



Implications of the Election for the Health Care System

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Michael Doonan, PhD, Schneider Institute for Health Policy,
The Heller School for Social Policy and Management, Brandeis University

Brooke Evans, MA, MSW, LCSW, CSAC, Doctoral Candidate, Schneider Institute for Health Policy,
The Heller School for Social Policy and Management, Brandeis University

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Opening Session Dinner Night One: What the Polls Tell Us about the AHCA, Trump Voters, and Us

Drew Altman, President and Chief Executive Officer, Henry J. Kaiser Family Foundation

Altman's opening night presentation provided public polling insights on the American Health Care Act (AHCA), including the Trump voter viewpoint from recent focus group data collected by the Kaiser Family Foundation. While the data shows major differences by political party, Altman cautions that health care—except for Medicare—has not played a major role in election decisions.

The primary take away from Altman's talk is the power of partisanship in explaining health policy positions. The Affordable Care Act (ACA) is growing in popularity, with 48 percent now supporting it and 41 percent opposing (April 2017). Party differences remain extreme. Over 70 percent of Democrats support the ACA compared with only 17 percent of Republicans. The gap, by political party, of those that support repeal of the ACA, is similarly wide, with 81 percent of Republicans in support of repeal compared to 19 percent of Democrats.

Partisans believe and disseminate their own facts, and the data shows incredible misinformation. For instance, 50 percent of Republicans believe the ACA included "death panels," 32 percent think the law reduced the number of uninsured, 38 percent know it decreased cost sharing for preventive care, and just 29 percent understand that the ACA prohibited insurance companies from charging women higher premiums than men. Perceptions of whether the law helped or hurt families were skewed more by party affiliation than actual impact, Altman reported. This partisan divide even persisted among physicians. Moreover, recent evidence suggests that partisanship is more influenced by natural geographic sorting (83 percent) than gerrymandering or changes to district boundaries (17 percent).

Polling shows that Republicans now own the healthcare issue and will be held accountable for the impact of any reforms. Further, most people do not generally rank health care as a top legislative priority except for dealing with prescription drug prices. A majority of the electorate—68 percent of Republicans, 84 percent of Democrats, and 73 percent of Independents—support action to reduce prescription drug costs.

Altman ended with a Venn diagram showing that politicians, policy makers, and the media view health care reform (ACA and AHCA) from different perspectives; the health care and research communities are most interested in health care value, delivery system transformation, and payment reform; and the public is primarily concerned with pocketbook issues (i.e., out-of-pocket costs). He concluded that we need to have a more consumer-focused agenda that takes price and access barriers, which real people face, into consideration.

Welcome

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

Altman opened the 24th Princeton Conference by welcoming guests and speakers, thanking the generous funding partners, and recognizing Richard Besser, President and CEO of the Robert Wood Johnson Foundation (RWJF).

Richard Besser, MD, President, and CEO, Robert Wood Johnson Foundation

Besser welcomed the participants and speakers. He discussed the vision of the RWJF and its commitment to improving health care access for all Americans. Besser highlighted many of the challenges to improving health and health care coverage in the United States and noted that despite much improvement, 28 million people are still uninsured. Pointing to RWJF's focus on access to health care and the broader social determinants of health, including upstream issues such as jobs, housing, and employment opportunities, Besser stressed that no one should be left behind. He thanked the organizers of the event and commended the work being done by the distinguished attendees.

Session I: Repairing or Replacing the ACA Insurance Market: Why Do It?

Joseph Antos, Wilson H. Taylor Scholar in Health Care and Retirement Policy, American Enterprise Institute (Moderator)

Antos moderated this panel on ACA insurance markets. He introduced the speakers, highlighted their expertise and noted that the panel will focus primarily on changes included in the AHCA.

Tom Miller, Resident Fellow, American Enterprise Institute

Miller began with an overall discussion of the AHCA. In a whirlwind, Miller took the audience on a trip through the house of mirrors of health care. He spoke about how the AHCA includes both old and new ideas, including many of the features of the ACA. He described how Republicans speak and think about health policy—and how some of these perspectives are playing out in the AHCA debate. Miller discussed features of state delegation and innovation as those of evolution, not revolution. Many of these health care issues are old wine in new bottles, and leadership and solutions are proving a lot harder than criticism and cries to repeal "Obamacare." The timing of a replacement was a challenge and Congressional leadership and the White House were initially not prepared enough, and somehow lost the narrative, he noted. Reconciliation in the Senate has its limits and ultimately will restrict what can be done.

Miller spoke of the importance of addressing the real problem of cost containment. In this space, Democrats want to reduce provider payments and Republicans want to reduce the demand side for services. He said that the road ahead will grudgingly be downscaled ambition. Concluding his presentation, Miller noted the importance of repairing and fixing health care—to improve health care and lower costs—but that moving in this direction is still uncertain.

Stephen Zuckerman, Co-director and Senior Fellow, Urban Institute Health Policy Center

Zuckerman reported that we are in a different place than many anticipated. It was quite possible that by this point the ACA could have already been repealed, with some sort of a replacement to be worked out over the next couple of years. Zuckerman noted that the biggest objections to the ACA are the individual mandate, high deductibles, and affordability of premiums. The AHCA does not solve these problems, however. Zuckerman favors allowing the 19 non-expansion states to still have the option of expanding coverage with enhanced federal match funds. He lamented that the AHCA does not seem focused on addressing the problem of the uninsured and, as reported by the Congressional Budget Office (CBO), dramatically moves in the opposite direction.

Zuckerman added that opponents of the ACA emphasize marketplace premium increases of 21 percent or higher, but ignore the regional variation and the reasons for the increases. Non-Medicaid expansion states have the highest premium increases in their market places. Economists were correct; more competition in the marketplace does reduce premium prices. The challenge is that about one-third of the population lives in non-competitive areas with higher premiums, but the answer is not to insert more uncertainty into the market and eliminate subsidies, he said. Instead, markets should be made more competitive or we should have a regulated public option in these areas.

A more macro solution is to facilitate the type of competition that avoids risk selection and spreads risk across the entire population. The AHCA moves in the opposite direction. It will also make insurance less affordable for low-income people, particularly in high-cost areas, Zuckerman reported. Tax credits are extended up the income ladder to 450 percent of the federal poverty level and adjusted somewhat by age, but not by region and not based on affordability. Zuckerman ended his presentation by suggesting that the AHCA does one thing well: it redistributes income from low to higher income people.

Charles N. Kahn III, President and CEO, Federation of American Hospitals

Kahn opened with a description of the current health care reform environment in Washington—as a movement toward clinical depression. He noted lack of engagement with stakeholders in the process of making major health reform changes. Looking back at the passage of the Catastrophic Health Care Act in 1988, and its repeal one year later in 1989, he suggested that major health policy can be repealed. Support for the repeal of the ACA runs deep and is based on core conservative principles. For many, he reported, entitlements have grown too fast, taxes are too high, and savings from repeal should be used to reduce deficits and/or taxes. Moreover, he discussed that the last thing Republicans want is to expand the federal role. As such, they could never be for the ACA, particularly if Democrats had universal coverage as a goal in mind.

