



THE CHANGING HEALTH CARE LANDSCAPE

The 21st Princeton Conference

Princeton, New Jersey ■ May 13–15, 2014

The Council on Health Care Economics and Policy would like to thank our sponsors



We would like to thank the following individuals for their guidance of thematic and session content for the 21st Princeton Conference:

Kristine Martin Anderson, Booz Allen Hamilton
Gillian Barclay, Aetna Foundation
Ray Baxter, Kaiser Permanente
David Blumenthal, Commonwealth Fund
Carmella Bocchino, America's Health Insurance Plans
David Colby, Robert Wood Johnson Foundation
Jay Crosson, American Medical Association
Wendy Everett, New England Healthcare Institute
Karen Feinstein, Jewish Healthcare Foundation
Liz Fowler, Johnson & Johnson
Garth Graham, Aetna Foundation
Stuart Guterman, Commonwealth Fund
Sandra Hernández, California Health Care Foundation
Karen Ignagni, America's Health Insurance Plans
Sarah Iselin, Blue Cross Blue Shield of Massachusetts
Chris Jennings, Jennings Policy Strategies, Inc.
Chip Kahn, Federation of American Hospitals
Rob Mechanic, Brandeis University
Mary Ella Payne, Ascension Health
Uwe Reinhardt, Princeton University
Murray Ross, Kaiser Permanente
Len Schaeffer, North Bristol Partners
Audrey Shelto, Blue Cross Blue Shield of Massachusetts Foundation

We would like to acknowledge the contributions of the following staff members of Brandeis University's Council on Health Care Economics and Policy for their contributions to a successful 21st Princeton Conference:

Ashley Brooks, Events Manager, Council on Health Care Economics and Policy
Michael Doonan, Executive Director, Council on Health Care Economics and Policy
Elizabeth Pinto, Senior Department Coordinator, Council on Health Care Economics and Policy
Jenna Sirkin, Council on Health Care Economics and Policy

Dear Colleague:

The Council on Health Care Economics and Policy thanks you for your contributions to the 21st Princeton Conference: **The Changing Health Care Landscape**.

For the past 21 years, the Princeton Conference has afforded professionals in the health care field an opportunity to discuss the most pressing issues in health policy, and to create recommendations for meaningful change. We greatly appreciate the involvement of our sponsor organizations, our panelists, and our attendees in these conferences. We have received very positive affirmation from attendees over the past two decades that these conferences provide a balanced and comprehensive analysis of the pressing issues affecting the U.S. health care system.

The 2014 conference was organized by the overall themes of payment and delivery system reforms in the context of Affordable Care Act implementation and transformation in the U.S. health care system. Health care policy and industry representatives discussed how recent changes in financing, workforce, and care delivery have impacted value, quality, and access to health care. Panels focused on the preliminary effects of new policies for state government, the private insurance market, consumer access to care, and reorganization of care and the health care workforce across a variety of sectors and geographic regions.

Attached is a report that summarizes the panel presentations from each conference session along with the key discussion points and recommendations for future system change. I hope you find the report of interest.

Sincerely,

Stuart H. Altman, PhD
Chair, Council on Health Care Economics and Policy
and The Health Industry Forum

Table of Contents

INTRODUCTION	6
OPENING SESSION: SETTING THE STAGE	7
SESSION I: FORCES DRIVING INNOVATION IN THE DELIVERY SYSTEM: WILL THEY IMPROVE QUALITY AND VALUE?	10
SESSION II: THE NEW MEDICAL WORKFORCE	14
SESSION III: THE PRIVATE INSURANCE MARKET	18
SESSION IV: MEDICAID AND CHIP TRANSFORMATION UNDER THE AFFORDABLE CARE ACT	22
SESSION V: CONFRONTING THE AMERICAN HEALTH CARE HUSTLE	26
SESSION VI: APPLICATION OF EVIDENCE IN VALUE-BASED DECISION MAKING AND COVERAGE	28
SESSION VII: ENHANCING QUALITY THROUGH PAYMENT REFORM	31
SESSION VIII: INNOVATION IN COST CONTAINMENT AND DELIVERY SYSTEM CHANGE	35

Introduction

Speaker: **Stuart Altman**, Chair, Council on Health Care Economics and Policy and The Health Industry Forum



In kicking off the 21st Princeton Conference, Stuart Altman, Chair of the Council on Health Care Economics and Policy and of the Health Industry Forum, reflected on the conference's evolution. After meeting for several years at the Woodrow Wilson School and at a few hotels in Princeton, the conference

outgrew those sites. Since then, the Princeton Conference has annually been hosted at the Robert Wood Johnson Foundation and the Princeton University Faculty Club.

For the Princeton Conference's first decade or so, the Robert Wood Johnson Foundation was the conference's sole supporter. But support has grown. The Princeton Conference now is fortunate to also receive support from multiple organizations including Kaiser Permanente and the Jewish Healthcare Foundation. Other sponsors include the Aetna Foundation, the American Medical Association, the Blue Cross Blue Shield of Massachusetts Foundation, Booz Allen Hamilton, the California Healthcare Foundation, the Commonwealth Fund, and Ascension Health. Without the support of these sponsors, the 21st Princeton Conference would not have been possible.

Dr. Altman then introduced participants to the goals of the 21st conference, and to the content that would be addressed over the next two days of sessions. The 2014 conference was organized by the overall themes of payment and delivery system reforms in the context of Affordable Care Act implementation and transformation in the U.S. health care system. Health care policy and industry representatives were invited to present how recent changes in financing, workforce, and care delivery have impacted value, quality, and access to health care. The following dinner session and upcoming eight panel sessions would focus on the preliminary effects of new policies for state government, the private insurance market, consumer access to care, and reorganization of care and the health care workforce across a variety of sectors and geographic regions.

In closing, Dr. Altman took time to recognize the many contributors to the current meeting and to prior Princeton Conferences. The sponsors, he noted, make the Princeton Conference possible. The panelists and participants make the Princeton Conference great. Each panelist and participant is a leading health care expert with tremendous knowledge and experience. The collection of expertise is always impressive and makes the Princeton Conference such an outstanding event.

OPENING SESSION: Setting the Stage

Speaker: Chris Jennings, President & Founder, Jennings Policy Strategies

Overview

After the political wrangling to pass the Affordable Care Act (ACA), the Supreme Court decision, and a bumbling implementation, there are now about eight million people enrolled in health insurance through exchanges and perhaps ten million people with insurance who were not previously covered. This is an amazing accomplishment. And, significantly more people are likely to enroll, insurance premium increases are relatively low, and the overall rate of health care cost increase is lower than predicted. What the future holds for premiums, cost control, or politics is uncertain, but the ACA is now part of the nation's infrastructure and repeal of major provisions is highly unlikely.

Context

Health policy expert Chris Jennings, who has advised Presidents Clinton and Obama, shared his assessment of where health care reform stands, offered political observations, and responded to questions.

Key Takeaways

IT IS HARD TO BELIEVE HOW FAR WE HAVE COME IN SUCH A SHORT TIME, AND FURTHER PROGRESS IS LIKELY.

The passage and enactment of the ACA was a political miracle, which was an outgrowth of people concluding, "We have tried everything else."

Beyond the passage of the ACA, the progress in just the past six months or so has been astounding. It was a bumbling implementation, with challenging and stressful times. Yet even in the middle of the implementation crisis there was a commitment to work through it to avoid failure.

As a result, there are now about eight million people enrolled in exchanges and millions more, almost all of whom previously did not have insurance, enrolled through Medicaid. When netted

out, there are probably about ten million people with insurance today who did not have it previously. But this isn't the end. Next year, there are likely to be significantly more enrollees.

Based on the initial read of enrollment, the enrollee mix seems pretty good, indicated by what insurers are contemplating in bids for next year. Premium increases will probably be below 10%, and there is general acceptance that the ACA is addressing a need.

In addition, the ACA is now expected to cost \$1 trillion less than was projected at the time of enactment. This is because health care costs have been growing at a far lower rate than predicted. This is not directly attributable to the ACA; it is based on the overall decrease in the rate of health care spending growth. The challenge for policymakers going forward is to sustain the low rate of cost growth.

"The challenge for all policy makers going forward is to be able to sustain the success at reducing cost growth over the next 10, 20 years. Not on an aggregate level but on a per capita level, and probably on a per capita level that is close to GDP. If you can do that, you will be great."

— Chris Jennings



TO COVER ALL AMERICANS, IT WAS NECESSARY TO HAVE A POLICY WITH KEY ELEMENTS OF THE AFFORDABLE CARE ACT.

People may object to aspects of the ACA, but if there was going to be a consensus policy passed by Congress that provided coverage for all Americans, it needed to have core elements that are in the ACA. This includes:

- A pooling of federal funds to make things affordable, with rules for insurers to make sure they competed on cost and quality, and not risk selection.
- An individual mandate, along with subsidies.
- An exchange concept.

A policy with these elements was necessary because health care reform had to be built on top of the complex existing health care system, without fundamentally disrupting the existing system.

MULTIPLE VARIABLES WILL AFFECT PREMIUMS IN THE COMING YEAR, WITH COMMITTED, AGGRESSIVE STATES LIKELY TO HAVE LOWER PREMIUMS.

It is uncertain where premiums will be as of next year. What is known is that the market will be the market, with significant variations in premiums between states, within states, and throughout the country. There are eight variables that will affect premiums:

1. The base premium that insurers put in for 2014. This is whether or not their initial bid for this year's premium started off to be generally accurate for the populations eventually received.
2. The trend rate in health care costs. Health care costs will probably increase, and the trend is likely going to be between 5% and 8%.
3. Reinsurance financing from the federal government will decline, which will increase premiums.
4. The numbers of people who enroll and the mix within each marketplace.
5. A number of transition policies will be offered in several states, which will likely push up premiums within the exchange.
6. There will be an improvement in projected premiums based on what the administration has done particularly on risk corridors and reinsurance payments.
7. In each marketplace it is necessary to look at how many plans are being offered and what kind of competition exists.

8. Whether states are being very active at reviewing and pressuring insurers to lower their bids.

The net outcome of these variables is uncertain. But states that have been aggressive in adopting the ACA have exchanges, expanded Medicaid coverage, a fairly active insurance commissioner, multiple plan options, active outreach, and a good case mix, and will have lower premiums than those states that did not engage in these various activities.

CONGRESSIONAL POLARIZATION HAS RESULTED IN MORE POWER FOR THE EXECUTIVE BRANCH AND SUPREME COURT.

In looking at the political climate, everyone knows it is polarized and dysfunctional. In both parties, and particularly the Republican Party, the leadership is being driven away from the center, making it virtually impossible to reach a consensus on anything. As a result, Congress is unable to pass any meaningful legislation; they can't pass a law and don't engage in oversight, making Congress less relevant. In the absence of congressional action, power has shifted to the executive branch, to federal agencies in particular.

“If you look at what has happened, no longer are the [congressional] committees relevant. The committees, who should be the power centers of all thoughtful policy and oversight, have become basically an afterthought.”

– Chris Jennings

In the absence of Congress, the other relevant player is the Supreme Court, which has the authority to decide when the executive branch has overreached.

REPUBLICANS ARE LIKELY TO FARE WELL IN THE 2014 ELECTIONS, BUT MAY OVERREACH.

Heading into the 2014 elections, the Republicans feel good, and they should. There are far more Democrats up for reelection, which bodes well for the Republicans, and in a non-presidential election year Democrats don't turn up to vote. Republicans will play to their base, who hate Barack Obama and the ACA. Once elected, they will interpret their win as a mandate to repeal or substantially change the ACA, and will likely overreach in attempting to alter the law. (And they won't be able to change it because President Obama will veto it.) If the Republicans

overreach, the beneficiaries are likely to be Democrats running in 2016, particularly the Democratic candidate for president.

In looking to 2016, further discussion of health care reform is not likely to be a centerpiece of the election. The election is likely to be about the economy, education, and climate change.

