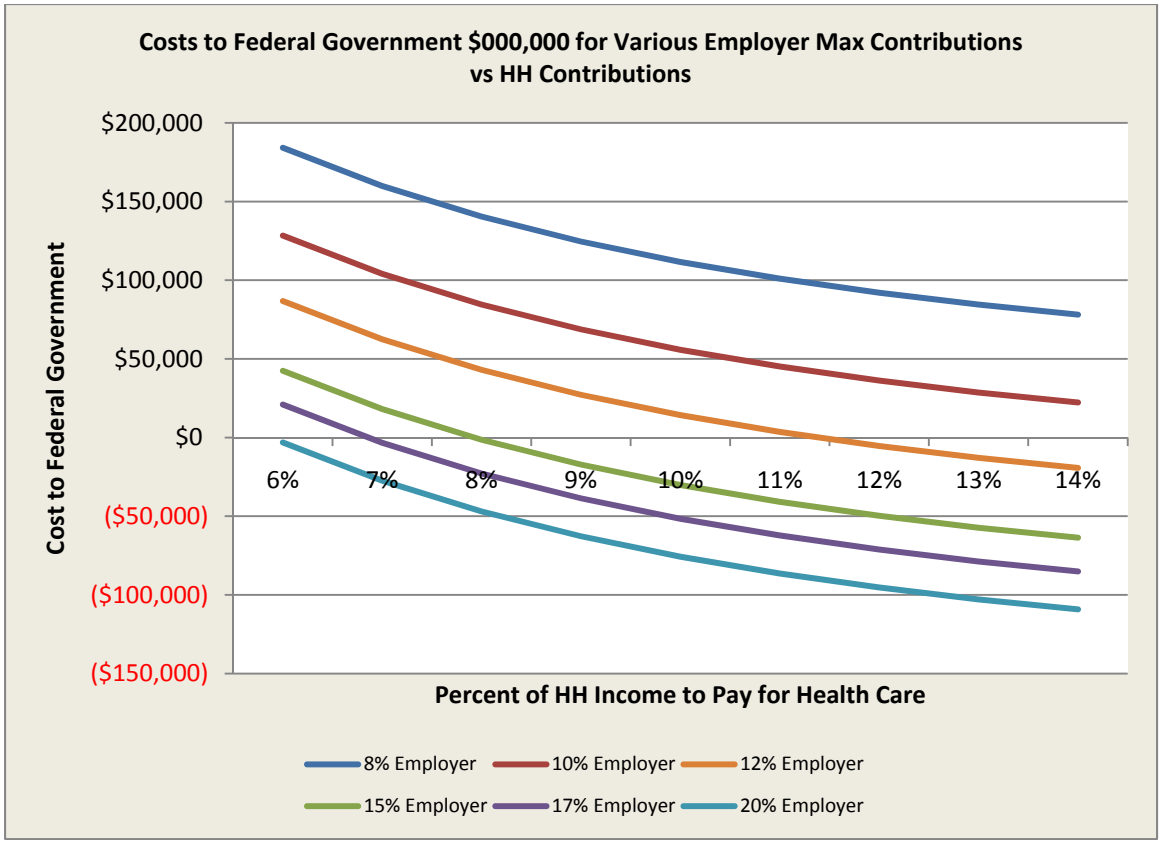
Let us review the Plan payment details:

1. The Core Plan requires three sources of payment; an annual out of pocket, a deductible, and an employer payment. We assume that the self employed will have to make the employer payment and that there is no tax benefit difference between what the employer or the self employed makes.