The post-election thinking was that the repeal bill, which was passed and vetoed by President Obama, would be the template moving forward. Here the question was quite straightforward: How long should it take to phase out the ACA? It should have been simple because this legislation had already passed (before being vetoed by President Obama). They extend the premium subsidies to more people, but older Americans will have to pay higher premiums. It is no wonder then how the bill ran into trouble as moderate representatives began listening to constituents at town hall meetings.

Finally, Kahn observed three areas that may cause problems in the Senate. First, CBO will need to score enough savings so that the bill can be passed through reconciliation (i.e., a simple majority is necessary for passage). Second, there may be parts of the bill that will make it ineligible for the reconciliation track. Third, there may be “time bombs” in the bill that would make it difficult to pass. For example, if language allowing tax credits for insurance that covers abortion is included in the Senate bill, this may be unacceptable to the House.

Discussion

To start off the discussion, Antos asked the panel about their predictions for how the AHCA will play out in the Senate. Zuckerman and Miller both suggested that proposed cuts to Medicaid are likely to be a challenge, even with some Republican Senators. This could lead to a shortage of 10 to 15 votes, although some of this lost ground could be regained through negotiations and more money. One possibility is that legislation will pass and just push the painful cuts down the road to deal with another day. This could potentially lead to an annual fight to reinstate Medicaid funding.

It was also suggested that Senator Susan Collins and Senator Rand Paul may be in opposition from either end of the debate, which leaves little margin for error. Furthermore, Majority Leader Mitch McConnell is a much more transactional leader than Speaker Paul Ryan, which may cause the issue to play out differently. McConnell wants a vote before August 2017. There was also concern that should a Senate plan pass, it would have trouble passing the House. Kahn said, however, that if the Senate can get the needed 50 votes, it will likely pass the House. Again, the abortion issue may prove tricky though. In the end, some on the panel were skeptical about passage; others gave it a 50-50 chance.

The conversation then turned to how the cost-sharing subsidies might be handled, and the arrangement to delay deciding on this for another three months. This uncertainty is causing harm, however, as health plans need to set rates for next year by August 16, 2017. Health insurance carriers may retreat from the market place without a promise of subsidies. It was also suggested that the true motivation for the AHCA is an ultimate desire for tax cuts. Miller disagreed, but did acknowledge that tax cuts and smaller government are basic principles of the current Congressional majority leadership. Kahn suggested that the real surprise here is the limited role of stakeholders in this process. It is a new political world. However, interest group and more centrists may reassert themselves in 2018.

Session II: Implications of Proposed Financing Changes and Added State Flexibility to Medicaid

Michael Doonan, Associate Professor, The Heller School for Social Policy and Management, Brandeis University; Executive Director, The Massachusetts Health Policy Forum (Moderator)

Doonan provided background for the Medicaid session and thoughts on how ideological beliefs shape policy prescriptions. Medicaid spends over \$530 billion annually to cover over 70 million people. Thirty-one states expanded coverage under the ACA, covering an additional 11 million people. The program covers half of all births and most nursing home care. Provider reimbursement is 56 percent of private payment rates, leaving very little room to lower or scale back payments. The AHCA proposes to cut \$880 billion, over 10 years, from the Medicaid program and the CBO projects that 14 million fewer people will then be covered by the program. Enhanced federal funding will be eliminated and coverage of the expansion groups will become a state option at regular state reimbursement levels. Per-capita caps will set budget targets for each state and a straight state block grant option will become available.

Doonan suggested that the right views Medicaid as a welfare program and this leads to particular policy prescriptions: work requirements, regular redeterminations, enhanced cost sharing, asset test requirements, detailed applications and reporting requirements, time limits, minimal benefits, and perhaps waitlists. Policy would discourage enrollment and encourage people to get insurance or health care on their own. In contrast, those on the left view Medicaid as part of a system of universal health care with different policy prescriptions: universal income-based eligibility (cover all people with low income), presumptive eligibility, limited out-of-pocket costs, fewer barriers to enrollment, generous benefits, and transitions to other coverage options as income increases. Turning to the panel, Doonan suggested that there may be a middle ground between these extremes.

Matt Salo, Executive Director, National Association of Medicaid Directors (NAMMD)

After offering background on Medicaid, Salo provided insight into the program from the perspective of state Medicaid directors. Medicaid, which is the largest source of public health coverage in the United States is a vital program for individuals, families, and communities, but often goes under appreciated. Medicaid is the major source of funding for safety net hospitals, health centers, nursing homes, and community-based long-term care. Almost two-thirds of Medicaid spending is for the elderly and people with disabilities, and the top five percent of beneficiaries account for more than half of the costs. Dual eligible beneficiaries—those with Medicare and Medicaid coverage—are the largest portion of the budget (40 percent) and are not controlled by state Medicaid programs.

NAMMD is bipartisan and takes no position on repeal and replacement, or per capita or block grants. They are concerned about changes in the framework for covered populations, the impact of reform on current enrollees, and how payment levels could change under reform efforts. Medicaid is currently the default long-term care program in the country, and increasingly, the program is being depended on for covering mental health and substance use treatment services. Medicaid Directors are concerned about financing, state flexibility, and how to keep programs afloat in uncertain times. Salo highlighted the importance of bringing these Medicaid leaders to the table and involving them in the health care reform discussions. He concluded by suggesting a potential disconnect between what Congress demands from the program, and how this will play out in a reality of \$880 billion in potential cuts.

Sandra R. Hernández, MD, President and CEO, California Health Care Foundation

Hernández discussed the Medicaid program and potential changes from a California perspective. While California is largely a blue state, there is a large red line down the middle of the state, which often impacts how the state views certain programs and services, like Medicaid. In California, a high percentage of state residents are enrolled in Medicaid, and public funds (e.g., Medicaid, Medicare, ACA subsidies, public employees insurance) pay 71 percent of total health care expenditures in the state (2016). Hernández noted that the large role of public payers needs to be actively considered in any health reform conversations.

Hernández spoke of the active role that California played in creating system change, moving innovation forward, and curbing health care costs. She noted that waivers are a key ingredient to help with these efforts. Hernández discussed the example of addressing Medicaid beneficiaries with multiple chronic conditions, and the need to provide “whole person” care. A state waiver helps the state direct funds and resources toward these high-cost beneficiaries. While California is heavily invested in preventing decreases in Medicaid funding levels, if Medicaid is cut, the state will adapt and change in innovative ways to meet the needs of beneficiaries. She presented several examples of how this could take place. Acknowledging that federal cuts would be devastating, Hernández concluded by noting that California will remain committed to sustaining Medicaid coverage.