Discussion

- **Medicaid growth.** Because of the ACA and how it is structured, there are millions of new Medicaid enrollees, many of whom were previously uninsured. These new enrollees most likely would not have been eligible in the old Medicaid program. Still, there remains a huge population that has not yet been targeted for Medicaid enrollment, with some states increasing their efforts to do so. Other states still have not chosen to opt in, despite the attractive deal from the federal government. Longer term, most states will yield to financial necessity and take advantage of this deal.
- **Premium variability by state.** Those states that are committed to and invested in the expansion of health coverage not only are expanding coverage, but their premium increases are likely to be lower. Ultimately, lower premiums may be what drives states to relent and to participate in the expansion.
- **Surprises and worries.** When asked what would surprise him and what he is worried about, Mr. Jennings said he would be surprised if there is not a significant increase in enrollment next year and is slightly worried about employer-sponsored coverage issues.
- **Repealing ACA?** Even if a Republican is elected president in 2016, Mr. Jennings doesn't see the ACA getting repealed. Any candidate will have to run to the center to win, making it difficult to repeal the entire law. Also, the ACA has now become part of the country's infrastructure and people will be reluctant to give up something that they fear losing.
- **Controlling costs.** While there seems to be some bipartisan support for payment and delivery system reform, in practice, proceeding with any reforms that move away from fee-for-service will be difficult as no one wants to bear risk. Further, as long as health care growth rates remain low, there will be a disincentive to push ahead on major payment or delivery reforms.

SESSION I: Forces Driving Innovation in the Delivery System: Will They Improve Quality and Value?

Moderator: **Robert Mechanic, MBA**, Senior Fellow, The Heller School for Social Policy and Management; Executive Director, The Health Industry Forum, Brandeis University

Panel: **David Blumenthal, MD, MPP**, President, The Commonwealth Fund

Melanie Bella, MBA, Director of Medicare-Medicaid Coordination Office, Centers for Medicare and Medicaid Services (CMS)

Glenn Steele Jr., MD, PhD, President & Chief Executive Officer, Geisinger Health System

Jeanene Smith, MD, MPH, Administrator, Office of Health Policy and Research, Chief Medical Officer, Oregon Health Authority (OHA)

Overview

The health care market has been slow to adopt new models that emphasize value over volume. Despite all of the talk of value, and various initiatives such as accountable care organizations (ACOs), efforts focused on value have yet to reach a tipping point. Providers are thus forced to simultaneously live in two worlds: the more dominant fee-for-service, volume-driven world, and a growing value-based, population health world.

With this as the context for health care delivery, a great deal of experimentation is taking place, through various government initiatives (at the state and the federal levels) and private-sector efforts to expand and scale innovations that are working. There is optimism about the potential of these experiments, but also an acknowledgment that they will take time, commitment, investment of money and resources, and behavior change—and there is some skepticism about whether these innovations will ever be able to control costs.

Context

The panelists shared their perspectives on delivery system innovation and described various experiments underway to improve the value being delivered.



Key Takeaways

SOME REMARKABLY POSITIVE INDICATORS SUGGEST RECENT IMPROVEMENTS IN THE VALUE PROVIDED BY THE U.S. HEALTHCARE SYSTEM.

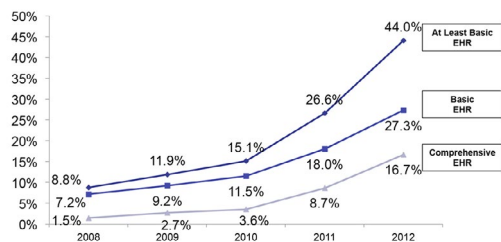
Dr. David Blumenthal of The Commonwealth Fund cited several positive quality-related developments that suggest system-wide improvements in value. These include a dramatic reduction in health care-associated infections. Central line-associated bloodstream infections were reduced by 44% from 2008 to 2012, and surgical site infections for 10 common procedures were reduced by 20% during this time. Diabetes-related complications have also been reduced dramatically over the past two decades. As a result, lives and money are being saved. Dr. Blumenthal

said these improvements are “the definition of improving value, which is for any given problem reducing the likelihood that complications or an adverse event will occur.”

Also, Dr. Blumenthal cited positive developments in the structure of the delivery system.

- **Spread of ACOs.** There are now more than 600 ACOs in the U.S., with 366 Medicare ACOs and 235 non-Medicare ACOs. ACOs are an important step in modifying fee-for-service payment.
- **Increasing integration of physicians with hospitals.** The number of physicians in solo practices has declined significantly, falling from 41% in 1983 to just 18% in 2012. As solo practices have declined, now 29% of all physicians are part of hospital-owned practices or are hospital employees. This is important in creating a more integrated, more organized system.
- **Adoption of electronic health records.** As of 2012, 44% of hospitals had adopted at least a basic electronic health record (EHR) and some sources believe the number now exceeds 60%, which is past the tipping point. The mode of health information collection is now digital.

EHR Adoption Among Hospitals, 2008-12



Source: DesRoches, CM, et al. Adoption Of Electronic Health Records Grows Rapidly, But Fewer Than Half Of Hospitals Had At Least A Basic System In 2012. Health Affairs, July 2013.

HOWEVER, OTHER FACTORS CAUSE SKEPTICISM ABOUT THE ACHIEVEMENT OF SYSTEM-WIDE VALUE.

While efforts to improve quality and create a more integrated infrastructure are steps in the right direction, Dr. Blumenthal is less optimistic about:

- **Realizing the benefits from delivery system changes under a fee-for-service system.** The benefits of the structured changes taking place won't be realized until “we drive a stake through the heart of fee-for-service payment,” which remains a viable business model for most providers. Until this is no longer viewed as a viable model, providers won't be focused on value. Dr. Blumenthal sees potential for dramatic change in the value of services provided, but believes that

realizing this opportunity depends on how care is paid for, and whether there is the political will to move forward with risk-based payment on a massive scale.

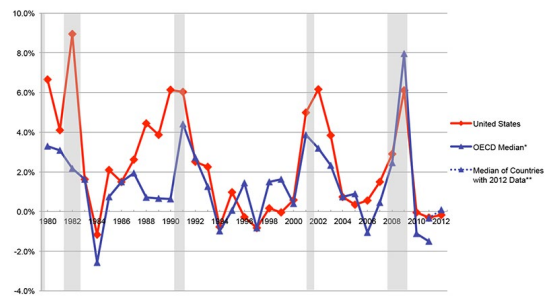
- **The overall performance of America's health care system.** Currently, there are tremendous disparities in the performance of health care in the United States—resulting in two Americas. Some parts of the U.S. have high-performing health care; others are performing at a lower level. These differences may be exaggerated based on how states responded to the ACA. Participating states tend to be higher performing than non-participating states.

“Almost everyone doing an ACO is riding two horses simultaneously: a fee-for-service horse and a financial risk horse. The question is which is going to ride faster into the future, because if the fee-for-service horse rides faster, people are going to be sitting on that horse for a much longer period.”

– David Blumenthal

- **Controlling spending over the long term.** Dr. Blumenthal is not optimistic that health care spending will be controlled going forward. Some health economists believe the slower growth in health spending in recent years is not linked to the economy and is likely to be sustained. Dr. Blumenthal presented data over the past 30 years from the U.S. and other industrial countries showing that when economic times are bad, excessive health spending growth tends to be reduced or is even negative. But when economic times are good, health expenditures tend to exceed the growth in gross domestic product (GDP).

Excess Health Spending Growth in the US and Other Industrialized Countries
 “Excess” = %Δ Health Spending — %Δ GDP



Source: 2013 OECD Health Data. US health spending data are from National Health Expenditure Accounts, adjusted to meet OECD definitions. Note: Periods when the US economy was in recession are shaded. * The OECD median includes only the 23 OECD countries with 25+ years of data between 1980 to 2012. ** In 2012, data was only available for 12 OECD countries, including the US.

Dr. Blumenthal expects that as the economy recovers, the growth rate of health spending will again outpace GDP growth. He would not be surprised if health care exceeds 20% of U.S. GDP in 2021 or 2022.

However, Dr. Blumenthal does not believe this conclusion represents an inevitable future. It may be possible to achieve better value by paying for care differently.

THE CMS INNOVATION CENTER HAS A BROAD PORTFOLIO OF INITIATIVES FOCUSED ON PRODUCING GREATER VALUE FROM THE DELIVERY SYSTEM.

Melanie Bella of CMS described CMS' broad portfolio of innovations. Common themes include moving from volume to value; from fragmentation to coordination; from fee-for-service to anything other than fee-for-service; and from an unsustainable system to one that is sustainable.

“We are very fortunate through the Affordable Care Act to have the CMS Innovation Center with the authority and funding that comes through [the Center] to allow us to test a variety of things . . . it's a rich portfolio.”

– Melanie Bella

Ms. Bella focused on four areas of innovation:

- **Accountable care organizations (ACOs).** There are more than 360 Medicare ACOs, with more than five million enrollees. Early results are positive in both the savings achieved and the quality delivered.
- **Bundled payments.** There are four bundled payment models being tested, with broad participation.
- **State innovation models.** CMS is working with six test states on new innovation models, with 19 additional states in the design and pre-test phase of various innovations.
- **Dual eligibles.** There are about 10 million people who are “dually eligible” for both Medicare and Medicaid. The cost to care for these individuals is around \$350 billion per year, and they frequently receive fragmented, uncoordinated care. CMS has launched a demonstration project to coordinate funding and services for this population.

The challenges that CMS faces in moving forward with these innovations include resource capacity for CMS and providers to manage dual eligibles, as assessing and managing dual eligibles requires significant capacity; time frame issues in that realizing a positive return on this investment may take longer than desired; and challenges in getting providers to assume risk.

OREGON IS TRANSFORMING ITS HEALTH SYSTEM THROUGH A COORDINATED CARE MODEL.

Oregon has chosen to transform its health system, driven by the governor's vision, supported through a robust public process with more than 75 public meetings, and backed with bipartisan support. The state negotiated a federal waiver that brought in \$1.9 billion for the state, in exchange for being held accountable for delivering quality and controlling costs. Specifically, in exchange for this waiver the governor agreed to reduce the annual increase for state Medicaid spending by 2%, while improving the quality of care.

“There are significant penalties to the state if we do not achieve these [accountability commitments] over time.”

– Jeanene Smith

With this waiver, Oregon has developed a coordinated care model, starting with Medicaid patients, with the intent to spread this model to other state-purchased coverage. Care is delivered through coordinated care organizations (CCOs), which coordinate care at every point of delivery. There are currently 17 CCOs in the state, which receive one global budget for all care (including dental and mental health services), have standard metrics for safe and effective care, are required to perform community health risk assessments with partners in the area, and have some degree of local flexibility.

Oregon has created infrastructure to support implementation, including a Transformation Center and Innovator Agents, Learning Collaboratives, Community Advisory Councils, and more.

The CCOs serve over 90% of Oregon's Medicaid population and are meeting the state's commitment to reduce per capita spending by 2%. Progress is being made on measures of quality, utilization, and cost. Thus far, there have been decreased emergency department (ED) visits and expenditures; decreased hospital readmissions; and decreased hospitalizations for congestive heart failure (CHF), chronic obstructive pulmonary

disease (COPD), and asthma; and there are increased primary care visits and increased enrollment in patient-centered primary care homes. Oregon is now focused on extending the care model across more populations, including state employees.

Key lessons from the CCOs include the recognition that change is very hard, that it takes significant time and resources, and that creating ROI is a huge challenge.

AMONG GEISINGER'S STRATEGIC PRIORITIES IS SCALING AND GENERALIZING INNOVATION.

Geisinger has long been seen as a high-performing, high-quality, innovative health system. Because of Geisinger's focus on experimentation and innovation, CEO Dr. Glenn Steele termed Geisinger a "five billion dollar skunk works." Among Geisinger's strategic priorities are extending the Geisinger Health System (GHS) brand and scaling and innovating through a series of experiments involving GHS, Geisinger Insurance Operations (GIO, the organization's insurance arm), and xG (a new company that provides analytic and care management services to a range of healthcare organizations to help change the provider behavior).

