

FRESH Thinking – Workshop #8
Transitions Issues for Comprehensive Healthcare Reform
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Summary of Paper by Alice Rivlin

Comprehensive health reform means 3 things

1. Clear path to universal coverage = basic coverage at an affordable cost
2. Moving towards more efficient and effective healthcare
3. Moving to slower projected rate of growth in total healthcare spending since current rate is not sustainable

Current conditions make it the right time to attempt changes:

- Significant government spending in infrastructure (as part of stimulus package), and
- More people than ever will need help with healthcare due to recession (increase in job losses which provide health insurance).

What change do we pursue? Goal is to build on the strengths of the current system to chart a path forward. Those strengths include:

1. State Models (Vermont and Massachusetts) – Good ideas; however, opportunity may have passed due to economic problems and lack of federal momentum, and 50 different systems would be a nightmare
2. Individual Coverage – Building on this model, the Federal government could implement an exchange and /or voucher system to provide individual coverage. The fiscal implications may be too big an obstacle, however if executed well as a viable alternative to employer based systems, this may be a feasible alternative as the employer model erodes due to companies' increasing inability to subsidize health care.
3. Current Federal plans (e.g. Medicare and SCHIP)
4. So, where are we now?
 - The Obama team proposal is to build on the employer plan model – since it has popular support, and institute pay or play, and add an exchange system with federal subsidies to buy into the federal employee plans. However, the administration has made two mistakes, which may erode support:
 - Trashing elimination of the exclusion of employer benefits from income taxes (which was proposed by the McCain campaign) which may be required to help subsidize the plan, and
 - Affirming that we can save \$2500 per family through IT, reducing insurance admin costs, prevention and disease management, which may be optimistic.
 - Not convinced that employer based insurance will not erode in the long run. However, if the alternative is good, this might foster greater migration as employers might prefer to pay into the system than manage health care benefits themselves.
 - IT – must make infrastructure investments, but fraught with potential disaster. Must build national database that will be useful to make healthcare more cost effective, and design a reimbursement incentive.
 - Who should oversee the alternative plan? One option is an entity like a “health fed” (like Federal Reserve) – a prestigious, independent, qualified body, insulated from politics to oversee healthcare system. But there are also big concerns with this model:
 - This model is good for data analysis (like the NIH) but there are concerns about giving lots of money and power to an unelected, elite group

- The Federal Reserve isn't very monetarily efficient (for example, there are 12 regents as a result of how this body has evolved, but today they are not really required, yet it is hard to change this system)

None of these options or plans has any method for controlling top-line costs. Some people believe that is we just drive down costs (e.g. change reimbursement rates and be more efficient) and the rate of growth that we can continue with the existing system. Alice is not convinced that is the case. As medical treatment options increase at some point we will have to manage overall spending, looking at one overall budget.

Leonard Schaeffer Response

- Universal coverage – do not underestimate the challenge with developing a basic benefits package. This may be the toughest single thing to do and hold the line on benefits expansion. Every parent will want to extend coverage to meet their child's needs.
- There are significant challenges to changing behavior among medical providers to evolve healthcare IT infrastructure. Wellpoint gave away \$42 million in IT equipment to physicians to upgrade their IT systems; much of it was not used for the intended purpose. Financial incentives will be necessary to change behavior. Physicians do NOT view the world in terms of a system; they view it in terms of their individual patients.
- Current healthcare costs are unsustainable – there will be an increasing sense of urgency to reign in costs. Budget hawks will raise this issue, it will become a National Security issue as national debt rises and foreign countries (e.g. China) begin to purchase more and more government bonds

Jon Kingsdale Response

- Jon shared results to date of the Massachusetts universal health care system, including a low un-insurance rate of 2.6%, new enrollee cost \$2000/per year, compared with \$10,000 per year for Part D, a 75% approval rating for the system among likely to vote adults in the state. What can be learned from reform in Massachusetts?
1. Sequence reform – You need to take a long term view to transition the health care system, and prioritize which issues to address, for the following reasons:
 - a. Competing issues, e.g. Benefit coverage vs. Cost containment. Establishing and/or expanding benefit coverage represents business opportunity and potential reward for healthcare providers/insurers, while cost containment means reducing income. Impossible to reconcile both at the same time. MA chose to focus on coverage first.
 - b. Takes time to fully implement a new policy. For example, existing multi-year insurance contracts will need to expire before they can adapt to new rules, can take 1-2 years.
 - c. Significant differences in the needs of different states, e.g. MA vs. CA – which will required different insurance rules across the country; 5 years is aggressive
 - d. Successful execution is critical – for success and to build support. Whatever you decide to do you must do well. Need to be focused to insure successful execution. In his experience, this meant:
 - i. Delegating issues that cannot be successfully defined by a legislative body
 - ii. Specifying deliverables on a tight timeline
 - iii. Sufficient resources for implementation
 2. Individual Mandates for universal coverage are critical. Need shift in perspective to see that coverage is something that everyone should have; that it's like minimum wage (high deductible, minimum coverage).
 3. Public understanding of the issue is absolutely critical for cost containment. People do not understand that this is a \$2.4 trillion problem. They see it in terms of having to pay \$30 for a prescription without realizing that Medicare is subsidizing Kaiser \$8000-9000 per year to cover them.