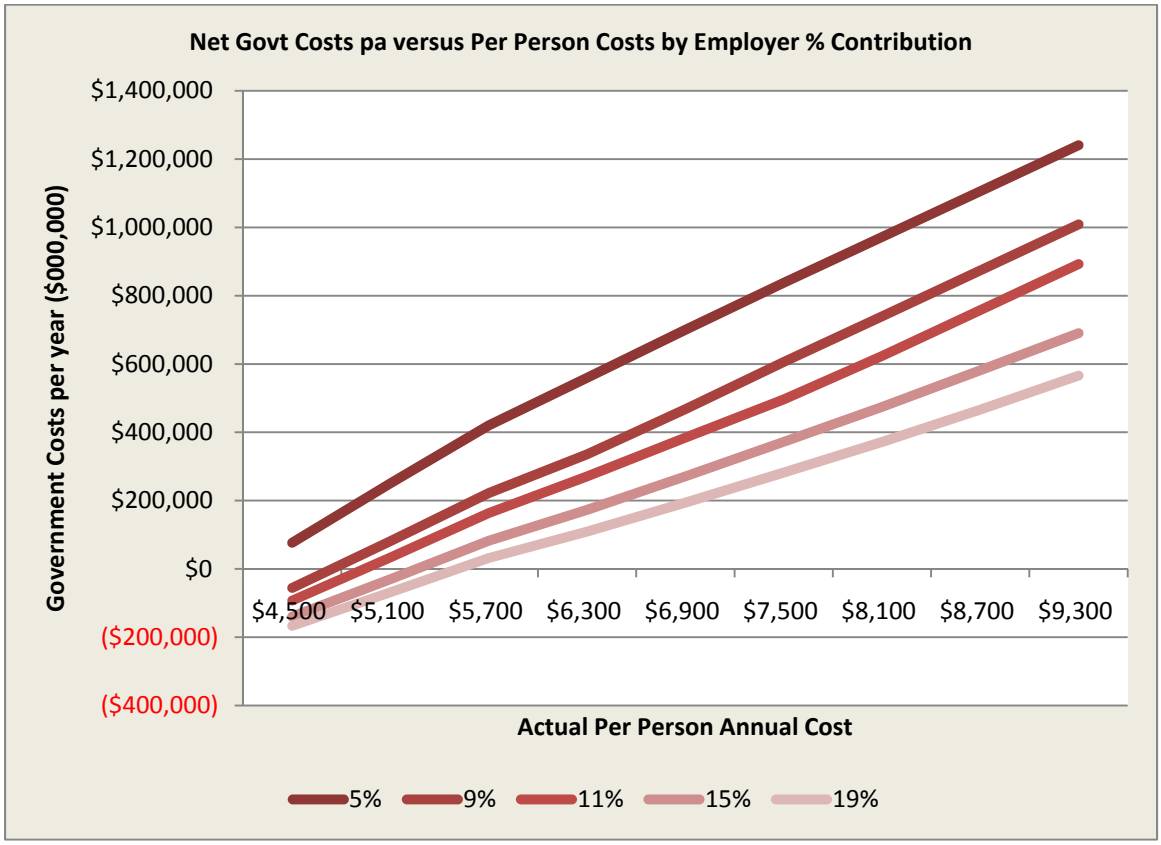
2. We assume that there is a cap on maximum payments from either the individual or the employer. The individual's total out of pocket payments, or a HH if that is the case for a family, must not exceed in our current example 10% of their gross income and an employer no more than 15% of the gross salary paid. These of course are changeable with resulting consequences. For many below a certain income level this then create a shortfall on the revenue required to cover the expenses. The shortfall would be from both HH and employer funds.

3. The shortfall must be made up from Government funding. We are suggesting that the current Medicaid funds be applied to this shortfall as we have shown above. This Core Plan would eliminate any need for Medicaid. If we then apply Medicaid funds we still have a shortfall. We then suggest that we place a bottom cap on health care expenses. That is we have a maximum and we have a minimum. If we have say an 8% of gross income as a minimum, then if one has a $1,000,000 gross income than one would be expected to pay $80,000 on health care. If health care costs say $20,000 the remaining $60,000 goes to the funding mechanism for the Core Plan payments. That is every HH or individual signs up for a plan and they pay their plan fee or the maximum they can pay under the Plan and the remainder is taken care of by a Government payment, with funds from Medicare and the minimum care payment fund.

The following Figure shows the sensitivity of this proposal to such factors as changing minimum deductible and employer contributions. In our analysis above we assumed a 10% deductible and a 15% employer contribution. The vertical axis shows the unfunded part still required by the Government if the Plan is operated at those differing percentage points. For example at an 8% employer contribution and a 6% deductible the cost is an added $180 Billion per year.