"What we are trying to do is build out a portfolio of real live experiments . . . that can be applied to other markets, with other fiduciary structures, and other conditions."

– Glenn Steele Jr.

Geisinger is very intentional about where it is expanding on the provider side, selecting geographic markets where Geisinger believes its model and value proposition will work. These are markets that can be consolidated and where Geisinger can win (with an underlying belief that there must be winners and losers). Geisinger is also extremely intentional about where to expand GIO, including a big bet on Medicaid managed care.

Geisinger's experiments are based on a view that health systems must transition to new, value-based business models, with a shift from volume to population-based risk models, and must be able to succeed with reference pricing. Geisinger anticipates, and is in favor of consolidation of, provider markets, payer markets, and vertical integration. Geisinger knows there is excess capacity and units of work, and that when units of work are reduced most providers try to increase prices. But this won't work; health systems have to be prepared to decrease the price per unit.

All of these experiments are driven by changes in fiduciary behavior and require changes in the behavior of health system leaders, providers, patients, and regulatory authorities.

Discussion

- **Drivers of innovation.** Factors driving these innovations include a consolidation of commercial payers and a move by fiduciaries to population-based risk. Driving innovation even further requires changes in payment by government payers.
- **Not yet at a tipping point.** While there are more than 600 Medicare and commercial ACOs, panelists and participants still view fee-for-service as the prevailing payment model. ACOs are being treated by most providers as an experiment and not as a core business model.

"I don't think, as encouraging as the accountable care organization phenomenon is, that it constitutes a tipping point yet. I'm not sure how to get to that tipping point."

– David Blumenthal

- **Aligning provider incentives.** In an environment where providers are participating in systems that have both fee-for-service and population-based payment, it is not clear what type of incentives can be used with front-line physicians to align their behavior. As Dr. Blumenthal said, "We haven't a clue about how to pay providers in order to get them to behave consistently with the interest of the organization. It is not as simple as it seems."
- **Hospital changes.** Dr. Steele said there should probably be 20–25% fewer acute care beds, and that in this environment, hospital CFOs need to attack their fixed cost structure and/or expand their market share.
- **Differing markets.** Some participants said that highly fragmented provider markets, where insurers experience high rates of patient churn, are not conducive to ACOs. Dr. Steele agreed, remarking that population-based models are not appropriate for every market and reiterating that Geisinger has made very intentional choices about where to expand.

SESSION II: The New Medical Workforce

Moderator: **James Madara, MD**, Chief Executive Officer & Executive Vice President, American Medical Association (AMA)

Panel: **Uwe Reinhardt, PhD**, James Madison Professor of Political Economy and Professor of Economics, Princeton University
Joyce Pulcini, PhD, RN, PNP-BC, FAAN, Professor & Director of Community and Global Initiatives, George Washington University School of Nursing
Stephen Shortell, PhD, MPH, MBA, Blue Cross of California Distinguished Professor of Health Policy & Management, University of California-Berkeley School of Public Health

Overview

For decades there have been vacillating forecasts about physician surpluses and shortages, which causes those with some historical perspective to take the current proclamations of looming shortages with a grain of salt. However, regardless of one's view on physician shortages, there is agreement that there are opportunities to improve the productivity of physicians by taking a more team-oriented approach, delegating, keeping people healthier, which reduces the work required of physicians, and using technologies to streamline care. These activities will affect the health care workforce as nurses and pharmacists can play more prominent roles. Several participants argued that these professions, as well as other types of health care workers, need to be integral parts of care teams and practice at the top of their licenses. Also, a prevailing view is that shifting to risk-based payment will accelerate the shift to team-based care and will increase the role and significance of non-physician medical workers.

Context

The panelists discussed how the ACA and other trends will affect the workforce needed to deliver high-quality health care.



Key Takeaways

THE AMA'S THREE FOCUS PRIORITIES ALL DEAL WITH THE WORKFORCE IN SOME WAY.

The CEO of the American Medical Association, Dr. James Madara, described the AMA's three focus priorities and explained how they deal with the workforce:

1. **Delivering what patients want.** Patients want good outcomes in the context of an increasing burden of chronic disease, and fewer physicians than will be needed—perhaps 100,000 to 150,000 fewer in 2025. Managing chronic diseases involves reaching outside of the traditional medical system to involve communities, which has implications for the workforce. For example, one idea is to proactively work to prevent chronic diseases, such as preventing pre-diabetes from becoming diabetes. This can involve engaging workers in the community, as opposed to physicians and health care workers. In this spirit, AMA has launched a partnership with the YMCA that focuses on improving community health and wellness.

“In the context of this workforce problem, we have to think about ways of expanding the workforce to make it more efficient. We also have to think hard about ways to decrease the amount of work.”

— James Madara

2. **Delivering what physicians want.** Physicians want personal satisfaction and practice sustainability. Satisfaction increases when physicians are able to spend time with patients, delivering care. Dissatisfiers are things that interfere with the doctor-patient interface. Physicians actually want feedback on quality and performance, which is much more powerful in changing practice patterns than financial incentives.
3. **Delivering what society wants.** Society wants a population of physicians who fit the evolving health care system and are continually creative. This creativity must take place as care is shifting from inpatient to outpatient, and outpatient to home. It is shifting from single providers to teams of caregivers. However, the way in which care is delivered today and will be delivered in the future is not being taught as part of the medical education process. The AMA is working to change this by working with a group of medical schools to innovate how medical education is delivered.

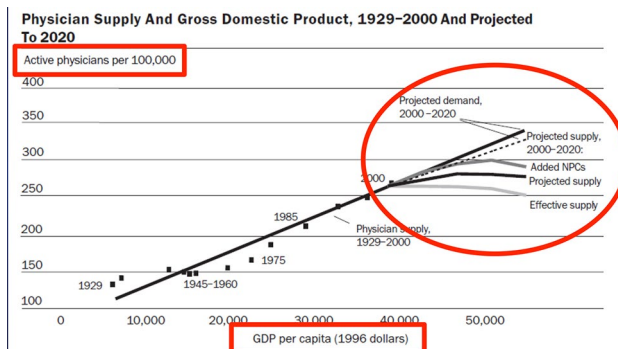
These priorities focus on changing how practices are structured to be more efficient, decreasing the amount of work that physicians are expected to do by shifting work elsewhere, and increasing the number of students who are trained in the right way to be efficient.

INSTEAD OF FOCUSING ON A PHYSICIAN SHORTAGE, THERE SHOULD BE GREATER EMPHASIS ON INCREASING PHYSICIAN PRODUCTIVITY.

Professor Uwe Reinhardt recounted the history of predicting the physician workforce. In the 1960s and 1970s, the country and other professions grew simultaneously, but the number of physician slots was kept constant. Policy wonks predicted a massive physician shortage, and in response, medical school capacity was doubled by the 1980s. However, the story changed over that decade when it was estimated that there would be a surplus of 70,000 doctors by the year 2000.

Then, in 1994, a report estimated that in 2000 there would be a shortage of 35,000 general physicians and a surplus of 115,000 specialists. Another paper estimated a physician surplus in 2000 of 165,000 physicians, which would cause the supply of specialists to be 60% more than required. These were followed in 1995 by the Pew Commission recommendation that by 2005 medical schools reduce the size of their entering classes by 20–25%. There was concern that physicians would be unemployed.

Fast forward to a 2002 article in *Health Affairs*, predicting an impending physician shortage, that became accepted as the gospel.



With this as the prevailing belief, concerns of a shortage were only exacerbated by the ACA, which brings more patients into the system. In one paper, a shortage of 63,000 doctors was estimated by 2015, growing to 91,500 in 2020 and 130,600 in 2025.

With this history of fluctuating forecasts, Professor Reinhardt's perspective is, "We're OK." Instead of worrying about forecasts, he recommended focusing on increasing physician productivity by creating larger care teams and delegating additional responsibilities. He also suggested that policymakers have more faith in the health system's ability to adjust to and compensate for shortages of particular types of health workers.

"We just need to develop teams and delegate, and it won't be the same health care everywhere. . . . It will be slightly different care, but I think that will be fine."

– Uwe Reinhardt

AS THE NEED FOR PRIMARY CARE INCREASES, OTHER MODELS AND TYPES OF PROVIDERS ARE NEEDED.

Professor Joyce Pulcini discussed how as the ACA is fully implemented, the need will increase for primary care services and providers. However, there is not adequate primary care capacity. Today, only one third of physicians work in primary care and medical school graduates are not choosing primary care.

With increased primary care demand and limited capacity, other types of caregivers and models are needed. This is an area where nurse practitioners (NPs) can make a significant

difference, as NPs can provide 90% of the primary care services provided by physicians. The Initiative on the Future of Nursing, by the Robert Wood Johnson Foundation and the Institute of Medicine, had four key messages about the role of nurses:

1. Nurses should be able to practice to the top of their license, to the full extent of their education and training. This is not happening today.
2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
3. Nurses should be full partners with physicians and others in redesigning U.S. health care.
4. Effective workforce planning and policymaking require better data collection and an information infrastructure.

“This is where expanded scope of practice for nurses and other health professions comes in.”

– Joyce Pulcini

IMPORTANT WORKFORCE CONSIDERATIONS INCLUDE THE COMPOSITION OF THE WORKFORCE, THE NATURE OF WORK, AND HOW HEALTH CARE IS PAID FOR.

Professor Stephen Shortell offered observations on several aspects of the medical workforce:

- **The composition of the workforce.** There is a great deal of conversation about whether there are too many or too few physicians. But these conversations often fail to take into account the changes in the composition of the health care workforce and the changes in health care teams. One issue is whether nurse practitioners, physician assistants, pharmacists, nutritionists, and other health professionals are being allowed to practice to the top of their competency. In addition, health professionals are often still practicing in silos, not as interdependent teams. And, rarely are practitioners trained to function as part of a team.
- **The nature of work.** An idea that is catching on is the concept of relational coordination. This involves creating an interdependent process where people share the same goals, mission, and values, with communication that is timely, accurate, and relevant.

A study of top-performing physician groups in California described attributes of how they work. They have relatively high EHR functionality and use registries to identify high-risk patients; physician-specific feedback reports; aggressive phone outreach; and pharmacists on care teams. However, somewhat surprisingly, they still have relatively limited use of multidisciplinary care team approaches.

- **Workforce involvement in patient activation and engagement.** Often patients are not thought about as an important part of the care team, but there is growing interest around patient activation and engagement, which has workforce implications. Research summarized in the slide below shows that fewer than 50% of all physicians receive training in patient activation and engagement and fewer than 50% of high-risk chronic patients in an ACO receive health coaching. Also, only 5% of physicians say that 10% of their compensation is based on patient experience data.

	N	Mean (SD)
% of PCPs that have received training in PA&E	101	48.5 (30.7)
% of PCPs that work with patients/families to develop a treatment plan that sets goals for their care	101	61.6 (29.0)
% of ACOs high-risk chronic illness patients that receive health coaching	101	45.4 (27.5)
% of PCPs that offer patients/families evidence-based decision aids	101	46.2 (30.8)
ACO uses telehealth	101	52.5%
If YES, % of ACO's patients that use telehealth	53	20.4 (26.4)
ACO recruits patients/families to participate in quality improvement activities (yes/no)	101	50.5%
ACO recruits patients/families to participate in patient/family advisory councils (yes/no)	101	67.3%
0% to 5% physician compensation based on patient experience data (yes/no)	101	66.3%
Greater than 10% physician compensation based on patient experience data (yes/no)	101	5.0%

Source: National Accountable Care Organization Patient Activation and Engagement Survey, Center for Healthcare Organizational and Innovation Research (CHOIR), School of Public Health, UC-Berkeley, May, 2014. Funded by the Gordon and Betty Moore Foundation.

A bold idea expressed by Professor Shortell is around eliminating office visits. An analog for this is how other industries (such as rental cars or banks) have automated customer interactions, decreasing wait times and improving the overall experience. Eliminating office visits in health care would affect thinking about the workforce supply that is needed.