Fundamental conflict – must contain costs in order to maintain coverage, while providers are asking for increases in payments.

Alain Enthoven Response

Agrees with objectives outlined in Alice’s paper, but shared two concerns:

1. Politicians want coverage, but without cost containment
2. Situation is more urgent than people think. In 2008 total Federal health spend will exceed \$1 trillion, and will double within 10 years

He agrees that we should build on the strengths of current system, but sees them differently.

1. Does not see Employer Based Insurance (EBI) as a strength:
 - It is not a cost conscious system,
 - employers do not understand health insurance and make mistakes,
 - it is inequitable because it denies low income people the lower costs plans they might prefer and locks people into high costs systems and
 - it leaves many people out
 - Risk equalization is essential to get incentives right, yet sees no way that millions of employers can do this on their own, yet it is required for the entire market

Alain sees the following strengths to build on:

1. Large multi-specialty group practices (MSGPs) (aka integrated delivery systems). They currently care for over 40 million Americans and are modeling best practices required to transition the healthcare system, and we should build on them. Their care model is practical, delivers great value for the money and is desired by people. They:
 - Integrated and coordinate care well
 - Are way out in front in the sophisticated use of information technology
 - Emphasize chronic disease management and prevention
 - Can cost 30% less
 - Over 450 MSGPs exist across the country, in both rural and urban areas – meeting the needs of a variety of communities.
2. Large scale examples of cost conscious consumer choice to help manage competition show that this idea is practical on a large scale.

How best to manage the transition to reform the whole system?

1. Create an independent body to create and operate healthcare “exchanges” to manage competition in every region. It should operate with congressional oversight and be viewed as democratic, but its independence would eliminate earmarks and pork barrel spending.
2. Require employers to buy employee health insurance through exchanges, to help spread risk, save administrative costs and give people choice.
3. Reform Medicare
4. Cap employee health insurance tax exclusion and use tax savings to expand exchange coverage

If we did this, within 10 years, health expenditure could be 30% less. In the long run, real competition will drive down costs, cutting expenditures in half with better quality of care.

America should make a maximum effort to take advantage of incentives and organization, with informed, organized consumer choice, in order to improve quality and equity, before rationing and budget cuts.

DISCUSSION

Cost Containment vs. Coverage Packages

Question: Shouldn't cost containment come first before basic coverage definition? If you define a basic benefit package that is acceptable, without thinking about costs, how can you ever get to acceptance of a lower cost/lower coverage plan once a threshold has been set?

- Mandates allowed Massachusetts to rethink benefit packages. Mandates can keep the minimum benefit package small since they shift people's mindset to see a basic benefit package like minimum wage, and not the ideal benefit package or a benefit that someone else is paying for. Capping tax deductibility of the benefit package is also a way to limit a basic benefit package. Neither way is sufficient alone.
- Concern that narrow benefit/high deductible coverage packages are not a path forward to change the system. They are good for hospitals to ensure they'll be paid for providing coverage, but do not help anyone with chronic care needs (such as diabetics) who are trying to manage payment of their deductible.
- Need to figure out how much money you have, and use that fixed budget define what you can offer.
- How do you price anything if you don't know what is in the package? How much it costs to produce the benefit is also an important consideration. You can't deny the interrelationship of benefit packages, cost of delivery, and cost containment. In the long run, you must decide on a basic benefit package.
- We can find more ways to deliver care more efficiently, but there is relentless pressure to expand the definition of what health insurance should cover, which is too challenging for legislators to withstand (e.g. parent pressure to expand health coverage to include special education for autism at \$70K per year). Deductibles and co-pays will not address this growing issue.
- In crafting deductibles, need to consider how different groups will react. For example, seniors were not getting flu shots because their seasonal timing came at the beginning of their annual deduction window, and they wanted to "use" their deductible on something important. Once flue shots were exempted from the deductible flu shot frequency grew considerably.
- Must consider the economic situations of those who need coverage the most (uninsured and underinsured). For many, even \$25 a month can impact their lifestyles – need to watch providers who want to augment the package
- Challenge to the benefit packages is how it will be used, and the politics around this will be enormously complicated. It will be used to:
 - o estimate what we can buy
 - o determine tax exclusions
 - o define adequacy
 - o whether people will have to change what they get today as a result of what will consequently be subsidized by the federal government (e.g. Unions will have great concern about what the taxable benefit will be)
- Cannot consider ways to address cost containment without understanding the key drivers of health care costs. Today, 80-85% of health care dollars is spent on individuals with chronic illness, yet no benefit package would exclude these people. We are an aging population and technology is expanding the number of health care choices. Not only must we contain costs, we must eliminate waste and stop focusing on unit costs (30% of costs provide no value) in order to reduce overall health care costs so we can afford new health care technologies and treatments.
- For the Massachusetts system, benefit packages are used to establish a standard to be included in the plan exchange and to determine the minimum amount of coverage required to avoid a tax penalty. The frameworks requires a basic package that meets a minimum set of legislated requirements, with 3 additional plan options – Bronze, Silver and Gold, that offer different coverage levels. Within that structure there are a myriad of plans, providers and coverage packages.