Stuart M. Butler, Senior Fellow in Economic Studies, Brookings Institution

Butler rounded out the Medicaid presentations by discussing the underlying philosophical issues at play in the current Medicaid debate. He discussed four underlying themes involved in the debate, which includes the following: (1) The original vision of welfare reform; (2) Horizontal equity with simplicity and stability; (3) The devolution of power to the states; and (4) Social determinants of health. Keeping these themes in mind, he noted the great value of state flexibility and its potential to help meet state and national objectives.

Butler looked back at welfare reform as a model for state flexibility to better meet individual needs and suggested this could be replicated in health care. For example, states could use health insurance resources to address social determinants of health. State flexibility encourages innovation through experimentation. Sharing financial risk with

states could provide an incentive for efficiency and innovation, and allow for political adaptation and learning. Butler also suggested that adding flexibility raises questions about the parameters. He suggests the possibility of including “guardrails” to add a level of accountability and enhance fiscal responsibility. The key is finding the right balance. The current administration approves waivers, but one could imagine a commission or a very different process.

Discussion

In response to questions, Salo acknowledged that consensus between governors is a challenge, with members coming from different ideological perspectives. However, Medicaid Directors face similar administrative and funding challenges, and their experience can help inform the federal process and improve program operations in the long term. Hernández reflected on how potential Medicaid cuts might impact California. She stated that when one-third of the population is covered by Medicaid—the case in California—pulling Medicaid money out presents a major challenge. Hernández pointed out that whenever large cuts are made in state budgets, education is always disproportionately impacted. She also reiterated that the state is committed to fighting these cuts and to protecting the investments made in the health of children, the elderly, people with disabilities, and others covered by Medicaid. Butler suggested that significant change could be achieved with a smaller, more limited government. He went on to say, that the overall key is to drive the system toward greater efficiency.

The discussion then turned to the merits of state flexibility and the role of guard rails. Guardrails are important to help states live up to the intent of the law. Butler stated that the tension comes from how wide or narrow the corridors of flexibility are. The key, he added, is to figure out how to guide and encourage certain behavior, but to not have parameters so tight that they stifle innovation. He also noted that there is a constant fear of over-restricting and second guessing with guard rails.

There was also discussion about California’s efforts to combine Medicaid, state employees, market place/exchange into one insurance market to enhance purchasing power and the potential to have more control over cost and quality. It was suggested that combining the markets could decrease the stigma associated with Medicaid and make for smooth transitions between more and less subsidized options as income and family status changes. Salo pointed out the more general need to educate people about what Medicaid does and who it serves. Hernández added the importance of greater transparency regarding price and quality of hospital and provider services. The discussion also turned to the role of safety net providers and their potential role in more integrated systems. Finally, there were concerns that if new reforms cut \$880 billion or more from Medicaid, it would have a dramatically negative impact on the entire delivery system.

Session III: Possible Medicare Changes: Impact on Beneficiaries, Payers, and the Federal Budget

Murray Ross, Vice President, Kaiser Foundation Health Plan, Inc. (Moderator)

Ross moderated this panel on Medicare changes, with a focus on how the AHCA and/or other reform efforts might impact beneficiaries, payers, and the federal budget.

G. William Hoagland, Senior Vice President, Bipartisan Policy Center

Hoagland began with an analysis of the national debt and potential long-term implications for Medicare. This year, the country’s deficit is three percent of GDP; the debt, or accumulation of deficits, however, is \$20 trillion, or 70 percent GDP, and is projected to increase to 90 percent of GDP in the near future. Most of the debt (60 percent) is

owned by foreign investors. The spending reductions in President Trump's budget focus cuts on Medicaid and non-defense discretionary. This places an unfair burden on one-third of federal spending and disproportionately impacts low and middle-income families. Medicare is growing faster than Medicaid, yet reform in this area seems off the table.

Greater efficiency could be realized by targeting better care at lower costs for high need Medicare beneficiaries with chronic conditions, Hoagland reported. Over one-third of beneficiaries (36 percent), those with four or more chronic conditions, account for 76 percent of total spending. He asserted that we need to move away from fee-for-service toward incentives for better coordination of care. Hoagland went on to state that while the average cost per enrollee is going down slightly, Part D growth is likely to reverse this trend. Moving forward, reform efforts should be focused primarily on Part D and slowing the growth of prescription drug prices.

Hoagland ended with data showing that non-college whites with lower life expectancy, higher rates of obesity, and poorer health index measures had the greatest percentage increase in support for Trump over support for Candidate Governor Mitt Romney in the previous presidential race. These individuals, he commented, live in dying communities and they voted for change.

Tricia Neuman, Senior Vice President; Director, Program on Medicare Policy, Henry J. Kaiser Family Foundation

Neuman discussed Medicare changes included in the ACA, and how cost savings and enhanced benefits have not been suggested for elimination in the AHCA. She noted that ACA Medicare provider payment reductions remain primarily because costs would likely dramatically increase otherwise. Benefits have not been reduced because this would be politically difficult to do. While Medicare is not a prominent component of the AHCA, the ACA was very much about Medicare. To-date, the AHCA preserves many of these aspects, such as filling in the Medicare Part D "donut hole," preventive services without copayments, the Center for Medicare and Medicaid Innovation (CMMI), and even the controversial Independent Payment Advisory Board (IPAB). (However, a proposal has been inserted into the President's budget to repeal IPAB.)

The AHCA would repeal the Medicare payroll tax, however, which is likely to impact the Part A Trust Fund. Furthermore, Neuman reported that Medicaid cutbacks will also impact Medicare beneficiaries (20 percent) who are also eligible for Medicaid (dual eligible), and who rely on Medicaid to access services. This includes 11 million seniors and people with disabilities. Additionally, Medicare Part D is growing by 5.8 percent, which is higher than either Parts A or B. IPAB could address Part D cost increases.

Neuman also discussed the popularity and growth of Medicare Advantage (Part C), which has grown to 33 percent of beneficiary enrollment and is projected to further grow to 41 percent. She said that while beneficiaries might benefit from switching plans, there is relatively little switching and people generally stick with their plans. As Medicare Advantage continues to grow, traditional Medicare may become less important.

In conclusion, Neuman projected that Medicare will not be able to continue to fly under the radar, and will likely return as a budget issue. Reform options might include any of the following: raising the eligibility age, cutting benefits, shifting to premium support, means testing, and/or raising revenue. These options are politically difficult and it may take a crisis for policy makers to find the political will to tackle them.

Lina Walker, Vice President, Health Security, AARP Public Policy Institute

Walker reiterated how important Medicare is to seniors. She noted that a total of 77 percent of seniors consider Medicare very important and 75 percent say it is working well. While no major changes are currently under consideration, several policy changes could still have major implications for Medicare beneficiaries. For example, it is unclear how the “Doc fix” changes in provider payment will impact access to care. Walker suggested that as we move toward value-based payment, private contracting, and balanced billing, we need to ensure that “value” is being provided to the beneficiary. When evaluating alternative payment systems, she reported that measuring outcomes and consumer experience are critical. For instance, if we measure the effectiveness of something like flu immunizations, the focus should be on the direct reduction in flu related costs.