“In health care, let's get rid of office visits, given some of the other technology that we have.”

– Stephen Shortell

The key to accelerating delivery system innovations is reforming the payment system by moving away from fee-for-service payment. Moving to capitation and global risk-based payment will drive innovation.

Discussion

- **Role of management.** Panelists mentioned that in other industries, organizations have had a burning platform, and management has put systems and processes in place to drive change. In health care, there has not been a burning platform and management has not led change. However, some panelists believe that financial pressure is now being applied, which will serve as a burning platform and a catalyst for systemic change.
- **Payment reform or scope expansion?** In response to a question about which should come first, payment reform or expansion in the scope of practice for professions such as nurses, Professor Pulcini said, “Do them both.”
- **Behavioral health.** A panelist observed that there seems to be increasing mention of behavioral health among industry thought leaders, and wondered about the impact on the health care workforce. Professor Shortell commented that many behavioral health issues are related to healthy beginnings in the first three years of life, which needs to receive more attention and resources through earlier interventions and interventions that involve the community. Professor Pulcini believes that the model involving counselors and psychiatrists can be improved. She believes that counseling and medication adjustments should happen in the same visit, which is actually what psychiatric nurse practitioners already do.
- **Self-health.** There is an explosion of apps and other technologies that allow people to measure and monitor their own health, in a game-like sort of way. These technologies are engaging people in managing their own health, and could ultimately affect the health workforce.

SESSION III: The Private Insurance Market

Moderators: **Robert Galvin, MD, MBA**, Chief Executive Officer, Equity Healthcare, The Blackstone Group

Panel: **Joseph Zubretsky**, Senior Executive Vice President, National Businesses, Aetna, Inc.

James Capretta, MA, Senior Fellow, Ethics and Public Policy Center; Visiting Fellow, American Enterprise Institute

Tim Jost, JD, Robert L. Willett Family Professor of Law, Washington and Lee University School of Law

Claire McAndrew, MPH, Robert L. Willett Family Professor of Law, Washington and Lee University School of Law

Overview

The initial enrollment in insurance through private exchanges is in line with expectations, but there is significant uncertainty about continued enrollment growth in the next few years. Insurance is seen by many consumers in the small group and individual markets as unaffordable and it is not clear to what extent the individual mandate will be enforced.

For employers, a stratification is taking place, with some employers (mainly those in tight labor markets and where companies/CEOs value health insurance) remaining committed to offer health benefits, while shifting more responsibility and financial risk to consumers. At the same time, other employers (mainly those in industries with high employee turnover, like retail or hospitality) are more actively considering moving employees to exchanges, particularly private ones. Employers aren't exiting health insurance, but many are transitioning their models of sponsoring them.

Private insurers see significant opportunity as: 1) the market for insurance coverage expands; and 2) health systems need help in transitioning from fee-for-service to a population health model. In this new model many health systems need assistance from insurers in managing and analyzing data, taking financial risk, and developing and marketing insurance products. However, insurers must also deal with new rules and regulations and uncertainty regarding the evolution of employer-sponsored plans.

“The only certainty is continued uncertainty.”

– Robert Galvin

Context

Dr. Robert Galvin led this panel in a discussion of changes taking place in the private insurance market based on the ACA, with perspectives regarding potential further changes in the next few years.



Key Takeaways

ACA-DRIVEN HEALTH INSURANCE ENROLLMENT IS OFF TO A GOOD START, BUT FUTURE ENROLLMENT IS HIGHLY UNCERTAIN.

Several panelists mentioned that more than six million, and possibly up to eight million, Americans have signed up for health insurance because of the ACA. This was cited as “a remarkable achievement” that is already reducing the number without insurance in the United States. However, James Capretta pointed out that while symbolically important, these six million enrollees are only a minor part of the entire U.S. health care system. Those now covered because of the ACA represent a far smaller number than those already receiving coverage through employer-sponsored plans, through Medicare and Medicaid, and even through the Children's Health Insurance Program (CHIP).

The panelists agreed that if enrollment growth were to reach the level predicted by the Congressional Budget Office (CBO)—24 million in 2016—this would make a big dent in reducing America's uninsured population. Yet achieving this level of enrollment, requiring 18 million more enrollees in two years, is

viewed as highly uncertain. The panelists identified three key issues affecting enrollment:

- **Public education.** Professor Tim Jost explained that even though there were significant public education efforts, there are still many individuals who are eligible for subsidies who were unaware of these subsidies and didn't enroll. Further education and awareness efforts hold some potential to help further boost enrollment.
- **Affordability.** Professor Jost cited research indicating that the primary reason that those without insurance chose not to purchase it is because it is seen as unaffordable. Some argue that the benefit package is bloated, driving costs up. Some argue that insurance costs are high because cost sharing is too low (even though many individuals see cost sharing as excessively high). And others attribute the unaffordability to the end of underwriting, the end of coverage limits, and that insurers can no longer exclude individuals with pre-existing conditions. These factors increase access to coverage for higher-risk people, while driving up the costs of insurance for everyone, particularly healthy individuals. The lack of perceived affordability and high deductibles are causing healthy people to elect not to purchase coverage.

It is not clear what actions can be taken to improve affordability—such as modifying the minimum benefit package, which is unlikely to have much impact on affordability—without rejecting the basic premise of the ACA that guarantees coverage to all.

“If we are most concerned about costs, we could reinstate exclusions to keep high-cost people out, but this would reject the basic premise of the ACA.”

– Tim Jost

- **The individual mandate.** Mr. Capretta believes the key to whether the 2016 enrollment projection of 24 million can be achieved is related to the level of enforcement of the individual mandate—which is highly uncertain. If the individual mandate is enforced, the penalty becomes significant, which could drive 12 to 15 million more people to enroll. However, it is not clear how rigorously the mandate will be enforced. The administration seems to be providing many exceptions to the mandate, with language that allows for exemption based on “any hardship.” If the mandate is not enforced, there is significant uncertainty about the ability to reach the long-term enrollment projections.

“By 2016 the CBO is expecting 24 million people to be enrolled [in health insurance through exchanges], which is up 18 million from today. That is very related to whether the individual mandate is enforced or not.”

– James Capretta

Professor Claire McAndrew of Families USA is looking beyond just the number of individuals who have signed up for insurance to the care that those now receiving coverage are getting. Her organization is pleased with the progress thus far in the level of enrollment, but is concerned about everyone with insurance now getting access to providers on a timely basis through adequate provider networks.

“Is the network adequate? Can those with insurance get care on a timely basis?”

– Claire McAndrew

EMPLOYERS ARE LIKELY TO CONTINUE PLAYING A CENTRAL ROLE IN PROVIDING HEALTH INSURANCE, BUT THAT ROLE COULD CHANGE AS EMPLOYERS STRATIFY.

Dr. Galvin said that when the ACA was passed four years ago, employer-sponsored insurance was seen as remaining central to how insurance was obtained, though some feared that employers would exit and stop offering insurance benefits to employees. While it is still early in the implementation of the ACA, Dr. Galvin sees employers rethinking their insurance benefits and revisiting the social contract with employees, but not exiting or abandoning insurance.

Joe Zubretsky, whose company, Aetna, provides insurance coverage for more than 22 million members, agrees that employer-sponsored health insurance is not going away anytime soon. He said that every C-suite is having a conversation about their social contract with employees, and about compensation and benefits. He sees employers in many industries competing fiercely for labor, making them reluctant to abandon their commitment to health insurance. He sees employers delegating more responsibility to employees, pushing more financial risk to employees, and giving employees more transparency and tools to participate in health care decisions—turning employees from observers in the process to more engaged and empowered

participants. But he doesn't see employers exiting health insurance. (He does, however, see some employers moving their retiree plans to exchanges.)

“Most employers are not about to change the social contract they have with employees, but they are thinking about it much differently.”

– Joe Zubretsky

Dr. Galvin doesn't think it is possible to lump all employers into one bucket. In his current role he sees many different types of employers, all of which are thinking differently, based on their history, industry, competitive situation, culture, and leadership. He identified three major stratified groups:

- **Group 1:** This group is composed of very small employers who don't currently offer health benefits to employees. The ACA is unlikely to compel them to provide health insurance. They will pay the penalty and their employees will be on their own to purchase coverage through public exchanges.
- **Group 2:** Employers in this group are in sectors with high employee turnover of low-skilled, non-technical workers, many of whom work part-time. The retail, hospitality, and foodservice industries are good examples. Employers in this group (such as Sears and Darden) are looking for a way to stop offering health insurance and are considering both public and private exchanges. Some analysts are saying, “There go employers exiting from offering health coverage.” Such a generalized conclusion isn't accurate. More accurate is, “There go the players in this group.” Dr. Galvin believes that among this group there could be significant growth in private exchanges, possibly growing up to 40 or 50 million people, and he believes the growth will be in exchanges that offer a self-insured funding model.
- **Group 3:** These are employers in sectors with a high degree of labor competition, where high-quality health benefits are needed to attract and retain talent. Employers in this group might also have a strong cultural or CEO belief in health, or may be in the health care business. These employers will continue to offer employer-sponsored benefits but are likely to evolve to shift more responsibility to employees/consumers. Dr. Galvin sees employers providing protection through high-deductible catastrophic plans, with more first dollar responsibility by individuals.



“I think we will see that this is a transition for employers; not an exit.”

– Robert Galvin

FOR PRIVATE INSURERS THERE IS BOTH SIGNIFICANT OPPORTUNITY AND UNCERTAINTY.

The millions of new enrollees in private insurance through public exchanges, and the potential for tens of millions more enrollees, represent significant opportunities for private insurers. But Mr. Zubretsky sees the opportunity for private insurers like Aetna as much greater. Many health systems—which have low margins (~3%) and high fixed costs (~70%), and are seeing their reimbursement cut by the government—are trying to shift from a fee-for-service model to one based on population health. But few providers have the ability to make this shift on their own. They need collaborative partnerships with insurers such as Aetna to help aggregate and analyze population data, to drive out excess utilization, enter into and manage risk-based agreements, and develop and market new types of insurance products.

Aetna sees the opportunity to leverage its capabilities as an insurance company to collaborate with health systems in entirely new ways. For example, Aetna can be the “Intel inside” of insurance plans that will be developed for some markets in collaboration with well-established providers in the marketplace. These will represent joint ventures where Aetna provides insurance capabilities, expertise, and possible capital. Already Aetna has reached collaborative agreements with about 40 health systems, and expects to get to 60 agreements by the end of the year, representing about \$2 billion in medical costs. These collaborations improve the alignment between providers and insurers, while enabling both providers and insurers to transform themselves.

However, others see greater uncertainty for private insurers. Dr. Galvin pointed out that with ACA there are new fees, underwriting rules, and MLR (medical loss ratio) constraints. There are new rules that are still being decided, there is ongoing regulatory uncertainty, and the shape and future of employer-sponsored plans—which have been a mainstay for private insurers—are far from certain.

Discussion

- **Differing local markets.** Whether a provider will choose to offer its own insurance product in collaboration with an insurer will differ greatly by geography, explained Mr. Zubretsky. In a market with one dominant player this is unlikely. But such a model is attractive to a provider in a market with three or four players, each of which has a market share of 20–25%.
- **Narrow networks.** Professor Stuart Altman wondered if without restricting networks it will be possible to control costs; he suggested that perhaps the only option to control costs is through narrow networks where providers offer lower prices in exchange for higher volume. Professor McAndrew expressed concern about this approach, but conveyed that her focus is not on the size of a network but on access to care. She believes that consumers should not be given endless choice, but doesn't see limiting access as the key to controlling costs. Mr. Zubretsky said that networks are now being created based on clinical value and sees the potential for controlling costs through disease state bundles.