Question: How are other countries better at resisting pressures to expand coverage?

- Other countries have a greater commitment to providing a certain level of care for the entire country; and every system has an escape valve for the individual.
- Other countries, when tested (e.g. Israel) have held to rules and guidelines when challenged (and chosen to not include new
- Parliamentary governments are better at resisting lobbying by particular interest groups
- Physicians buy in to a particular approach and belief in what is appropriate care (e.g. do not refer people of a certain age to specialized care)
- Other countries are willing to trust professional organizations to determine what care will and won't work, to work with limited budgets and are willing to ration care. We are not willing to do that.

Question: Would a global budget make a difference in our country?

- Top down budgets will not work. You need to work with physicians to change patient's expectations; that just because we have the technology doesn't mean you have to use it. Then, if you change the market demands for health care technology, you will limit the growth in expensive treatments.

Question: What policy tools do we have to move in the direction of MSGPs to help get more value out of the interaction of the individual with the healthcare system?

- We need 3 things to accelerate the number of people who can get care through MSGPs, to build a portfolio of incentives to evolve our delivery system:
 - o Payment & Incentives – what can Obama administration build on reform of payment? Perhaps better alignment between doctors, hospitals, nursing homes with bundled payment approach; chronic illness based payment
 - o Capability to respond to incentives (IT) – Studies show it takes 6-12 months for IT to show return on investment, based on the disruption that occurs in the doctor's office, maybe consider low cost loans or grants in exchange for cost/quality data to change behavior
 - o Public reporting transparency and accountability - Exchanges would report data to show which plans are the most cost effective and provide incentives to sign up for more cost effective plans
- However, we still have an underlying issue that we lack the political constituency for cost containment!

Cost Containment and Value

Question: - What are we getting for what we are spending?

- If there is no political will to limit benefits, how can we contain costs? People hate tax increases, a good idea is to have tax increases tied to benefit increases; if you want to increase benefits you have to raise taxes.
- There are two objections to tying tax increases to benefits, either:
 - o People don't like taxes, so that will drive down the benefit package, or
 - o People want more benefits, so that will just drive taxes up
- Advocacy groups can always find someone who needs a particular benefit. The key is to say yes to everything; the harder question is to say when you use it. Need incentives at clinician level to reinforce when you use it.]
- How can you determine when you would deny a particular drug and form of care? Studies of other countries have found that the most transparent processes are the most effective at determine what technologies to make available. The most effective system – in Australia – was the most opaque system.

How to reach universal coverage

Question: Are Employer-based systems a place to start? What forces will shift away from employer-based systems?

- A good reason to start with them is that is where we are. One advantage of the Obama plan is that not everyone has to do something different, but offers another possibility with subsidized entry into a pool that has a choice of competing plans. This is a place to begin, but employer based coverage may erode

quickly if the alternatives are good and deemed to be successful, and if alternative benefit is good enough. At that point, if exchanges are in place and effective, you could institute a new revenue system (e.g. VAT) to pay for more people to be included

- Problems with employer based systems are their heterogeneity of plans and inequity for low wage employees. An alternative is to expand EBI system – let any contribution be tax avoided (payroll and state tax). Then, coupled with an individual mandate, with some tax incentives to help afford it, they can go into an exchange; then employer doesn't have to change their compensation systems. Big push back will come from employers who will have to change their compensation systems.
- Core of employment based system is a fundamental distrust of government and correctly see that the only alternative to an employer-based system is an expanded role of government
- Public alternative to an exchange system (e.g. Medicare with some sort of subsidy) may be good enough to get people to sign up and move away from an employer based system
- Concern that employers would keep low cost employees, and send high-healthcare cost employees to a public plan for the government to pay for.

Question: What are impacts to employer based systems with an alternative/voucher-based exchange system?