Walker suggested that more emphasis needs to focus on affordability from beneficiaries’ perspective. Today, 27 percent of Medicare enrollees spend 20 percent or more of their income on health care and premiums. In a 2015 survey, 14 percent of beneficiaries reported that in the previous year they spent less on food, heat, and other essentials to pay for health care. Walker also noted potential concerns regarding access to primary care and specialists if more providers move toward balanced billing patients and begin not accepting Medicare payments.

Walker ended her presentation on an up note by describing a few promising practices that are working to improve chronic care treatment. She discussed strong bipartisan support for a chronic care bill that would address the unique health care needs of this high need, high-cost population. The bill would offer enhanced payments for coordination, better integrate behavioral health with primary care, and provide more support for independent living.

Discussion

In the larger discussion, audience members and panelists asked what has happened to the grand bargain—noting that there is not much interest in the combination of cutting benefits and raising taxes. Much of the easy cost containment fixes have been completed with Medicare. In the short term, Social Security and Medicare are not likely to be touched, but further reform will be needed down the road to ensure long-term solvency. Fiscally, it was suggested that we may be heading for a “train wreck” coming this Fall when raising the debt ceiling will be passed into law. At that point, there may be increased attention to wider program cuts.

It was suggested that the Trust Fund is not important to real Medicare sustainability, but is politically important if it begins to run out of money. In total, 42% of Medicare costs come from general revenues. The audience also expressed concern that 30 percent of the spending in Medicare is wasteful, and that by increasing efficiency, overall Medicare costs can be reduced.

Finally, the discussion shifted to the importance of increased revenue for Medicare. Without additional revenue, there are likely to be problems with the program down the road, and the middle class will take the largest hit. A few trends will be important to monitor in the future. With MACRA, providers will be moving toward some type of risk sharing. Better data will help identify costs and potential areas for increased efficiency. Additionally, Medicare Advantage is an area of growth and allows health plans to pay lower Medicare rates to hospitals than what they would be able to negotiate on their own. If fiscal changes are not made to Medicare soon, even greater changes will be required in the future.

Session IV: Prescription Drug Costs: What is Likely Moving Forward?

Elizabeth J. Fowler, Vice President, Global Health Policy, Johnson & Johnson (Moderator)

Fowler, the moderator for this panel, opened the session by raising the importance of discussing prescription drug costs. She stated that industry wants to be part of the solution and help move the system toward greater value. Fowler also noted the importance of moving away from things like importation, rebates, and other “easy button” ideas that do not always pan out. Instead, she reported, it is important to have more conversation and better ideas.

Steve Miller, MD, Senior Vice President and Chief Medical Officer, Express Scripts

Miller began with the statistic that prescription drug costs constitute 20 percent of health care spending, and is the fastest growing segment. High users in this health care arena also account for a disproportionate share of drug costs (i.e., one to two percent of people account for 40 percent of drug spending). Since 2008, the Consumer Price Index showed that branded products were up 208 percent. Miller noted that while drug companies suggest that the net prices are what matters, understanding gross prices is essential. He reported that there is no correlation between rebates and the cost of prescriptions.

Increased spending on drugs is not sustainable, Miller asserted. The United States has the highest prescription drug prices and is funding innovation for the world. Furthermore, it is crucial to move biosimilars into the market as these products are likely to have the same price mitigating effects that generics had in the last decade.

Miller also discussed the impact of price on consumers. High deductibles are designed for the rich, but being sold to the poor. Lastly, Miller addressed the importance of innovation moving forward. He concluded by saying that true change will require cooperation across the industry.

Peter B. Bach, MD, Director, Memorial Sloan Kettering’s Center for Health Policy and Outcomes

Bach opened his presentation by underscoring the importance of helping patients access affordable prescription drugs. He suggested that Hepatitis C medication is so expensive that access is often denied to the majority of people who would benefit most from it. Our society is paying too much for prescription drugs, and this spills over into other areas of health care with adverse impacts. Cost related non-adherence to prescribed medicines among adults is worse in the United States than in other countries. He asserted that prices should track with their value. Value-based drugs should have wide open access. Finally, Bach discussed outcomes pricing—noting that while important, this is not likely to be the magic solution. He was skeptical about value-based contracting arrangements and described them as a potential “Trojan horse” for the industry. Instead, other solutions need to be designed and tested.

Lori M. Reilly, Executive Vice President, Policy, Research and Membership, Pharmaceutical Research and Manufacturers of America

Reilly started her presentation with the idea that medicine is—and will continue to—transforming health. Hepatitis C treatments have cured more than 1 million patients, which is far greater than at any time in history. She noted that this will produce significant cost savings in the long run. Reilly reported that the major decline in cancer mortality is a direct result of innovative medicines, and this includes a range of drugs approved by type of tumor. She went on to discuss that manufacturers have spent billions in research and development on Alzheimer’s treatments that have failed. Despite these failures, the industry will continue to invest. Prescription drugs, Reilly stated, are the potential answer to reduce long-term care costs.

In 2013, drug costs were lower than average medical care cost growth. It would be bad public policy to solve for the recent spike, Reilly asserted. Drug price growth is declining and projected to be in line with the rest of health care spending soon. In fact, 2016 only saw between a two and four percent increase. Reilly indicated that drug costs fall over time because of competition, first with other brands and then through the increased utilization of generics. Cost reductions for pharmaceuticals are unlike any other area of the health care system. Furthermore, express scripts and other pharmacy benefit managers (PBMs) have many tools to control costs. List and net price both matters, as do accounting for discounts and rebates. Most of the revenue from rebates (62 percent) goes to the supply chain. Reilly also noted that patient cost sharing is outpacing underlying medical costs. Many patients must pay the full price of their prescription drugs (i.e., high deductible plans), which is a critical problem to tackle.

Discussion

Fowler opened the discussion by bringing up the importance of defining value. She asked how best to work with industry to provide value beyond discounts? Value means something different to everyone, she noted and can be taken from the perspective of the payer instead of the patient. The current model needs to evolve. The discussion led to some areas and ideas for further exploration including the following: giving patients better information about out-of-pocket costs at the point of service, the need for more innovation to assist patients with the cost of medications, and legislative or regulatory relief to enable value-based pricing.

Sarah Emond, Executive Vice President and Chief Operating Officer of the Institute for Clinical and Economic Review (ICER), described the positive role that cost-effectiveness analysis can play in helping inform pricing decisions that take value into consideration. The FDA does not approve drugs based on a comparison of what is available in the market, she noted. This can lead to very expensive drugs, with limited value, being brought to market over less costly alternatives. Some pharmaceutical manufacturers have been working with ICER in the effort to find a more value-based price point.

Several audience members spoke about the need for more price transparency about the price patients pay at the point of care. Further, prescribers often do not know how much particular drug costs and cost may vary depending on the patient's type of insurance. It was noted that Sure Script puts the price online, but these numbers are often difficult to access. The electronic medical record vendor must be able to display the data on cost for prescribers to access this.