SESSION IV: Medicaid and CHIP Transformation Under the Affordable Care Act

Moderator: **Sara Rosenbaum, JD**, Harold and Jane Hirsh Professor of Health Law and Policy, Milken Institute School of Public Health, The George Washington University

Panel: **Andy Allison, PhD**, Director, Division of Medical Services, State of Arkansas Department of Human Services
Michael Doonan, PhD, Assistant Professor, The Heller School for Social Policy and Management; Executive Director, Massachusetts Health Policy Forum, Brandeis University
Matt Salo, Executive Director, National Association of Medicaid Directors

Overview

Medicaid and CHIP are important health insurance programs that are administered at the state level, with considerable state flexibility. Under ACA, Medicaid will be expanding and taking on an even more important role. States are focused on expanded Medicaid enrollment, a streamlined enrollment process, and the systems to support expanded enrollment. Some states, such as Arkansas, have received waivers from CMS to innovate and restructure their Medicaid programs. These state-level innovations are a laboratory from which the rest of the country can learn.

CHIP provides coverage for children. It was passed with bipartisan support, has strong benefits, is generally affordable, and currently covers about eight million children. Some people believe that CHIP is no longer needed and can be rolled into Medicaid. But until the benefits for children are comparable and the coverage is more affordable, this is not a viable option.

Context

Panelists discussed the transformation and challenges taking place with state Medicaid programs and with CHIP.



Key Takeaways

UNDER ACA, MEDICAID WILL PLAY AN EVEN MORE ESSENTIAL ROLE IN THE U.S. HEALTH CARE SYSTEM.

Professor Sara Rosenbaum said that Medicaid, nearing its 50th year, “is probably the most essential part of the entire American health care system.” Medicaid is also extremely complex and not well understood. It is the insurance program for non-elderly citizens and long-term legal U.S. residents.

Matt Salo explained that Medicaid covers 72 million people (before ACA-related expansion) and will spend around \$450 billion this year. Medicaid pays for close to 50% of the births in the United States, the majority of long-term care, and the majority of the mental health treatments and HIV/AIDS treatments.

States administer Medicaid programs within broad federal guidelines, in which states have flexibility to determine the eligibility standards; the type, duration, and scope of services; and the rate of payment for these services.

“What Medicaid does in one state is quite different from what it does just across the state border. It is hard for people to grasp the full complexity of it.”

– Matt Salo

A major transformation of Medicaid is now in progress. Key elements include:

- **Expansion.** The biggest issue affecting Medicaid is that under the ACA, Medicaid has been expanded to manage the coverage for all low-income non-eligible people, though the Supreme Court gave states the ability to opt out, and about 24 have done so.
- **Streamlined enrollment.** Historically there has been a high rate of churn in Medicaid, as participants' income rise and fall, making it difficult for people to get into Medicaid and stay in.
- **Waivers.** Several states (such as Arkansas and Massachusetts) have received waivers from CMS, which provides them with flexibility and allows for restructuring their Medicaid program. An issue identified by several participants is that in many instances, while waivers are intended to be demonstrations, they essentially become the state's Medicaid program, with some renewed for decades.
- **Systems.** To implement existing and expanded Medicaid programs, states are focused on building new IT systems and fixing broken ones. This is an enormous, costly, and complex undertaking.
- **New models.** Mr. Salo emphasized that while much of the focus of state Medicaid directors is on coverage expansion, waivers, and systems, they want to be focusing on providing better health care to beneficiaries. This requires moving away from fee-for-service reimbursement to models that produce more coordinated care. This includes changing incentives through managed care and shared savings.

Professor Rosenbaum pointed out that as important as the eligibility changes impacting Medicaid include rethinking how health care is organized, financed, and delivered is even more important. These are individuals who are low income, often ill with costly chronic diseases, and often in long-term care.

Challenges faced in attempting to transform Medicaid include:

- **Actual implementation.** Thinking and talking about how to transform Medicaid is relatively easy. Actually doing it is incredibly hard.
- **Aligning Medicaid and marketplaces.** To reduce churn there must be greater alignment between Medicaid and other forms of subsidized coverage.

“A big issue is how do you align Medicaid and the marketplaces, where the same people often are moving between various forms of publicly subsidized coverage?”

– Sara Rosenbaum

- **Government bureaucracy.** Transforming Medicaid requires changes by big state agencies that are mired in bureaucracy. These agencies do not have adequate talent or administrative systems or receive adequate investments in areas such as infrastructure or data analytics.

ARKANSAS PROVIDES AN EXAMPLE OF INNOVATION TAKING PLACE AT THE STATE LEVEL.

The Republican leadership in Arkansas forged a compromise strategy that resulted in getting 75% of the votes in the state's House and Senate. The political motivations included shrinking Medicaid (or at least avoiding expansion), taking Medicaid private, and enhancing the private insurance marketplace. Other motivations were providing cost assurance (meaning predictability and confidence about costs) and lessening the financial impact of Medicaid on hospitals and small businesses. (Those in Arkansas advocating for Medicaid reforms were warned not to discuss expanded coverage and improved health with policy-makers, who would have no interest, but they did mention these concepts, and it worked.)

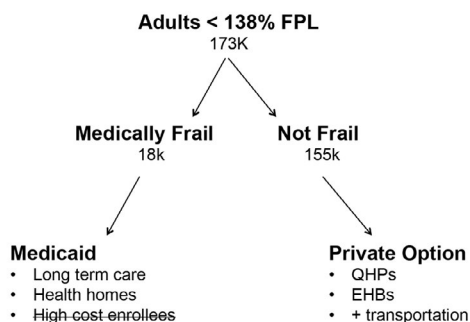
“There's no doubt that Medicaid expansion helps hospitals, helps small businesses, and helps the state, actually quite a lot.”

– Andy Allison

At the moment, the state Medicaid agency in Arkansas estimates that there may be around 225,000 adults in the state with income less than 138% of the federal poverty level (FPL). Of this group, Arkansas has currently made 173,000 of them eligible for Medicaid. Among those who are eligible, the strategy in Arkansas has been to divide them into two groups: 1) the “medically frail” who have significant health needs and will require long-term care or care coordination via “health homes” (18,000), and 2) the non-frail (155,000).

Through a screening process, the 18,000 medically frail remain in the state’s Medicaid program. The others are given a choice (through a pseudo-exchange) of private qualified health plans that offer the essential health benefits. For those receiving the private option, transportation is included, which makes this option feasible.

PRIVATE OPTION IN ONE PICTURE



The 155,000 adults in the private option have quadrupled the size of the state’s private marketplace, with positively selected individuals who are about a decade younger on average than others in the private insurance marketplace, which is helping create a healthier individual insurance market. This option provides greater continuity of coverage and provides attenuated (blended) provider payment rates, which is appropriate as providers no longer have as much uncompensated care. Provider reimbursement rates are likely to end up between where rates from commercial payers were and previous rates under Medicaid. The result: providers benefit, participating consumers benefit, and the government benefits by saving money.

“We’re now relegating to Medicaid what it started off as, which is taking care of the sickest of the sick. The private insurance market is now the place where everyone else goes.”

– Andy Allison

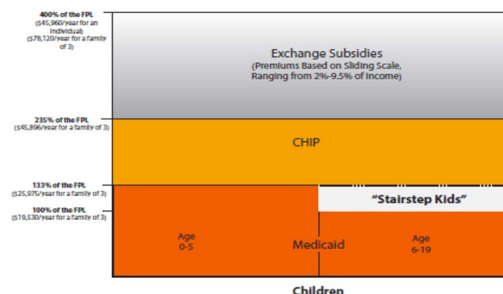
This transition in Arkansas is underway. After having one payer (BlueCross), next year there will be three statewide health plans competing in the market, creating the most competitive market that has ever existed in Arkansas. And, premiums are not expected to rise next year. As this transition occurs, challenges include defining “healthy competition” and clarifying the state’s price point.

CHIP IS A MODEL FOR MARKETPLACES, BUT MANY QUESTIONS EXIST AND NEED TO BE RESOLVED.

CHIP is a relatively small but very important child health financing program. Prior to CHIP, few states covered kids up to 200% of poverty, but since CHIP was passed states are covering kids up to 170 to 250% of the FPL. CHIP was passed with bipartisan support, and states cannot opt out. There are currently around eight million children enrolled, but 16–20% of kids are still uninsured. CHIP is funded through FY 2015, and will then need to be reauthorized.

Professor Michael Doonan described CHIP as wedged between Medicaid and employer-sponsored health insurance. CHIP has a higher match than Medicaid, and provides states a great deal of flexibility within federally prescribed corridors. Currently, 15 states have separate CHIP plans, 7 states have Medicaid expansions, and 28 states have combination programs.

Children’s Coverage in the United States, 2014



On the one hand, an argument can be made that there is no need for CHIP. That is because Medicaid has been expanded to provide coverage for kids up to 138% of the FPL and subsidies are available for families to go into the marketplace to purchase insurance if their income is up to 400% of the FPL, which will help avoid some churning. It would be possible to eliminate CHIP if benefits available in the marketplaces and patient out-of-pocket costs were comparable. This has the possibility of keeping families in the same plan and increasing plan continuity. States such as California and New Hampshire have gotten rid of their CHIP programs and transitioned kids to Medicaid.

But just eliminating CHIP may not make sense. CHIP does pretty well on affordability and there are issues with the affordability of Medicaid based on a “family glitch.” Marketplace benefits were not designed with kids in mind; there is higher cost sharing in the marketplace; there are transition costs; and there are more limited networks.

“Maybe we could eliminate CHIP if marketplace plans were more comparable [to CHIP], if the benefits were more appropriate to meet the needs of these kids, and if the premiums and copayments were affordable.”

– Michael Doonan

Professor Doonan’s conclusions are that CHIP is a model for marketplaces, especially in how CHIP has both state flexibility and federally driven accountability. If CHIP’s benefits and affordability could be mirrored within exchanges, then it might be possible to eliminate CHIP, which could reduce churn, but that is not the case today.

SESSION V: Confronting the American Health Care Hustle

Moderator: Julie Rovner, Robin Toner Distinguished Fellow, Kaiser Health News

Speaker: Susan Dentzer, Senior Health Policy Adviser, Robert Wood Johnson Foundation

Overview

With the ACA expanding insurance coverage, it is more critical than ever to look at the costs of health care. And in looking at health spending, it is apparent that a massive hustle is taking place in the American health care system, with a great deal of “gray” behavior that results in huge and often unnecessary expenditures. There continues to be huge variation in the care that is delivered, huge price increases, and other expenditures that take on the appearance of players gaming the system. Unless the leaders of the health care system confront these realities, the system will not change.

Context

In introducing Susan Dentzer, Julie Rovner shared thoughts on the media’s coverage of the implementation of the ACA. Ms. Dentzer then used the movie *American Hustle* as a metaphor for understanding the challenges in controlling health care costs.

Key Takeaways

THE MEDIA DIDN’T DO A GOOD JOB COVERING THE IMPLEMENTATION OF THE ACA.

Julie Rovner stated what has become obvious: that the rollout of the ACA was not the Obama administration’s finest hour. But she asserted that it was also not the media’s finest hour.

“Much of the past seven months was a case study in how not to cover a story to help the public understand something.”

– Julie Rovner

Purported “victims” of the ACA, who had policies cancelled, were given significant attention. Yet many members of the media covering the story didn’t conduct adequate due diligence, didn’t get the facts straight, and lacked adequate understanding. They took stories and claims at face value, failing to truly investigate them. For example, some individuals who stated that insurance policies were unaffordable were unaware of their eligibility for subsidies. As a result, many of the stories about the ACA’s implementation lacked both content and correctness, and these stories missed the opportunity to help educate the public. However, Ms. Rovner expressed optimism that in the past year there has been a rise in analytical and explanatory journalism websites that have the potential to reach and educate people about health care policy.

NOW THAT MORE PEOPLE ARE GETTING INSURANCE COVERAGE, IT IS IMPORTANT TO RE-LOOK AT THE COSTS OF HEALTH CARE.

In health policy circles, some analysts say, “As Massachusetts goes, so goes the nation.” In Massachusetts, 97% of residents now have health insurance, which is a tremendous accomplishment. But with this level of coverage having been achieved, Massachusetts is now squarely focused on the costs of health care. This pattern is likely to follow—and needs to take place—throughout the United States.