- Leave employer plans in place, offer subsidized alternative to purchase from an array of choices on an exchange. Key is the level of the subsidy – if it is similar to current federal employees, then the employer based system will erode quickly. But, doesn't address what we are offering to people outside of the current employer based system.
- New revenue source will be required if more people shift to the exchange based system and goal is to expand number of people covered
- If you set a benefit package that is too low, you will lose the support of the middle to left, and will have tremendous political opposition. However, if you subsidize a higher benefit package to build support – it will cost a fortune.
- This same argument was made against the S-CHIP program – people assumed that everyone would put their kids into the program. But this didn't happen.
- Which problem are you trying to solve? Are we trying to expand coverage to un- or under-insured (e.g. low income working parents). This impacts the strategy and choice of a voucher system or exchange system.
- Recession may impact which problem we are trying to solve as more people become un- or under-insured due to job loss
- There are advantages to maxing out the existing programs and building new mechanisms in parallel.
- Need to maintain a sense of reality. This is big business, and saying “no” is tough. Ultimately doctors as a political constituency are going to fight any change that would reduce their income levels.
- Within an exchange, selection of public plans competing with private plans can be dealt with through risk adjustment, but the exchange itself needs rules for selection to ensure its viability. Need guidelines as to who gets to participate in the exchange.
- Including a public plan like Medicare in an exchange will make it hard for the exchange to work, since Medicare can dictate costs, compared to private plans. One option would be to give private plans access to the Medicare fee schedule, as an alternative to being taken out the market by payers that can under price them by 50%.
- Issue with this – is that doctors would need to get to the point where there are no better income choices so that they have no choice but to take the public patient/public equivalent reimbursement – right now very difficult to get doctors to join public payment programs
- How can all the providers survive if all payment structures shift to Medicare levels?
- In a political conversation, health insurance providers are getting killed every day when they say “no” to paying the extra amount. Saying “no” to constituencies is very hard – you get killed by the media, by customers, by competitors. This requires political will, but how do you recommend to the President which constituency to hold the line against? And, can you get enough of a consensus to hold the line? Otherwise all this is a dream.

- Medicare fee schedule induces a lot of inefficiencies, which could move us in the wrong direction, however it is inconceivable that you could pull that much money out of the current system, without a long transition
- You could phase it in – offer 125% of Medicare payments or offer a global payment alternative to inadequate fee for service

Question: How does the cost per treatment impact healthcare costs? Could just knowing that you could do it more cheaply drive costs down?

- Canadian anesthesiologist working in San Francisco observed that US fees were 4x's what he gets for the same procedure in Canada; while volumes in Canada were much higher than in the US. There seems to be a disconnect between the volume of work done by medical specialists.
- We use fewer drugs, fewer days, and fewer visits. We are relatively efficient; we just pay twice as much for every unit of service. And it is all due to negotiating leverage.
- The numbers of specialists providing a service determine costs. The market system will hire just the right number to keep specialists busy, but with a good living. Having the right number of specialists can take costs out of the system.

Question: How do payment structures impact healthcare costs?

- Bundled payments. Could provide lump sum per procedure – and let care providers determine the most cost effective way to deliver.
- Concern that “defensive” medicine to avoid malpractice claims is driving up costs. Believe this is a myth – no physician can say how much costs would drop if malpractice was removed as a potential cost.
- You can't just give people the information about cost drivers and assume they'll do the right thing. We need to track every dime spent in this system. 50% of the time, procedures are unnecessary.
- Somewhere in the system we will need to invest in the specialties, because the evidence shows that Doctors need to be able to translate evidence and science into appropriateness and quality criteria, and there is no infrastructure in medicine today to do this – only the government or health plans telling doctors how to practice medicine. The profession itself needs to take the lead on eliminating waste, but they can only lead if they have the ability to translate the science into practice guidelines with the help of specialty societies – which they can't do because they are spending all their money suing people.
- What is the different in cost drivers between us and other OECD nations?
 1. Numbers of Specialists and payments to specialists
 2. More procedures (twice the number of coronary procedures and knee replacements)
 3. The price of prescription drugs (although this is lower than it's ever been) - 10%
 4. The unit price of hospitals
- Legal barriers to lower costs. Initiative to drive health plan members to networks of more cost efficient providers was blocked by organized medical societies and several states (e.g. New York attorney general). This prevented health plan from driving people to more efficient networks of specialty providers to save costs. Legal challenge was consumer fraud – advertising physicians as “high value” when they were really just low cost.
- The difference today that may build support among physicians for reform is drive for better infrastructure for information sharing – as long as doctors are part of developing the solution
- When you start making changes to increase efficiencies (e.g. identifying best quality, cost effective physicians), that involves moving patients among doctors, using a variety of incentives, you have a difficult set of real world political challenges – state regulators and AMA will likely challenge. It will move, but it will be politically complex and take several years to do.
- One option to deal with barriers is to make the data available about quality of doctors – however, you need to make sure and fund this. The ACC, as a specialty organization, is trying to take on comparative studies but grappling with funding issues.

- As we consider our health reform plans – with connectors and exchanges, we may need to pay greater consideration to how we define market power (and how health care providers – hospitals – are exercising market power) and do more with anti-trust to enable the changes discussed. Will need to look at outcomes of anti-trust cases in last decade.
- Information, evidence and guidelines do not change behavior, particularly when doctors are asked to change contrary to their own economic self interests. What is effective is pride and professionalism, which can incent physicians to determine the right level of care for the patient, and identify efficiencies in delivering care.