The discussion also looked at the limited consensus on how to deal with high cost, high-value products. Paying over time was one suggestion, but this is difficult if an individual requires multiple high-cost drugs. Another option discussed is reference pricing to favor high-value choices. Reilly reiterated the importance of defining value. Value for one person could be higher than for another; variation is possible, and this needs to be considered in defining value.

Session V: Pros and Cons of Changing the ACA's Essential Benefit Requirement

Audrey Shelto, President, Blue Cross Blue Shield of Massachusetts Foundation (Moderator)

Shelto moderated this panel addressing the pros and cons of the ACA's essential health benefits. To open the session, she listed the essential health benefits and explained how implementation was based on what has traditionally been offered in each state.

Rodney Whitlock, Vice President, ML Strategies

Whitlock argued against required essential benefits. He compared health insurance to a car and described the difficulty and limits of standardization. Each individual values, needs, and wants something different from a car. The

same can be said of health insurance, he asserted. The AHCA's MacArthur Amendment would give flexibility to the states to reconsider the definition and value of essential health benefits. In thinking through what to include or not include, however, Whitlock noted that everything is a tradeoff. As more benefits are deemed essential, health insurance premiums and costs increase. Whitlock suggested that the fact that 6.5 million people took the penalty for not having health insurance last year, and another 19.2 million were exempt from the individual mandate, demonstrates that the current options do not meet individual needs. Whitlock ended by reiterating that essential benefits do have a cost, and ultimately deciding on them is all about tradeoffs.

Sabrina Corlette, Research Professor, Center on Health Insurance Reforms, Georgetown University

Corlette argued in support of essential benefits and offered background on what the individual market looked like prior to the ACA. Before the ACA, only one in five plans available in the individual insurance market included prescription drug or mental health coverage, and many had annual and lifetime limits. She went on to describe what essential benefits now offer consumers. The 10 benefit categories are linked to a "typical employer plan" in each state. Most small group plans include most of these benefits, apart from pediatric dental and eye care and rehabilitation. ACA coverage added stronger protections for people with pre-existing conditions. Corlette argued that if the essential benefits are removed, key protections will go away, and the whole system is likely to unravel.

It is important to define what insurance means in order to link coverage to subsidies, Corlette noted. If insurance companies are permitted to define benefits, rather than there being some degree of standardization across companies, consumers will likely be even more confused about what plans cover. Standards that apply to all plans for complying with the individual mandate make it possible for apples-to-apples plan comparisons. Insurance is not like an a la carte menu, Corlette argued. Without standardization, insurers can structure plans to avoid groups of people, and these individuals may once again be uninsurable. This could lead to an insurance race to the bottom. Ultimately, Corlette noted that consumers and providers will pick up the cost of bad debt from an increasing number of uninsured and underinsured.

Richard Frank, Margaret T. Morris Professor of Health Economics, Department of Health Care Policy, Harvard Medical School

Frank agreed that removing essential health benefits will lead to adverse selection in the market. Coverage areas that will be disproportionately impacted include the following: maternity services, mental health services, and substance use disorders treatment. This is particularly problematic in a time of an opioid crisis and increasing suicide rates, Frank asserted. He went on to mention that \$15 billion was included in the AHCA to pay for some of these services because the authors understood that removing essential benefits would likely cause ripple effects in areas like mental health and substance use disorders treatment. These resources, however, do not come anywhere close to covering mental health and substance use, he argued.

The ACA, along with the Mental Health Parity and Addiction Equity Act (MHPAEA), has been a game changer for expanding access to mental health and substance use disorders treatment. MHPAEA requires comparable coverage and management of care for mental health and substance use treatment services relative to medical surgical care. The essential benefits that then came under the ACA required that these benefits be covered. Together, these laws dramatically improved coverage for millions of people across the country. If essential benefits become optional, and we allow flexibility into the system, insurers are likely to begin adding riders or surcharges for people to receive this type of coverage, Frank stated. He then shared estimated surcharge amounts and discussed how these would gravely impact consumers—in particular, individuals with mental health and substance use disorders.

Discussion

Shelto asked the panel where the tradeoffs regarding coverage levels are best made – at the individual, state, or federal level? And what are the implications at each level? Whitlock suggested that federal policy makers are making the tradeoffs and that this would be better done by the states or individuals. Stuart Altman asked if coverage levels are mandated by government, how much should the healthy be required to subsidize the sick? And if, on the other hand, individuals can make decisions about which benefits they want to buy, what is the impact on risk pools? Insurance companies can make money by avoiding people who need certain services, not only because of the direct cost of those services but because of the full continuum of care these individuals need.

If slimmed down plans are available, healthy people may leave more comprehensive plans, causing an insurance death spiral. In contrast to the earlier car analogy, buying a cheaper car probably impacts no one other than the purchaser. However, with health care, buying cheaper (and less full) coverage, could impact others if the purchaser becomes sick and needs services beyond those that they bought.

It was suggested that moving sicker people to risk pooling is unfair, as historically these pools were under resourced. Broader reinsurance might make more sense. Additionally, high deductible health plans make it more difficult for individuals to access the care they need. For example, an individual may be eligible to go to a mental health counselor but may have to burn through a \$2,000 deductible before their insurance kicks in. Affordability for young adults is a problem with the ACA, and more efforts are necessary to encourage young people to move into the non-group market.

Finally, the discussion moved to a debate about the nature of insurance. Some described insurance as a protection from large, unanticipated costs. Others suggested a broader, more expansive role for health insurance, which included access to a range of preventive and treatment services. While no conclusions were reached, all agreed that the issues of essential health benefits, as well as other issues like pre-existing conditions, are inextricably linked to the issues of risk pools and how one views the role of insurance.

Dinner Night Two Keynote: Can We Take the Business Out of Healthcare? Should We?

Elisabeth Rosenthal, MD, Editor-in-Chief, Kaiser Health News

Rosenthal discussed her book, *An American Sickness: How Healthcare Became Big Business and How You Can Take it Back*. Starting with a personal experience of her own routine, uncomplicated colonoscopy that cost \$10,000, Rosenthal recounted stories of people facing enormous health care prices for what is a fraction of the cost in other countries. A woman in Seattle was charged \$45,000 for an overnight stay for a minor gynecological issue. She then owed \$34,000 and was threatened with collection procedures. Another story was of an MS patient with drug costs of \$3,000 to \$4,000 a month. Rosenthal's book documents how the values of business dominate and subjugate the values of medicine and healing. Less time is spent with patients than with billing codes. During her talk, Rosenthal asserted that it is time to roll back the infusion of commercial interests in health care in the United States. She ended with a call for change and noted that this change will not happen overnight. Just as the problems in the system developed gradually over time, solutions will need to be enacted slowly. We can no longer afford to wait though, she said.

Session VI: Health Care Delivery System Reforms: Where Should We Be Heading?