IN LOOKING AT HEALTH CARE SPENDING ACROSS THE U.S., IN MANY WAYS, A HUSTLE IS TAKING PLACE.

In the movie *American Hustle*, there were hustles on multiple levels. There were major crimes, smaller-time crooks, and seemingly nice guys whose conduct slid over time, as they engaged in questionable behavior. These nice guys rationalized their behavior as “that’s the way the world works” and by viewing the world as “not black and white, but extremely gray.”

The same behavior is taking place in health care. There have been major fraud schemes in health care, including the Mafia, and there is no shortage of smaller-time crooks. But even more problematic are physicians and others in health care who engage in gray behavior that pads their own pockets. Consider the following:

- **Choosing Wisely survey.** Choosing Wisely is an initiative from the American Board of Internal Medicine (ABIM) Foundation, which has persuaded 16 medical professional specialties to identify practices in their profession that are worthless and wasteful. A recent Choosing Wisely survey found:
 - 73% of physicians said the frequency of unnecessary tests and procedures is a “very or somewhat serious problem.”
 - 53% say even if they know a medical test is unnecessary, they order it if a patient insists.
 - 72% say the average medical doctor prescribes an unnecessary test or procedure at least once a week (which per Ms. Dentzer could be an indication of their own behavior).

The reason cited by physicians for ordering these tests is “malpractice.”

- **Variation studies.** In just one study—and there are many—there was more than a four-fold variation in tonsillectomies in children in different New England communities from 2007 to 2010, at an average cost of \$5,000. There were 10.9 tonsillectomies per 1000 children in Littleton, New Hampshire, and 2.7 tonsillectomies per 1000 children in Bangor, Maine. There is also tremendous variation in Medicare spending post-acute care, driven by enormous differences in home health care, in the use of skilled nursing facilities, and in hospice care.
- **Price increases.** A 2013 article in JAMA found that since 2000, rising prices of hospital charges, professional services, drugs, devices, and administrative costs have produced 91% of the increases in health spending. These rising prices are specific to the United States and are not universal. For example, an appendectomy in the U.S. costs approximately \$28,000 compared to around \$3,000 in Germany and France.

An analysis of the potential impact of reference pricing found that if a reference prices were established for knee and hip replacements at the 67th percentile among all prices charged in each Hospital Referral Region, savings would average about \$10,400 per procedure.
- **Hospital hustle.** Hospitals are purchasing physician practices and are then shifting many procedures from physicians’ offices to hospital outpatient facilities, where they can impose

“facility fees.” MedPAC and CMS are pushing “site neutral” policies that would save an estimated \$900 million per year.

- **Drug costs.** Two examples were shared. In one, ophthalmologists, who are reimbursed for administering a drug for macular degeneration at a rate of “average sales price” plus 6%, often prescribe a drug costing \$50,000 per year when an identical drug by another name is available for \$650 per year. Another example is a drug for hepatitis C which is priced at \$84,000 per year in the U.S. compared to \$57,000 per year in the U.K. and \$900 per year in Egypt.

These examples all illustrate how well-intentioned caregivers—who are saving lives, creating jobs, and innovating—are making minor day-to-day decisions with financial benefits, which are causing the system to go broke.

THE QUESTION FACING POLICYMAKERS AND HEALTH SYSTEM LEADERS IS “WHAT TO DO NOW?”

There is a great deal of talk about controlling costs, and many possible actions are being discussed. These include global budgets, bundled payments, greater transparency, and much more. But it is not completely clear that health system leaders understand or are confronting the harsh realities of the situation, or if any of the solutions being considered will truly make a difference.

“Are we really at a point where we’re confronting the truth of the system that we have at hand, or are we kidding ourselves? . . . We better figure out a way that we’re not hustling ourselves to the point that we are now.”

– Susan Dentzer

Discussion

- **Consumer transparency.** When asked where the health care system will be in five years, Dentzer said, while the profit motive will remain alive and well in health care, the system will also be characterized by more price consciousness, price and cost transparency, and pressure on prices. As an example, consumers facing high deductibles will become far more active in “shopping” for care. There will be apps on smart phones and greater levels of transparency, enabling consumers to access information to make more informed decisions for many types of services.

SESSION VI: Application of Evidence in Value-Based Decision Making and Coverage

Moderator: **Steven Pearson, MD, MSc, FRCP**, President & Founder, Institute for Clinical and Economic Review (ICER)

Panel: **Elizabeth Fowler, PhD, JD**, Vice President, Global Health Policy, Government Affairs & Policy Group, Johnson & Johnson
Troy Brennan, MD, MPH, Executive Vice President & Chief Medical Officer, CVS Caremark Corporation
Jo Carol Hiatt, MD, MBA, FACS, Chair, National Product Council & Chair, Inter-Regional New Technologies Committee, Kaiser Permanente

Overview

With anticipation that health costs may begin to rise again and a host of expensive new treatment options in the pipeline, it is more important than ever to use evidence to make value-based decisions, to ensure that funds are spent only on proven, valuable treatments.

In concept, the idea of making decisions based on value seems obvious, but in practice it is extremely difficult. In the United States there is no accepted standard for measuring value and each stakeholder thinks about value differently. And, while ACOs and risk-based provider arrangements are gaining momentum, the fee-for-service payment system still reigns supreme. The mindset of some stakeholders may be beginning to shift to consider value, but this will be a long, slow transition.

Supporters of using evidence to make more value-driven decisions were enthusiastic about the creation of the Patient Centered Outcomes Research Institute (PCORI) to provide evidence for more informed decisions. Though still early, it is not clear if PCORI is yet furnishing meaningful evidence and it is not clear if payers or providers will use whatever evidence is furnished to make value-based decisions. Ultimately, controlling costs will mean restricting treatment options by not paying for treatments for certain patients if other options represent a greater value. But restricting options, in the face of patients who want such options, requires strong will that to date has rarely been demonstrated.



Context

The panelists discussed how they see evidence being used and what the concept of value-based decision making means.

Key Takeaways

THERE ARE DIFFERING VIEWS ON WHETHER THE ACA IS DRIVING MEANINGFUL DELIVERY SYSTEM AND PAYMENT REFORMS.

Elizabeth Fowler asserted that the delivery system reform and payment reform provisions in the ACA are almost more important than the bill's coverage provisions. Contrary to those who say, "There is nothing in the ACA pertaining to cost containment," she sees the ACA as containing virtually every idea anyone has ever thought of to try to control health care costs. She acknowledged that many providers are still deeply wedded to the fee-for-service payment model, and will ride that model for as long as they can, but she still sees change taking place as other models begin to take hold.

Dr. Troy Brennan sees it differently. While he has heard some people proclaim that accountable care and physician risk agreements are reaching a tipping point, this is not what he sees. He doesn't see any big changes related to cost containment coming out of health care reform, and doesn't see the government taking action to strengthen or implement any such provisions. He sees most providers running as fast as they can in the fee-for-service world and changes away from fee-for-service as occurring extremely slowly. He also believes that after this period of relatively slow cost growth we will see a resumption in substantial health care cost inflation.

SOME (BUT NOT ALL) PANELISTS SEE A GREATER EMPHASIS ON VALUE AND A SHIFT IN MINDSET.

In addition to optimism about payment and delivery reform, Dr. Fowler also sees multiple stakeholders beginning to think about value differently. She sees providers looking at data on outcomes and quality, believes that physicians are increasingly receptive to considering evidence, and see drug companies focused on value and considering concepts related to value earlier in the product development process. Again, Dr. Brennan doesn't see any noteworthy changes in mindset or behavior among providers or drug companies.

“I think there is a shift in mindset to think about value.”

– Elizabeth Fowler

AGREEING ON VALUE IS DIFFICULT BECAUSE THERE IS NOT ONE DEFINITION OF VALUE.

Unlike other countries, such as the U.K., there is not a systematic way of looking at value in the United States. There is not one board or body that looks at evidence and renders a definitive judgment of value. In fact, different stakeholders think of value very differently. A drug manufacturer may define value in one way, a payer in another, and providers and patients in still other ways.

Dr. Steven Pearson described how during a recent panel discussion a participant from a pharmaceutical company indicated that it is possible to have a “high-value drug” even if that drug is unaffordable. But other panelists representing payers disagreed, saying that affordability is part of value. Therefore, if a drug is not affordable, it can't be a good value. This exchange shows basic differences among two key stakeholders in thinking about the concept of value.

In most instances, argued Dr. Brennan, value is relative. He cited the example of a new eight-week treatment for hepatitis C which can eradicate the disease. This treatment has overwhelming clinical value, but with a price of \$84,000 for the treatment, the question is, “What is its relative value?” One way to assess relative value is by looking at the cost to develop a drug. In this instance the cost was around \$11 billion. If the company that owns the drug can treat every patient in the U.S., it will generate a return of 20 to 25 to one. That may seem high, but other drugs developed for this space will now be eliminated because of this new breakthrough, which could happen to this drug at some point. Therefore, the company with the drug sees only a limited period of time to realize its return. Another way to assess relative value is based on how much other treatment

options cost. The \$84,000 cost is in the middle of currently available options. Based on these considerations, the \$84,000 cost and the possible system cost of \$250 billion seems high, but there is an argument that the relative value is reasonable.

“When you think of value, you start off with the relative value of the American health care system that is already extraordinarily high and then [each new development] inches it up a little bit each time. But we're so high now, we're inching out of affordability.”

– Troy Brennan

ORGANIZATIONS LOOK AT INTERNAL EVIDENCE WHEN THEY CAN, BUT IT IS OFTEN NOT ADEQUATE.

Kaiser Permanente has a well-defined process of using evidence and seeking value in its technology purchasing decisions. Kaiser consolidates the evidence in a particular area (including both internal and external data), and has committees of physicians and analysts review this evidence. When decisions are made about which products or technologies to purchase, those decisions are made by credible colleagues and are supported with extensive evidence.

“Value efforts really have to be focused on establishing that we've made credible choices in which physicians' colleagues have participated, and we have lots of data to support what we do.”

– Jo Carol Hiatt

Kaiser has many internal sources of evidence, including registries, and attempts to use them as frequently as they can. However, because the scale is limited, the conclusion is often one of “insufficient evidence.” Such findings often push the clinicians and researchers focused on a certain area to create further evidence.

CVS Caremark also has good data, specifically on the pharmacy side. But to know outcomes, the company needs claims data from insurers. CVS Caremark has partnered with a few insurers to get claims data, but in general, even CVS Caremark doesn't view its data set as large enough to provide credible evidence.

If Kaiser and CVS Caremark don't have large enough data sets, who does? The panelists expressed hope that PCORI would have the scale to create meaningful and important evidence. However, PCORI doesn't look at cost and doesn't think much about value, and to date, the panelists were not clear about meaningful evidence produced by PCORI.

A KEY WAY TO USE DATA TO LOWER COSTS IS TO HAVE EVIDENCE THAT ENABLES DECREASING CHOICE.

Dr. Brennan argued that an important use of evidence is to show if one treatment is better than another. If a treatment is inferior, or if one treatment is comparable to another but the cost is more, evidence provides the support to reduce the choices available to providers and patients. In Dr. Brennan's experience, if evidence indicates that drugs in the same category are comparable, and if health plans and employers are willing to adopt a closed formulary (which means restricting choices), CVS Caremark can concentrate its volume on one product and typically negotiate a 30–40% decrease in cost.

“You've got to decrease choice if you want to reduce costs.”

– Troy Brennan

A problem Dr. Brennan sees is that evidence is rarely invoked to deny or limit choices. Dr. Pearson mentioned that Blue Shield of California reduced coverage for proton beam therapy because evidence did not support improved outcomes and this therapy cost more than other options. Dr. Jo Carol Hiatt described how Kaiser delayed in purchasing da Vinci surgical robots, even though physicians were asking for them, because “the evidence was nonexistent.” (Kaiser later relented in order to hire and retain top urologists who wanted these devices, but put conditions on who could use the devices and when they could be used.) However, these examples of using evidence to restrict treatment options are the exceptions rather than the rule.