Commentary by David Ellwood

1. Is this a time when we can leap ahead to dramatically real reform, or are we starting a process?
2. If we are starting a process (which is more likely in his opinion), then where do we want to go in 8 to 10 years? Consider equally what seeds you need to plant along the way.
3. What do we need to put in place now, to get us on the right trajectory to get to where we want to be in 8 to 10 years?

What can we learn from welfare reform?

1. Strike while the iron is hot – really important to move when you have an opportunity
2. Interconnected elements become disconnected in Congress (e.g. in welfare reform the plan included time limits combined with jobs, however in Congress this became time limits with no jobs). Grand schemes rarely survive the political process
3. Combination of altered incentives AND strong institutional messages can dramatically accelerate change. Make sure the messages are right, along with the incentives.

Can we leap to the future? Why did health reform failed before? David believes it failed for the following reasons:

1. Clinton fully believed that we could do everything: cover everyone, improve quality and dramatically change, but this required massive complexity to address coverage, cost control and which was almost impossible to understand. and dramatic change
2. 80% of people also think the health care system is broken, but 80% of people believe their coverage is fine and see change as “they’ll screw our coverage up”

Complexity combined with this perception led to failure. So, the key lesson is don’t try to do the big stuff, rather, start where you can, plant the essential seeds and then go for long term reform.

Why does the healthcare market fail?

- Small is NOT beautiful in healthcare markets:
 - o Risk selection is amazingly significant, such a skew in costs that means there is huge amounts of money to be made with even minor risk selection
 - o Good information is very difficult to get – even for educated, knowledgeable consumers
 - o Individual Providers are inefficient, you can monitor them and makes cost control almost impossible

It’s just the wrong kind of market. Coverage is the easy part (it’s just money, but it is good place to start)

1. What should be the role of the employer?

- There are a lot of things bad with employer based systems (inequitable, they lock people into jobs, bad for competitiveness). However, they do solve selection issues – which are the biggest single problem for the individual, they can be cost conscious, and can be value-conscious. Employers can also limit choices – which government cannot do.
- There are many ways to speed or slow the employer role. Deciding how quickly you want to move away from an employer based systems is really important at this stage, but maybe they can be seen as part of the solution.

2. What should be the role of individual consumers making individual choices?

- The choices for a consumer are almost incomprehensible. Really need something to help make the market work. Attractive element of Connector is structure to choices and accessible way to know about them (shopping online in Massachusetts)
- Individual mandate is absolutely critical.

3. What should be the role of Government?

- There is little support for a high level government program. But, Government does get coverage and care to a lot of people through Medicare, Medicaid. Eventually, government can force some reckoning of costs, to get more for less, and set up a more level playing field for competition. Real danger of government alternative is selection chaos. Must limit choices and use power to push down prices.

Recommendations:

1. Must create a more functional insurance market – absolutely central. Exchanges or connectors, with limited options and choice, with individual mandate, increase cost
2. Individual Mandate
3. Get employers to be more cost and quality conscious, and do not rush to push them out
4. Like the idea of a Health Care “Fed”
5. Experimentation! – During welfare reform, everything they learned came from state experimentation and especially in the current situation where we are not sure about where we want to go, this is critical.

Commentary by Donna Shalala

- All great social policy leaps in this country (social security, Medicare, Medicaid) had 3 characteristics in common by the time they got to a national framework and national legislation:
 1. Roots in state programs - Welfare reform is the most modern example. They learned more from state experiments about program possibilities, AND learned about where political consensus was and how interest groups would play against each other. States are labs of innovation. The idea that the administration can solve all details is dangerous.
 2. Consensus about the problem
 3. Consensus about the solutions and that there would be a strong government role
- Do not recommend submitting a logical, rational list to Congress, because it will get disconnected, and because we don't know enough about what will and won't work.
- A sense of urgency and crisis can build support for change. In the New York City fiscal crisis of 1975, in order to shift fiscal home rule from city of New York to state, they kept crisis feeling going in order to build support among various partner to engage, build consensus, and make concessions. Need a feeling that you can't do business as usual – it must reflect a crisis, not simply what experts believe need to be done.
- What can we do realistically today? Things that can be done immediately, with existing resources, to build credibility:
 1. Agree on a framework.
 2. Close gaps with existing programs, but must be tied to unemployment (e.g. public sees the connection between unemployment and losing health care coverage) to build support. Tie package to current fiscal crisis to build consensus.
 3. Implement waivers in States. May be able to clean up programs (such as Medicare) through waivers in states to help build constituency for change and improve quality. CMS Director and partnership with OMB could learn a lot through these state programs.
 4. Attack costs from all directions. Attack fraud (not waste)! It doesn't cost you anything since anything you spend up front you recover and put back into the program. However, key is to

- identify areas where there is serious fraud (not just low hanging fruit), this builds credibility with the public and gives you more resources.
5. Programs to address chronic illness. Every part of HHS should have a chronic illness strategy are critical for all – since this is where bulk of costs lie.
 6. Focus surgeon general on “Eat Right/Avoid Tobacco” program. We need to build credibility with the American peoples. Building credibility is key – particularly because people are very scared about loosing their jobs and not having health care. People will understand this and how it will affect their lives and health care costs.
- Before you develop an entire framework, would work with Congress to figure out what they will support. The President must have a set of principles upon which to negotiate a package with Congress; in parallel, must take steps to impact people’s everyday lives to build credibility and trust for a more complex plan delivered by government.