Stuart Altman opened the second day by discussing themes that had developed during day one. The first day, he reported, did a wonderful job defining and describing the problems in the system. He noted that many of the negative trends have occurred on “our” watch. Day two, he stated, will look forward and focus more on solutions and system transformation options.

Karen Wolk Feinstein, President and Chief Executive Officer, Jewish Healthcare Foundation (Moderator)

Feinstein began with the idea that technological innovation can transform how people receive health care, and what health care looks like. She showed a video illustrating a day in the life of someone living with advanced health care technology that can monitor and provide real time feedback to improve health and wellness.

Rasu B. Shrestha, MD, Chief Innovation Officer, UPMC

Shrestha demonstrated how much of this technology and innovation is already in use, and that more radical change is likely down the road. He discussed his belief that health care organizations are at a strategic inflection point faced with an innovative imperative. Creating, embracing, and taking advantage of emerging technological innovation could lead upward to exponential growth. Alternatively, not being a part of these changes might lead to catastrophic decline. He noted that opportunities spring from changes such as the digitization of health care, artificial intelligence, and remote patient monitoring. The key will be to focus on the people and make technology work for them.

Shrestha went on to say that there is an abundance of hope and hype. Electronic medical record adoption has increased from nine to 90 percent, but if not used correctly can be a barrier between the patient and provider. Further, he reported that currently emergency department doctors spend 44 percent of time entering notes into the system. It is critical to making technology invisible and harnessing it to humanize care. We also need to leverage big data analytics to manage risk and population health, and at the same time use personalized data to increase individualization. Shrestha ended by saying that the current cost pressure combined with an increased emphasis on quality can lead to better opportunities to remake the system. Innovation can move care out of the hospital and beyond just curing disease to improve quality of life.

Nancy Gagliano, MD, Chief Medical Officer, Culbert Healthcare Solutions

Gagliano, who oversees primary care provider policy at CVS health minute clinics, began her presentation with the idea of putting consumers first. She described how health care will change—must change—because of consumer demand. The systems in place should be responsive to the needs of people. Increased access, convenience, quality, and cost transparency are essential to making our lives easier, she reported. Consumers are currently looking elsewhere for medical information (e.g., online), wellness, and health care services. People are increasingly turning to user-friendly sites like WebMD and other sophisticated web sites that know how to reach consumers. Telehealth is increasingly available to help manage chronic illness (Note: Medicare Advantage can do telehealth, but traditional Medicare cannot). Gagliano reported that 79 percent of people are willing to wear a health device and Fitbit had \$1.9 billion in sales in 2015. The current health care system, however, is not designed for wellness, Gagliano asserted. Instead, it is about curing illness, and this presents both a challenge, as well as an opportunity to improve the system.

Gagliano went on to say that there should be multiple front doors to care, including an option of retail health. CVS minute clinics are in 35 states and currently seeing 6 million patients a year. They are open on evenings and weekends and enjoy high levels of consumer satisfaction. Patients spend an average of 22 minutes on average with the physician assistant or nurse practitioner, which out paces most primary care visit times. Pharmacies are increasingly prescribing drugs (e.g., contraceptives, Naloxone), and providing services such as vision, audiology, and phlebotomy. Since the pharmacy knows what medications people are taking and are in regular contact, they are poised to play a greater role in chronic care management. Gagliano ended with the idea that empowered patients, combined with new technologies, will revolutionize the way health care is delivered.

Christopher Gibbons, MD, Chief Health Innovation Adviser, Federal Communications Commission

Gibbons demonstrated the connection between universal access to broadband internet and health. Part of the mission of the Federal Communications Commission (FCC) is for everyone to be connected to the services they need, whenever they need it, and wherever they are. His task at the FCC is to help accelerate broadband adoption and health innovation. Historically, changes in communication and technology have been revolutionary (i.e., railroads, radio, electricity, television and now the internet). In the future, there will likely be less inpatient care and more ambulatory care and higher volumes of technology-mediated interactions.

Much of what hospitals currently do will move into the home and online. Without widespread connectivity, however, many people will be left behind and unable to access necessary care. Gibbons discussed the importance of ensuring that everyone can enter this new health care space. He went on to describe that more care will be offered in smart care communities, within geographic ecosystems of care. This may be part of the new Accountable Care Organization (ACO), which includes post-acute care and chronic care self-management empowered by technology and driven by nurses and other non-physician providers. Gibbons spoke of the need to move toward smarter care to promote prevention, better treatment, and to reduce caregiver burnout. He also discussed the importance of ensuring that mobile health (mHealth) is available for when people are in between places and visits. Virtual care centers could play a more central role in triage as a command center, like an air traffic control center. All of this, Gibbons asserted, requires widespread connectivity and it is imperative that as we move forward, we do not leave any communities, families, or individuals behind.

Gary Kaplan, Chairman and CEO, Virginia Mason

Kaplan, an internist and CEO at Virginia Mason, discussed the value and applicability of the Toyota management production system to health care. Noting that many in health care consider this system to be “cook book medicine,” Kaplan described it as a platform for innovation. He also shared his experience of working in hospital governance and methods for working with a board of directors. The key is to engage the board before a crisis, and bring them into the process while respecting the line between leadership and management. Moreover, the board should reflect the demographics of the community served, which can sometimes be difficult to do. Changes in society and in health care are being propelled by a younger generation, but most board members are over 60-years-old, Kaplan noted. It is imperative, he reported, to have the board help the system focus on the future, while also keeping things running in an increasingly hostile and challenging medical environment. Even if systems are not first out of the box with new technology, they can at least be an early adopter, Kaplan stated. He ended with a call for keeping the patient at the center—not always an easy endeavor—but critical for success.

Discussion

Feinstein opened the discussion by describing a future of health care full of incredible possibilities. The discussion included several people mentioning concerns about data privacy and data disruption problems. The response from the panel was to give attention to these problems, but not let them block progress. It is critical to remain vigilant, but not be so paranoid as to stifle creativity. The time of technology is here, they noted, and this also means systems must increase cyber security to counteract growth in cyber terrorism.

The discussion also touched on the perceived inability of a more traditional, conservative health care system being unable to embrace change. Often, providers are suspicious of new technology and concerned about cost. The potentially high cost to Medicaid plans was also noted. Gagliano reported that innovations like Minute Clinics, however, have lowered costs and prevented unnecessary emergency room visits. Some patients do not want a primary care provider (PCP), and others cannot access the provider they have. We need to move beyond the PCP as the sole person on a patient's team toward a community approach. Technology and innovation are on the horizon and rapidly transforming health care systems and spaces. While questions of cost, competition, implementation, and resistance were discussed, the panel ended with an idea that this is coming and slowly, but surely, we must all become involved and look to the future of health care.