AN ISSUE WITH THE USE OF EVIDENCE IS THE LACK OF ACCEPTANCE BY CONSUMERS.

The panelists see a growing acceptance among some physicians in using evidence and considering costs in treatment decisions. For example, the American College of Cardiology recently announced that it was going to include value for patients as one of its guidelines, and the American Society of Clinical Oncology plans to incorporate value as a consideration for oncology drugs.

However, even though physicians' mindset and readiness to use evidence regarding value might be shifting, it is not clear that patients are yet open-minded in using evidence to make care-related decisions. The prevailing view among most consumers is that more treatment is better than less, and more expensive treatment is better than less expensive treatment. Consumers may care in a general sense about the sustainability of the health care system, but when they or a family member has a health need, they want the absolute best treatment possible, especially if others are paying the bill.

“I agree that physicians are more ready [to consider evidence involving value]. The group we haven't talked about are patients, and I'm not sure how ready they are.”

– Jo Carol Hiatt

Panelists believe that education is necessary to engage patients and convey to them the implications and tradeoffs associated with unchecked health spending. One way to illustrate the situation is to show how spending on health care is eating up other parts of the social safety net, such as spending on prevention, public health, and other social programs.

“People have to begin to realize that the health system is just eating up the rest of the social safety net, and it's not a good value. Public education is important.”

– Troy Brennan

SESSION VII: Enhancing Quality Through Payment Reform

Moderator: **Karen Wolk Feinstein, PhD**, President & Chief Executive Officer, Jewish Healthcare Foundation

Panel: **Mark McClellan, MD, PhD**, Senior Fellow & Director, Initiative on Innovation and Value of Healthcare, Brookings Institution

Dana Gelb Safran, ScD, Senior Vice President, Performance Measurement and Improvement, Blue Cross Blue Shield of Massachusetts

Neel Shah, MD, MPP, Executive Director, Costs of Care & Faculty Investigator, Ariadne Labs for Health Systems Innovation, Harvard School of Public Health

Sandra Hernández, MD, President & Chief Executive Officer, California Health Care Foundation

Overview

Payment reform is seen as one of the key levers to enhance the quality of health care that is delivered. Blue Cross Blue Shield of Massachusetts (BCBSMA) has developed a new type of provider contract that links compensation to quality and cost measures, and is producing dramatic results. Regional health improvement collaboratives are focused on making their regions “best in class” in the care delivered.

But payment reforms that emphasize quality and value are often not being translated to front-line clinicians, who continue to behave as if they are in a fee-for-service world. Clinicians have been taught to “do more,” making cultural and behavioral changes among physicians an essential step. The results from BCBSMA show it is possible to make these changes and deliver positive results.

Context

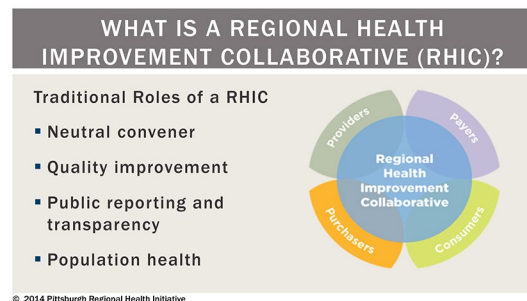
The panelists discussed ways that payers can change how they pay and can establish processes and measures to enhance quality.



Key Takeaways

REGIONAL COLLABORATIVES CAN PLAY AN IMPORTANT ROLE IN ALIGNING PAYERS AND IMPROVING QUALITY.

The traditional roles of regional health improvement collaboratives (RHICs) are to be neutral conveners, work on quality improvement, work on public reporting and transparency, and advance population health.



Areas of focus for RHICs in working with payers and others to bring value to health care include:

1. **Keep the regional health care system open and transparent.** The idea is to go from data to information by providing consumers with the right information at the right time so they can comparison shop. The role of RHICs is to see what is happening in the region.
2. **Make regions and states best in class and relentlessly progressive.** This involves identifying the best providers and the best practices. It involves identifying and resolving gaps in care, encouraging experimentation and lowering the risk for experimenting, and tracking outcomes.

3. **Keep costs reasonable.** This goes beyond just producing the best value to completely inventing a new future that includes new ways to achieve population health. In managing population health and keeping costs reasonable, technology is a game changer.
4. **Advance the health in health care to keep people out of hospitals.** A major area of focus for the Pittsburgh Regional Health Initiative is keeping people out of hospitals. Important elements of doing so include primary care and using IT to find patterns, make predictions, and identify the most complex patients for customized goal-driven health care.
5. **Attend to workforce issues.** The health system needs to move from a fee-for-service workforce to a value-based workforce. This involves changing the education provided to clinicians and maximizing the use of technology.

“No one is better at aligning the payers in this brave new world than the regional collaboratives.”

– Karen Wolk Feinstein

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS' ALTERNATIVE QUALITY CONTRACT HAS DRAMATICALLY IMPROVED QUALITY WHILE CONTROLLING COSTS.

Health reform in Massachusetts in 2006 caused a bright light to shine on unrelenting double-digit increases in health care spending. In response, in 2007, leaders at BCBSMA challenged the organization to develop a new contract model to improve quality and outcomes while significantly slowing the rate of growth in health spending.

Developed by BCBSMA was the Alternative Quality Contract (ACQ), believed to be the first contract of this nature in the country, with accountability for outcomes. The ACQ's key components were:

- **A global budget.** Providers received a population-based budget that covered the full continuum of care. The budget was based on historical claims, was health status adjusted, involved shared risk, and had trend targets set at baseline.
- **Quality incentives.** This included incentives with significant earning potential for both hospital and ambulatory care, with a particular focus on helping patients with chronic conditions control their conditions. The quality measures

were based on nationally accepted standards, with a continuum of performance targets for each measure. (Participating providers enthusiastically accepted these quality measures and wanted them weighted heavily.)

- **Long-term contract.** Agreements had a five-year team to provide a long enough time horizon for investment in infrastructure and to show improvement. BCBSMA viewed these relationships as partnerships and worked closely with the leadership of participating organizations to provide data, consultative support, and sharing of best practices to help support success.

Participating providers were not in competition with each other and the performance targets were not relative; every provider could achieve their goals by providing exceptional care.

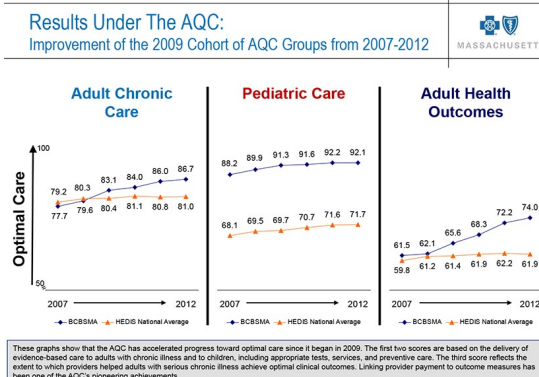
Providers participating in the ACQ have shown dramatic results in:

- **Quality improvement.** Across multiple quality measures those group participating in the ACQ from 2007 to 2012 showed dramatic improvement, with particular improvement in adult chronic care measures and adult health outcomes compared to national results.

“I have never seen anything as dramatic as the rate or scope of increases in quality that these groups achieved.”

– Dana Gelb Safran

- **Cost control.** Research has confirmed that the ACQ is reducing medical spending. Savings relative to control was close to 2% in year one and 3.3% in year two. In looking at total costs, by year three, BCBSMA had met its goal of cutting its cost trend in half (two years ahead of plan) and by year four, BCBSMA's total cost trend for ACQ was below the state's GDP of 3.6%.



The four strategies that provider groups have used to improve quality while reducing spending are: 1) new staffing models; 2) new approaches to patient engagement; 3) data systems and information technology; and 4) referral relationships and integration of care.

In looking ahead, BCBSMA sees the priority issues as continued evolution of the delivery system; expanding payment reform to include PPO; and focusing on getting payment incentives to front-line physicians.

IN GENERAL, CLINICIANS HAVE BEEN DISCONNECTED FROM THE CONCEPT OF VALUE.

Dr. Neel Shah provided a sense of why physicians behave the way that they do, explaining how clinicians are disconnected from costs and value.

- **No changes on the frontlines.** Dr. Shah described how health systems and physician groups are participating in various gain-sharing agreements, but this hasn't translated to any changes on the front lines. Physicians are still behaving as if they are part of a fee-for-service model.
- **General physician ignorance on cost/value.** Multiple studies have found that clinicians have no sense of the cost of various tests or procedures. When asked to estimate the costs, they are wrong by an order of magnitude. This presents a disconnect with many patients, especially those who are younger, tech savvy, and want to be able to access transparent information and ask questions about cost.
- **Ignorance about translating information into action.** Current research shows that clinicians are increasingly on board with the idea of dealing in some way with cost as part of their job. The problem is that they don't know what to do. They can be provided with information (both macro-level policy information and micro-level cost information) but they have no idea how to act on it and don't know how they should be treating patients differently. Ideas of population management and value are largely seen as abstractions.
- **No training regarding value.** As students, residents, and interns, young physicians are constantly asked, "What more could you have done that you didn't do?" This trains doctors to always be thinking about doing more. But no part of the educational process asks the question, "What did you do that maybe you didn't have to do?" This training influences behavior and decision making. This emphasis on doing as much as possible can be seen through the mantras of a few Boston-area hospitals, which are "Everything possible," and "Until every child is well." This is the ethos of what doctors are trained to do.

Further, while it is purported that physicians order multiple tests because of fee-for-service profiteering or to avoid medical malpractice, there is another explanation. Take an emergency room (ER) physician who has patients waiting. That physician's number-one goal is to deal with the patient in front of them. To that physician, it is far more expeditious to order multiple tests at once than ordering one test, learning the results, then ordering another test, and on and on. Physicians are simply being thorough and using their own time in the most efficient way, but are likely ordering excessive tests.

"The way we are taught actively trains us to be terrible stewards of resources."

– Neel Shah

An example of how to change physician behavior can be seen in efforts to improve hand washing. For years it was known that hand washing was important, but there were difficulties translating this evidence into action. Then, efforts focused on understanding why people weren't washing their hands, which was often related to inconvenience. So, hand sanitizer was placed in strategic locations outside of patients' rooms and the culture changed so that nurses (or patients) could call out anyone who entered a room without cleaning their hands.

PALLIATIVE CARE IS AN AREA WHERE THERE IS ALIGNMENT BETWEEN CONSUMERS AND PAYERS.

Palliative care is patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. It emphasizes patient autonomy and choice. However, many physicians don't think about palliative care for appropriate patients and fail to make patients aware of options and choices. As a result, 60% of Medicare fee-for-service patients with poor prognosis cancers were hospitalized in their last month of life and 25% were in the intensive care unit (ICU). Only 54% used a hospice, with a median of only eight days (versus a recommendation of one month), and 30% died in the hospital. These statistics would have been much different had patients and families been actively involved in making decisions about their care. In most cases patients and families would have chosen less invasive treatment, which would have resulted in an improved quality and would have actually improved the length of survival, and the health care resources devoted to these patients in their last few months would have decreased.

“[Palliative care] is a place where consumers and payers are in alignment.”

– Sandra Hernández

Discussion

- **Diversity in payment reform.** Dr. Mark McClellan sees a great deal of activity taking place related to payment reform, with a move away from fee-for-service. Moving forward, there are likely to be more global payments tied in some way to quality and cost. Among the types of reforms taking place are add-ons, such as medical homes; reforms that are shifting costs, such as fee-for-service turning to bundles; and some tracking versus a benchmark to achieve shared savings. There is not yet extensive systematic learning on which model(s) applies in particular clinical settings.
- **ACO challenges.** Among the challenges that providers that are becoming ACOs are having are: seamlessly integrating with post-acute care; working through situations where there is a lack of infrastructure, such as an electronic medical record; and the infrastructure is dependent on fee-for-service.