Commentary by Carolyn Clancy

- Instant credibility is very important. People are scared about losing their jobs and losing their health care.
- Need to build on the power of existing public programs. Agree with challenges of employer based system, but changing them for people for whom they work doesn’t make sense. Building on existing public programs can help expand existing capacity. Can learn a tremendous amount from various state programs take advantage of their strengths.
- Carolyn is most concerned about improving the quality and value of care. Providers really have no idea how their level of care compares with other providers in terms of quality. Benchmarking is key.
- There is a lot of excitement about investing in health IT. This is exciting because the data provided will have many applications – research, post marketing surveillance, identify effectiveness of treatments. However, does not see that the current industry is ready.
- Must get serious about reforming payments – state and regional experimentation and innovation could be very helpful great way to learn ways to do this, since systems will need to differ by region (for example, Miami vs. Minnesota)
- Need to evaluate benefit of Health IT investments on quality of care, and should make it a condition for funding to make products to make it easy to report on quality e.g. lab data, pharmacy data and imaging data; Current system tracks quantity, but not quality
- Chronic illness – current system not designed to evaluate comparative effectiveness of treatments – need to link health IT to this to make it possible
- Need to figure out how to network small practices; concierge practices centralize a lot of administrative functions that can be an incredible waste for small practices
- Focus on comparative effectiveness is necessary to learn what works, and to be able to put incentives in place to reinforce them, but we must also focus on efficiency of delivery needed – need to reward excellence (we don’t today), and there are no incentives in place to do this because no one receives the savings
- What’s going to break us in 10 years? (E.g. renal disease) – we must build an approach that helps us anticipate the problems we must face in the future

DISCUSSION

Question: Where do we want to get to? What do we need to do along the way? What ideas do we have that are new and fresh – and not the same ones that have been around for 40 years?

- Chronic illness – there have been lost of discussions on the need to focus on chronic illness since it is such a large cost driver. What is new is the potential for better information to learn about what is being done for better intervention. So, let’s focus payment and incentives on managing chronic illness better. We also know that providers do not want to treat their patients the same (too difficult), so you

must focus on providers rather than health plans to figure out how to structure what they are doing to manage chronically ill patients. This is a very different approach than discussing how to structure payment to get more people covered.

- We need to change the culture to make everyone cost conscious and incentives for productivity improvement to offset new technology costs and support medical innovation. If we change the incentives, that can promote technology development based on market demand.
- There seems to be consensus on need for Exchanges, and for individuals and small groups to participate. The Massachusetts system shows you can set up a health care Exchange. Beyond that, what do we want to experiment with and what happens to Medicare and self insured plans if we take on ERISA?

Question: What are the bigger changes we can make, rather than a few demo projects?

- What can we learn from state experiments, other than coverage? We could learn from the following which could be generalized to the general population.
 1. You can experiment at the state level with payment reform and payment incentives. For example, paying providers differently; paying for performance, perhaps providing incentives to the patients, not just the providers
 2. You can experiment with new delivery models – For example different ways for caring for chronically ill; perhaps private disease management companies or health plans working with providers on chronic care model to provide infrastructures (e.g. disease register).
 3. What are the workforce implications to health care reform? How do we deploy the workforce and what kinds of people are being trained? If we expand coverage, there will be an increase in demand for primary care physicians that we can't meet today – particularly due to the increase in specialists. We need to consider new ways to deliver care which would require changes in licensing and certification.
 4. Public reporting and visibility of data. The big impact is not on the consumer, but on the providers - no doctor want to see one star by their name when others have 3 stars; has great potential to change behavior.
- Payment reform – need principles for how to set levels for things such as voucher levels. Traditionally based on historical costs, but no relationship (by intent) to value, it's all about costs. How will we decide how to set levels? What are our fundamental principles? Based on desired endpoints? Maybe cost effectiveness is a principle. We really need to identify our principles which will set those levels.
- Pay for higher value outcomes with incentives for provider to build on more efficiency that will promote providers become more efficient over time.
- How can we use Medicare to learn? What about Medicare Advantage Plans? Let's put out RFPs for large health plans to develop a "Medicare Advantage Plan" at a state level for some large health plans to say how they would do things differently, perhaps for chronically ill and allow ERISA plans to buy into it. It might cost a bit more but we would learn a tremendous amount.
- Not clear what goal is for chronic illness. Is it saving money? Or improving quality of life? (e.g. Cancer today has become more like a chronic disease, but that's more expensive. Over the course of the life span of living with chronic illness, the total costs are going to increase. What is our goal in dealing with chronic illness?
- If you can get people to work together on chronic illness – that will spin off to other medical care issues (halo, trickle down). Clinical management system developed to support chronic illness offers benefits for other issues
- Sees 4 areas to leap frog forward today to more integrated care and better public health:
 1. Payment reform – fee for system doesn't work, we must change this – in the near term we can switch to episode treatment, beyond initial admission; bundle payment for physician groups
 2. E-prescribe to collect information to look at long term safety and effectiveness issues
 3. Force organized, integrated groups to foster infrastructure sharing, best practice sharing by providing incentives to do this by offering better payment (terms?)