Session VII: The Changing Payment Environment on Physician Practice

Robert Berenson, MD, Institute Fellow, The Urban Institute (Moderator)

Berenson moderated the panel and began by describing the physician payment changes in the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. This law, which passed overwhelmingly, was a bipartisan effort intended to stabilize physician fees and end the annual legislative efforts to postpone sizeable physician payment cuts under the Sustainable Growth Rate (SGR) formula created by the Balanced Budget Act of 1997. The new law, also known as the "doc fix," permanently averted what would have been a 25 percent payment cut to physicians. It also put in place a new performance-based physician payment model.

Berenson discussed the Quality Payment Program (QPP), which has two tracks for physicians to choose from: the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (AAPMs) track. Under MIPS, physicians receive annual bonuses or penalties of up to 9 percent based on a performance score made up of four categories: quality, cost, advancing care information (old meaningful use), and quality improvement projects. The MIPS program is budget neutral so that penalty payments to losers are equal to bonuses for the winners. Between 2019 and 2024, \$500 million is available annually for exceptional performer bonuses, which raises the maximum bonus to 27%. Given that an increasing number of physicians (400,000) are exempt or not eligible for the penalties or bonuses (e.g., they see less than 100 Medicare beneficiaries) the funds available for bonuses may shrink. (Note: Since the Princeton conference, the Trump administration in proposed rules recommends expanding exemptions to an additional 100,000 physician.)

Under the AAPM track, physicians who receive a sufficient portion of total Medicare Part B payments (or patients) through an AAPM like a Next Generation ACO are exempt from MIPS and receive a 5% annual bonus. Regardless of the payment track they choose, annual fee updates are sparse. From 2015 to 2019, annual fee updates will be 0.5 percent, with 0 percent increases from 2020 to 2025. Additionally, after 2025 there will be 0.25 percent increase with a 0.75 percent increase for those in an AAPM. While MACRA does stabilize payments, Berenson noted that the default MIPS payments are not generous and over the long run will likely produce a gap between practice costs and revenue.

Berenson suggested that the policy makers' primary goal is to shift as many physicians as possible to value-based payment. He warned that scorecards that purport to show the proportion of spending tied to value (either use of quality measures or some financial incentives for more prudent spending) can be highly misleading in that very little of the actual spending might be value-based. Berenson also warned that there may be unintended consequences in designing incentive based payments. For example, Medicare Advantage plans have proven very good at aggressive coding in order to generate higher risk-adjusted premiums, so providers taking risk might be even more successful at gaming the system; if a provider/system is being paid for an episode of heart disease, they will likely find more heart disease and of lower acuity (meaning lower cost to treat) – increasing their opportunity to generate savings based on historical spending targets. The bottom line is that these models may work—or not—depending on implementation and oversight. Alternative payment models, while aspirational, remain a work in progress.

Richard A. Deem, Senior Vice President, Advocacy, American Medical Association

Deem began with the idea that we are still in a fragmented health care delivery system dominated by fee-for-service. Accountability, he noted, is important and we need to move in the direction of greater efficiency, but must do so in the right way. MACRA rules are complicated, Deem said, and physicians are not always sure why they are receiving a bonus or being penalized. It is critical to have the right quality measures and to only hold physicians accountable for the care they have control over. Deem reported that there is strong support for a move toward more risk-based payment, but this often causes problems for small practices. Most physicians (58 percent) work in practices with 10 or fewer physicians. He went on to note that doctors are increasingly spending more time on administrative work than they are on treating patients, which is leading to job dissatisfaction and burnout.

Deem next discussed AAPMs. Considerable income is at risk and it is essential that physicians have the tools and ability to succeed. One of the greatest needs is accurate and usable data with the requisite data management and analytical capacity. Overall, physicians are generally satisfied with MACRA, particularly with options available for physicians to move at their own pace. Electronic health records are still a major concern, however, and will take more time to optimize. Harmonization between the components of AAPMs would be helpful, Deem said, particularly with performance measurement. Moreover, there should be additional models offered, more pilot programs, and organized workshops around improved care coordination. Finally, Deem stated that physicians are saving money by reducing hospital admissions and should receive notice and credit for this.

Francis J. Crosson, MD, Chairman, Medicare Payment Advisory Commission (MedPAC)

Crosson provided a MedPAC perspective on the changing payment environment for physicians. First, he identified several MedPAC payment principles, which include the following: assure beneficiary access to high-quality care, pay providers fairly, and provide for taxpayers and beneficiaries to receive value for their dollars. Crosson went on to note that as technology improves, many procedures are done differently and more efficiently, and this needs to be reflected in periodic updates to the physician payment schedule.

One MedPAC recommendation is to rebalance the fee schedule to better reward primary care. This is critical to improve payment equity and to support workforce and delivery system transformation. The second recommendation Crosson mentioned is to improve the information used in setting fee schedule values. This is challenging because of the number of codes and the persistent changes in the time and effort it takes to do particular procedures. Other recommendations include equalizing payments, where appropriate, for procedures inside and outside of the hospital, and changing the way physicians are paid for Part B prescriptions drugs, including incentivizing the most appropriate drug selection and utilization.

Crosson ended his presentation with a discussion about MIPS. He noted that the narrowly focused quality measures are not necessarily appropriate. Often, there is limited data in smaller practices, and the data is not statistically significant. Moreover, it will not succeed without being able to effectively differentiate between high and low-quality providers. This component needs more work and improvement as we move forward.

Discussion

The large group discussion began with a question and comment about the potential of AAPMs to improve integration/coordination of care and facilitate better value. It is often difficult for physicians to understand the purpose of alternative payment models or accept the validity and importance of performance measures at the individual physician level. Deem mentioned that MIPS is a positive option because many physicians do not have AAPM options available to them. Berenson agreed that physicians may be surprised to learn that an AAPM will not be available to them. MIPS is still a work in progress, however, with many physicians concerned about the reporting burden and even the validity of judgments about physician value based on a handful of performance measures in MIPS. It was suggested that behavior will not dramatically improve unless quality measures are able to adequately meet the need for valid measurement of physician performance.

Finally, the gap between what can be achieved through value-based payments that still rely on deeply flawed underlying physician fee schedules needs to be addressed. Medicine is complex, and it is increasingly being practiced in teams. How can we measure quality in ways that make sense to providers? How can we ensure availability of the proper mix of providers including the requisite number of geriatricians and PCPs, a goal that might best be achieved by increasing fee schedule payments for these specialties, rather than through new payment methods related to quality measurement and risk bearing? What changes can be made within the current fee schedule structure to offer new payment codes for care management, while also moving toward alternative payment arrangements?

Session VIII: Expanded State Activities to Lower Overall Health Spending

Christopher Koller, President, Milbank Memorial Fund (Moderator)

Koller moderated the final panel, which was focused on innovative state activities to control health spending. He highlighted the severity of the problem and the potential of state action to address increasing health care costs. While the economy is growing at a 2 percent rate, health care costs are growing at 5 percent. Health care expenditures are taking up more of a state's budget each year—leaving fewer resources for other priorities. States are being asked to do more with less, but do have some levers of control.