There are many other sensitivities we can examine but generally they all show the target numbers. The next Figure shows the sensitivity to two other factors; annual costs per person and the percent employer contribution



We can see from the above Figures that there are regions where the Plan Government funding requires no new funding other than what we have proposed. There are also many regions where the Plan would cost a considerable amount. Thus any execution of this type of Plan must carefully understand the regions of acceptable operation and not be surprised if the constraints are disregarded that one may result in a system which is ever so more costly.

5 CONCLUSIONS

As we look at health care costs they are just like the costs in any other business enterprise. You can see them growing and the issue is why. Regrettably politicians and Congress specifically just are incapable of digging down deep and ascertaining what the problems and how to fix them. First a general observation may be of some value.

The two segments of our economy which have costs growing well beyond inflation are health care and education. All of our other segments, the private ones, have increasing productivity. Someone should ask why. The general answer is increased regulation. In higher education there are more and more administrators whereas the faculty to student ratio is constant. In fact there are frequently fewer faculty. There are just more staff, and to do what, fill out forms and meet Government mandates. We know that health care administration is the fastest growing sector as well.

Now to several facts that must be added to the mix.

First the expenses. The expenses for 2007 demonstrate: hospitals have 31% of the total and physicians have 21%, and these are the top two totaling 52%. Drugs are just 7% despite the cry that they are a major factor. Nursing home care and home health care currently represent 10% of the total.

Second, the rate of growth of these expenses is large. Almost all expenses exceed both inflation and patient population base by 2-4% per annum. Presented this way these rates look frightening. Home health care and administration stand out. This should be a concern. Administration is 7% of the total costs and frankly they may be greater since there are administrative costs hidden in physician costs. Presented in this manner we see that home health care. hospital care and physicians still stand out above the norm. The reasons must still be determined. One must remember that hospitals get almost half of their income from Medicare and Medicaid and these are highly controlled to DRGs, diagnostic related groups, and thus it is generally more difficult to have inflation if the Government is directly controlling costs. In addition and on the negative side there is an increase in uninsured which does drive up ER costs.

Fourth, physician costs are dominated by specialists as we have shown.

Fifth the specialists costs a greater deal, usually twice, what the internist does.

But it still leaves us with the question regarding physicians; is it their salaries which are increasing, their overhead, the number of procedures, the cost per new procedure, the technology of the procedure, and so on. There is also the question of whether the costs have provided more benefit in terms of outcomes to the patient, the often heard cry for health care reformers. We argue that it will require digging down deeper into the details to determine this.

The total costs are readily broken down on a per person basis by disorder, its frequency, the medical service required, the processes per service and the costs per process. To date we have seen no such analysis from the Government and several private groups have done some preliminary work but not to the level required. This analysis is the necessary first step in both determining what is wrong in health care and what can be changed.

The problem is simply stated; reduce costs while maintaining or increasing the positive outcomes. This is unachievable until we first solve the above simple problem. It is just data gathering and the ultimate responsibility is the Governments, but they seem to have no ability to address this issue.

To summarize what we have proposed and analyzed in this report, it is as follows:

1. It is essential to articulate a simple set of principles about which any plan is constructed and stay within those limited principles. Problems arise when Congress fails in this step and further when Congress uses this opportunity to address a plethora of other parochial issues and interests. A simple and focused statement of principles is the sine qua non for success and acceptance.

2. Proposing a simple Core Plan which achieves the goals established by the principles is the next step. The Plan may be modified as is necessary but the Core Plan must satisfy the principles and reflect the cost target which may be achieved, and the cost target must be materially lower than what is presently the case.

3. It is essential to recognize where the problems are, what is causing the costs to increase. Failure to recognize the way health care works, like any other business, and seeing what the drivers are, the productivity factors or elements used by the drivers, and the unit costs are, will result in not achieving success. Cost can be reduced by reducing demand from disease drivers, improving productivity and/or driving down unit costs. This is a simple and well understood concept in any business and health care is in many ways just another business.

4. Target Areas of cost reduction must be articulated, with action plans, schedules, and accountability applied to them. The Target Areas must be periodically updated in order to have a process which continually drives out costs.

5. Implementation of the Plan requires Government intervention in two areas. First the provision of a supervisory role over the Insurers to guarantee the standards are met and that a competitive environment is enabled and maintained. Second the Government must provide funds to those who cannot afford the Plan based on income. However it is essential that this income support function be managed to eliminate fraud and abuse.

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