- **Behavioral health specialists.** Some primary care practices have begun to integrate behavioral health clinicians into their practices to help patients with a broad range of issues such as stress, sleep, motivation for behavioral change, and medication adherence. This is part of the new staffing and workforce models that were mentioned.
- **Impact of consolidation.** There are tradeoffs. The benefits include economies of scale, economies of scope, and coordination of care. The obvious concern is that consolidation leads to greater market power. The evidence so far on large-scale consolidation leading to cost improvements is fairly limited, as is data on prices and the quality of care. Thus far, the sophistication of the reporting of performance measures for large organizations is no different than the reporting from a small physician practice.

“There really is no excuse for organizations of that scale to not have much more comprehensive information on quality and cost available for how their populations are doing.”

– Mark McClellan

SESSION VIII: Innovation in Cost Containment and Delivery System Change

Moderator: **Stuart Altman, PhD**, Sol C. Chaikin Professor of National Health Policy, The Heller School for Social Policy and Management, Brandeis University

Panel: **Michael Cherner, PhD**, Leonard D. Schaeffer Professor of Health Care Policy, Harvard Medical School
Martin Gaynor, PhD, Director, Bureau of Economics, Federal Trade Commission & E.J. Barone Professor of Economics and Health Policy, Carnegie Mellon University
Suzanne Delbanco, PhD, MPH, Executive Director, Catalyst for Payment Reform
Josh Sharfstein, MD, Secretary, Maryland Department of Health and Mental Hygiene

Overview

While the rate of growth in health spending has slowed in recent years, many experts believe that cost growth will resume. With resumed cost growth and an aging population, there simply isn't enough money to continue to pay for the health care delivery system to operate as it has. Payers will have to change how and what they pay, and the delivery system will have to figure out how to operate differently.

BCBSMA's Alternative Quality Contract (AQC) is an initial example of a payer linking payment to quality and low rates of spending growth. In Maryland, the state government is using regulation and global payments in an attempt to control costs. And, large payer groups are attempting to use benefit design and transparency to affect consumer demand, along with payment changes to affect supply. Yet at the same time, hospitals are engaging in ongoing consolidation. This consolidation of the market has the potential to limit market power and has the potential to limit competition, increase prices, and hurt quality and innovation.



Context

This panel discussed different strategies for controlling health care costs, including payment reform, benefit design, regulation, and enforcement of anti-trust regulation to limit market consolidation.

Key Takeaways

IN THE FUTURE THERE WILL BE LESS MONEY AVAILABLE TO THE HEALTH CARE SYSTEM.

Professor Stuart Altman offered a short history of health care financing in the United States over the past several decades. In the 1970s, seeking to avoid regulation, the hospitals and doctors promised the government that the industry would solve the cost problems—which didn't work. In the 1980s, there was no government interference and health care costs grew dramatically. The 1990s ushered in the era of managed care, which from an economist's perspective worked well and constrained costs, but people hated it, resulting in a backlash. That resulted in unconstrained cost growth again in the 2000s and the 2010s. Even though cost growth has been slow for the past few years, it seems primed to begin growing once again, leading Professor Altman to conclude, "So here we are again."

Looking forward, Professor Altman simply doesn't see continued cost growth as sustainable. Neither the government nor private payers have the money. There will be less money available to the health care system and the delivery system will have to figure out what to do.

PROFESSOR MICHAEL CHERNEW DOESN'T BELIEVE THE SLOWDOWN IN SPENDING GROWTH WAS PURELY DUE TO THE RECESSION.

Professor Chernew shared multiple thoughts on health care spending growth, as well as possible solutions. These thoughts included:

- **The crux of the policy debate will be about taxes.** Everyone is familiar with the graphs of federal spending on health which show Medicare dominating federal spending and eventually the entire U.S. economy. Historically, the problem has been that per capita spending, particularly Medicare per capita spending, has grown 2% faster than income. But there is now an even bigger problem—the aging population. Even if per capita Medicare spending grew at the same rate as GDP, total Medicare spending would still grow significantly. The result is that the total portion of the U.S. economy devoted to Medicare is continuing to rise. The real issue becomes less about health care and is more a debate about taxes.
- **The slowdown in spending growth began before the recession.** In fact, the slowdown in the per capita growth rate of health expenditures began in 2005, with spending growth slowing each year since. It affected populations that were not as strongly impacted by the recession, and involved factors such as drugs going off patent, as well as fewer new drugs coming to market. That said, it is not clear that the slowdown will continue; it is not inevitable and future policies will matter greatly.
- **Payment reform is a fundamental policy change needed to keep spending growth in check.** Payment reform can mean paying less or paying differently. There are a wide range of strategies and there is not one “right” strategy. ACOs, bundles, and strategies used at the state level such as coordinated care organizations (Oregon) and hospital budgets (Maryland) all have potential for their context. There are also private innovations related to payment, such as BCBSMA’s AQC.

Basic features of all of the reform ideas include payment that spans different types of providers through global or episodic payment, payment that is risk adjusted, and payment built on a fee-for-service foundation. These innovations all have some pay-for-performance component, and contain varying degrees of technical support. Issues related to these payment reform initiatives include the fact that providers capture the savings; payers only capture savings if they

lower the payment rates. Also, after the managed care era, everyone is worried that global budgets could compromise quality, yet quality measurement systems in the U.S. are flawed. Improvements are needed, and providers need tools to help them manage payment reform and quality.

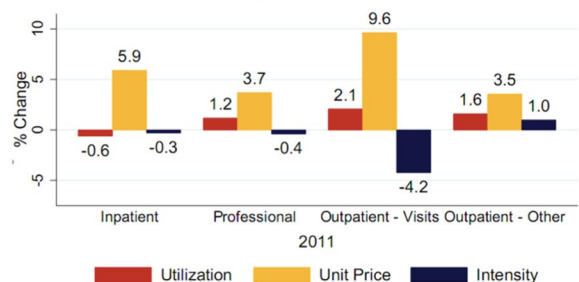
- **Payers who follow may benefit as free riders.** Conventional wisdom is that when providers enter into risk arrangements they are forced to change their processes, incentives, culture, and systems, which affects how they treat all patients. Based on this, some consulting companies are advising payers that the best strategy is to be a follower and to avoid investments in payment reform. The idea is that a follower can benefit from the changes initiated by the leader without incurring the expense. (Dana Gelb Safran from BCBSMA said that followers may receive some benefits, but argued that the leaders, who provide directed technical assistance and form strong partnerships with providers, receive more benefits.)

PROVIDER CONSOLIDATION CAN HURT COMPETITION AND INCREASE PRICES.

In discussing the state of the U.S. health care system, Professor Martin Gaynor emphasized that the U.S. relies on markets for the provision and financing of health care, but those markets don’t work as well as they could and should. Prices are high and rising, there are quality problems, and there is too little organizational innovation. A conclusion of many entities that have looked at the primary drivers of increasing health spending is that prices are the major factor. As Professor Gaynor stated, “No matter how you cut it, prices are a big factor behind increases in health spending.”

What’s Driving the Growth in US Health Spending? It’s The Prices

Components of Health Spending Growth, Private ESI Insurance, 2010-2011



Note: All data weighted to reflect the national, younger than 65 ESI population. Source: 2011 Health Care Cost and Utilization Report, Health Care Cost Institute, <http://www.healthcostinstitute.org/2011report>

Of concern to economists and regulators is the effect of provider consolidation on price and on properly functioning markets. From the 1990s onward there has been a great deal of merger and acquisition activity among hospitals, with more than 1,000 deals. Reasons include the desire to have greater scale for negotiations with payers, to create economies of scale in order to lower costs, and to align with other hospitals to avoid being left out in a game of musical chairs. A result is that many urban areas are now highly concentrated and are dominated by just a few large health systems. In addition, there is now increased interest among providers in hospital-physician consolidation.

“From 2009 onwards we have had a few hundred additional mergers in an industry that was already very highly concentrated.”

– Martin Gaynor

Those engaging in mergers typically cite benefits from integration, such as efficiency and lower costs. It is the perspective of the Federal Trade Commission (FTC) that many mergers can be beneficial or benign, and the FTC allows most mergers to go through with no investigation; the FTC takes action on only a very small minority of all mergers. That said, situations that would cause potential concern at the FTC include mergers that would decrease competition in a market. Results of decreased competition include higher prices, lower quality, poor service, and inefficiency. Increased prices are passed on 100% to workers.

Concerns about hospital mergers are supported by evidence:

- **Consolidation drives up prices.** There is a great deal of strong evidence from the hospital sector showing that in circumstances where a market is already highly concentrated, mergers can lead to substantial price increases, of 20%, 40%, and in some instances more than 50%.
- **Consolidation can hurt quality.** Evidence shows that markets with more competition deliver better quality, and quality can suffer in the absence of competition.
- **Consolidation doesn't necessarily boost efficiency.** Efficiencies are always claimed, but there is little evidence that greater efficiency is achieved.

A key to ensuring competition is active anti-trust enforcement, which provides a competitive market to support innovation and delivery system reform.

MARYLAND IS ATTEMPTING TO CONTROL COSTS THROUGH REGULATORY CHANGES.

For years, going back to a 1977 Medicare waiver, Maryland's Health Services Cost Review Commission (HSCRC) has set hospital rates for all payers. How this has worked is that each hospital receives a rate sheet and then bills all payers the same rate for the same service.

Medicare's participation in this system has been premised on Maryland keeping its per case increase below the increase in the national rate of growth for each case. Since 1977, Maryland has successfully kept its cost per case increase below the national rate, yet Maryland was experiencing two issues. First, the amount of its “waiver cushion” was decreasing year after year and “fell off the cliff” in 2010, putting the future of the waiver in doubt and creating anxiety in the state. Second, the emphasis on cost per case kept the focus only on hospital inpatient services, and not on overall health care spending. (It also created incentives for volume and readmissions.)

This led Maryland to develop an innovative solution. It involves retaining the all-payer structure, while focusing on total costs and quality. The idea is termed Total Patient Revenue (TPR). It establishes fixed global revenue levels for each hospital, for all inpatients and outpatients; each hospital's level is different based on its history and situation. Revenues are subject to adjustments for quality and performance. Hospitals invest and develop approaches to improve population health, coordinate care, and reduce hospital utilization. Savings from improved performance are retained by the hospital. This provides strong incentives for care coordination and ensuring that care is provided in less expensive and more appropriate settings.

“One of the key points is even though it is a rate setting system, it doesn't have to be done the same way for every hospital.”

– Josh Sharfstein

MAJOR HEALTH CARE PURCHASERS ARE SEEKING TO CONTROL COSTS BY INFLUENCING BOTH DEMAND AND SUPPLY.

Catalyst for Payment Reform is a national non-profit that provides coordination among large health care purchasers, including employers who are government entities. Catalyst is focused on identifying areas of major price and quality variation, getting price guidelines followed, having reference prices adopted, and fostering the creation of customized provider networks. Catalyst is also pushing for greater transparency, as despite the talk of transparency, there are still not good sources for consumers of price and quality information.

In asking Princeton Conference attendees whether consumerism (the demand side) or provider payment reform (the supply side) is likely to save the most money, attendees see greater potential in payment reform.

Discussion

- **Terminology matters.** Professor Altman took issue with the commonly used term “reimbursement.” This means that a provider incurs a cost and is then reimbursed for that cost. Providers have adopted a general mindset that whatever cost they incur, they will be reimbursed. In other industries, service providers render services and have to get paid. Health care should use the term “payment.”
- **Tax subsidy.** One participant argued that as long as the money spigots remain open and flowing, health care’s cost issues will persist. This individual suggested eliminating the tax benefit for employer-sponsored health insurance and having employers (and Medicare) provide defined contributions. Professor Altman agreed with the basic premise that there isn’t going to be enough money, but believes that attempting to eliminate the current tax subsidy will create a huge fight with consumer groups and unions.
- **Lack of tiers.** Professor Altman mentioned how many experts call for more limited or tiered networks. But the problem is that in many geographies there are no low-cost or alternative providers to tier. This gets at a larger issue which is that payers and regulators have not regulated very much at all. They haven’t restricted or limited anything.