4. Emphasis on public health (for example, obesity epidemic, 5% of people drive 50% of costs)
 - 100% coverage won't address affordability issue which is being driven by these epidemics; prevent health people from becoming ill.
- From a public policy perspective, we must consider the underlying public health drivers of health care costs. Cardio-vascular disease and stroke (\$400B) – this is going to skyrocket, due to tobacco consumption, diabetes, obesity and cholesterol and hypertension. Medical systems are good at saving lives, but costs will continue to rise - \$400 billion is headed to \$400 trillion. There is such an absence of energy around solving these underlying health issues because they are not exciting. When we talk about obesity, what is never talked about are the people who manufacture and deliver food. We need to bring this into the discussion. Policy group MUST think about these factors
 - There is a great disconnect between public health and nutrition programs. There is no link between nutrition and food assistance programs (e.g. WIC, food stamp, school breakfast/lunch programs). Need to influence the billions of dollars being invested in food assistance programs to be consistent with desired changes in health care policy. This discussion occurs in the Agriculture committee, not health, but there is a huge disconnect and we could leverage huge amounts of money to support changes.
 - Problem –while in principle we agree on the 3 points outlined in Alice's paper (universal coverage, more efficient & effective care, and a slower rate of growth) we and the public haven't agreed on an end point. However there may still be pressure for Congress to take some action and pick the low hanging fruit – but this might take us in the wrong direction. We need to help Congress think about what steps we could take in the short term that won't do any damage, what things to avoid, and what steps can be taken that will move us forward.
 - We can take some steps, that are good (e.g. e-medical records), but that alone doesn't get us on the right path

Question: What things can we do today that are relatively inexpensive that can move us forward?

- The following points can get us moving in the right direction, but are these the right seeds that will put us in the right place in 8 to 10 years?:
 1. Eliminate fraud (although, could just breed resentment)
 2. Quality measurements and public reporting – some quality measures exist today that could get us in the right direction
 3. E-prescribing – Focus this in ways that will be meaningful
 4. Payment reform:
 - a. For hospitals –make bundle payments, rather than episode payments and change the end point of the care (longer time frame)
 - b. For doctors – Stop paying doctors for drugs for defined activities and shift to bundle payment, such as for managing breast care.
 5. Comparative Effectiveness (of treatment options)
 6. Public health policy for longer term behavioral change
 7. Multi-disciplinary approaches – Coordinate support for prevention among existing groups – For example, coordinate efforts by SCHIP, US President's Council Surgeon General and Dept of Education to address obesity. There is nothing in Education that prepares children to be health conscious – must be added to the package.
 8. Centers of excellence
 9. Community enablement
- Need to add responsiveness to consumers to the list, to have a big impact and build constituency. Information and survey are never used to improve the process. Western European countries make a big deal about how they are making people's lives easier. They don't want to wait at CVS for a prescription. If doctors and hospitals reviewed weekly where they screwed up, that would have a huge impact.

- Delivery system reform - We seem to agree on the need for Delivery system reform. This will probably start in Massachusetts and California. If you can show that these delivery systems are better for patients and people are happier, and are for lower costs - then you can build on these models
- Need idea for limiting tax breaks (such as capping the tax break) to really help move the needle and help people understand the cost issues of health care
- We need a hard conversation about the political fight over the dollars. This is fundamental. We do NOT have delivery reform because there the dollars are free flowing! The battle is on the front page of the Globe on the same page says – “Limit Dollars” and “Pay doctors more” – that’s the battle you need to fight first before you can fight the battle to improve the delivery system
- Help American people understand that the major issues around their health is not related to number of times they see a doctor. Need to build up the core of people providing care and alternatives that impact behavior changes that lead to a healthier life style – e.g. self help groups, community education, to help move the needle. We don’t we train the sub-level jobs that can create change in communities? That will create much more change in behavior, and is linked to job creation. A “Health Corp” training non-professionals that can make a real difference in communities on nutrition, disease management and behavior change. This could be part of a new economy.
- Quality Measures – don’t hear enough about adherence piece. For chronic care, often patients are not taking medicine, and we need to factor this into the quality measures – if we want better IT we need to factor in patient role in adherence and provide back to doctor.
- We need to be careful about how we deal with health information. Would first focus on sharing with other doctors. Give incentives to primary care doctors to use information; important to maintain credibility.
- Information – issue is what is the intended use of the data –needs to get to doctors early
- We have good data on adherence and failure to respond -50% of failure to progress on a chronic condition is due to failure to increase (the delivery system), 25% is failure to adhere, 25% is drug therapy failure

Question: Do we need a new institution to drive some of these things? Or can HHS do this? Or a health Fed? How would we fund a new institution?

- Depends on what you want to body to do. Form follows function. What would their role be? How do you want it to function? Once you get into any kind of regulatory authority, you’ll get huge pushback for this body.
- Think that we already have an agency in place that has the capability and insulation from political process to carry forward the work of comparative effectiveness and quality measurement reporting with additional investment, and that is ARHQ. Could become a public/private partnership; would be a great start and not require starting from scratch

Question: How much choice should be offered to the individual?

- Increasing costs due to chronic illness is not bad; because it means people can live longer (death is much cheaper). Value of life expectancy is greater than growth in medical costs, but health care problem for public sector is the role of choice – Who is making the decisions? Many plans allow individuals to have choice. Is this good? Many studies show that expanding choice can lead to worse decisions.
- Choice is good because it conveys a sense of power and control, regardless of the intrinsic choice, and choice is required for competition. However, choice can be bad where there are too many possibilities (options can be manipulated by insurance companies to effect who signs up for what plan to reduce their risk) and it can inhibit development of efficient organizations of providers
- Need some simplification – information systems provide feedback to help make choice – but with so many dimensions – making choices can still be difficult
- Key is to ask what people really care about in making their choices – what they want choice about and what they don’t care about

- When you are evaluating a plan, besides co-pays and deductibles, you also need to evaluate the option price of making it feasible to go out of network
- Need to consider possible anti-trust issues you can't charge an employee different premiums for same plan depending on which provider they go to for their main care
- Will be very hard to ever have price transparency, which will reveal about plans
- Can we ever envision a federal plan building networks based on performance, to drive better quality or more affordability? Is there political will to foster organization based on performance?
- There is no capability to begin to exclude practitioners based on performance
- There is vast variation in outcomes from different providers, but what do people base their choices on? Do people want to go to better hospitals/care providers? Or do they go there because is part of their community? Need to understand.

Discussion around Centers of Excellence

- Designated centers of excellence can reduce reimbursements to providers, as long as you can demonstrate health improvement to show the public. One of the most useful tools available
- There are criteria that are rational, evidence based that will let you identify those centers. It is also possible to work through touch points with consumers to drive people to those centers. For high risk conditions (cardiac surgery) you can save 20% by driving people to those centers. This tool works. Increasingly, employers will provide incentives for their employees to go to those centers.
- Can you tie this to reimbursement to allow those centers to share in the savings? We are doing this every day.
- You can implement COEs (and implement bundle payments for total treatment including re-admittance and outcome) but and when you tie performance measures to reimbursements, people will say to hospitals – you make too much money – need to cap it
- When one tries to start designating centers of excellence – will start to argue about whose criteria are being used, who is selecting and what payment rate is.
- In practice, there are a lot of unmeasured characteristics about the patients, and a lot of vagueness about criteria, e.g. paying based outcomes assumes an adjustment based on patient characteristics
- Center of excellence model makes sense for those situations like complex cardiac surgery where clear volume/quality relationships exist. That's different than general provides who care for everyone. COE shouldn't be too broadly applied.
- Don't we have an obligation to provide performance information to patients?
- Could you select institution for payment benefits or COE inclusion based on performance that resonates with people, like hospital acquired infections – need data & transparency of information (potential legal issues in defining “excellence”)
- It is one thing to alter payment to change behavior; it is another to exclude from participation (from a network), and that is where you run into major problems, with huge legal and political ramifications
- Medicare – for complex issues, how can we deny access to better care providers?

Concluding Comments

- There are moments when substantial change is possible, and this may be one of those times. One are the most important set of things that we should do. The problem of coverage will likely be addressed first, and it will exacerbate the cost problem.
- Characteristics of actions are:
 - o Something happens to make a long term issue vivid in present
 - o Strange bedfellows become allies
 - o Leadership

- For climate change and health care reform, both may have all 3 conditions today to foster change. If you tie this issue to people losing health care because of job loss and reframe the need, this may build public support.

Do we need a new institution? A new institution, rather than existing ones, can be powerful mechanisms for change.

- There is support for data collection and analysis. We might be able to build on this to develop a new institution, but needs to go with expansion with coverage
- Caution about more bureaucracy; need more money for prevention and information to help people make better decision. However, there is no constituency to invest in this.
- But need to balance independence with accountability, linked closely to the expertise that already exists. Would better fund AHRQ rather than create a new agency, but perhaps it is a subsidiary.