Using data from the Centers for Medicare and Medicaid Services (CMS), Koller described almost twofold variation in total health care expenditures (including Medicaid, Medicare, private insurance, and personal health expenses) between states. Drivers apparently include per capita income, the number of insured, number of hospital beds, and chronic disease burden. There are also state-specific levers that can be brought to bear on health care expenditures – including Medicaid policy, public purchasing, commercial insurance rate review, health planning, and price transparency. This panel examined efforts to measure and reduce health care expense trends in Maryland, Massachusetts, Vermont, and Rhode Island.

Donna Kinzer, Executive Director, Maryland Health Services Cost Review Commission

Kinzer provided details on Maryland's cost containment efforts, which build on their 37-year history of hospital rate setting. The challenges for the state were that despite inpatient rate setting, total health care costs continued to rise and their waiver from Medicare regulations was expiring. Starting in 2012, two hospitals were given overall revenue budgets and others had budgets bundled into DRGs. Later in 2014, Maryland—in its waiver renewal with Medicare—moved away from rate setting toward a per capita, value-based payment framework for hospitals, to include outpatient services. This has included a shift from fee-for-service to a per capita global budget for hospitals, with eight percent of revenue at risk for meeting specific quality measures.

A variety of levers is being used in Maryland to incentivize change. These include revenue risk regarding inpatient readmissions and quality indicators on hospital acquired conditions. Current efforts are primarily focused on hospitals as the unit of analysis. During this shift, hospitals found that they needed to reorganize and create stronger links with community-based providers.

The results thus far are impressive. Maryland reduced hospital expense growth significantly in the first three years (1.47 percent annual increase, 2.31 percent, and 0.80 percent). The state achieved the required Medicare savings five-year target in the first three years. Moreover, readmissions are down 11 percent and hospital acquired infections are down 48 percent (though some of this might be due to coding).

David Seltz, Executive Director, Massachusetts Health Policy Commission (HPC)

Seltz discussed Massachusetts' efforts to rein in growing health care costs. He described the importance of addressing this problem. Healthcare costs are crowding out state funding for education, environment, infrastructure, public safety, and other priorities. Employee wage growth is all going into health care premiums. To address these problems, Massachusetts, in the wake of its pre-ACA efforts to improve insurance access, passed cost containment legislation in 2012, which established a statewide target for the growth in total health care spending. This included total costs from all commercial, Medicaid, Medicare, administration, and out-of-pocket cost. It was an "all in" measure to hold all payers and providers accountable for price and utilization.

The initial growth target was set at 3.6 percent growth. The HPC has some ability to hold payers and insurers accountable by shining a bright light on the business of health care and requiring entities to justify increases above the target. This is a political challenge as health care is the number one employer in Massachusetts, and the state has a strong life science and biotech industry doing cutting edge work. Nonetheless, the HPC can review the health care cost impact of mergers and acquisitions, and although it cannot block or stop them, Seltz noted, it can issue public reports and make referrals to the Attorney General for action.

These efforts have shown early success, but there are still challenges. Total health care spending growth in Massachusetts was higher than the U.S. average until 2012. Since then, the state has been on par or lower than the overall U.S. rate of increase. Cost growth averaged 3.57 percent over the first three years since implementation, just under the target, but was slightly over the target in 2014 and 2015. Seltz also noted that Massachusetts is one of the highest-ranking states in terms of income inequality. Affordability of health care remains an important issue, with one in five deferring care because of the cost of health care. Moreover, the state ranks near the top for hospital prices, with many expensive academic medical centers. While the state is increasingly moving toward value-based care, this movement has stalled somewhat in the last 2 years. The HPC's work is taken seriously, in part, because players want to avoid increased government regulation, which is a real threat if this effort fails.

Anya Rader Wallack, Acting Secretary, Executive Office of Health and Human Services, State of Rhode Island

Wallack discussed cost containment efforts in Vermont and Rhode Island, where she has had leadership responsibilities. She described them as the two smaller states, with incredible visions, that have had a long road so far in their efforts to address and contain health care costs.

Wallack began by discussing the Vermont system, which is now an all-payer system, using large ACO models that connect most of the providers in the state, and which serve the whole state. For instance, there is one large ACO that includes two tertiary hospitals and 14 community hospitals. She noted that the Vermont unit of analysis is unique—focused on the ACO level—because of a concentrated provider monopoly with most physicians employed by geographically distinct hospitals. Vermont's previous governor, with the support of the legislature, tried to move the state toward a "single payer" plan, including a global budget connecting the growth rate in spending to revenue. Budget projections, however, suggested that taxes would have to rise for upper-income groups and small businesses and this led to jettisoning the tax finance part of reform. This left the regulatory mechanisms with some constraints on cost.

The primary goals of the Vermont system are to (1) reduce the rate of growth in health care expenditures and (2) ensure and improve access to and quality of health care in the state. To measure these goals, the state set an all-payer growth rate of 3.5 percent, a Medicare growth target of 0.1-0.2 percent below the national average, and worked to align Medicare, Medicaid, and participating commercial payers. The primary agent for this work is the Green Mountain Care Board, which has rate review authority for insurers and Certificate of Need and budget authority for hospitals. Additionally, the state worked to improve access to primary care, reduce deaths from suicide and drug overdose, and reduce the prevalence and morbidity of chronic illness. The growth rate in Vermont has held steady at 3.5 percent, with savings demonstrated in both the Medicare ACO and the Medicaid ACO. Wallack also discussed Rhode Island's efforts in containing health care costs and spending growth. In 2010, health care affordability standards for commercial insurers were written into regulation. These included three primary goals: (1) primary care investment and transformation, (2) payment reform, and (3) cost growth control. The primary accountable unit in the Rhode Island system is at the commercial payer level—not hospitals—and rate review has been a tool for delivery system reform, articulated in the form of these affordability standards. Medicaid has made efforts to incorporate these standards into their managed care contracts. Since 2012, rate setting efforts have saved Rhode Island \$219.7 million. Early experience shows that many of the state's efforts at delivery system reform appear to have some success. Unlike Massachusetts or Vermont, the state does not measure total cost trends across all payers.

Discussion

Along with commenting on the overall state approach, Koller asked each panelist to speak about what is necessary to make progress and what advice they have for other states. Wallack mentioned that states must be willing to intervene in markets, need strong political leadership from the top and the administrative capacity to get it done, and must ensure quality data for monitoring and evaluation. Seltz added that if a state sets a cost containment goal in law, it can become an organizing principle. Discussing the Massachusetts experience, he noted that a target and a responsible entity do make a difference. Progress requires an independent agency to track, monitor, and hold people accountable. Kinzer discussed the importance of provider leadership that is informed, aligned, and moving in the right direction. She also noted that having a quality federal partnership is essential because many of these initiatives rely on federal support and buy-in. The discussion also focused on difficulties in implementation as it can often be challenging to create the cultural, political, and economic relationships needed to move in these difficult cost containing avenues.

Closing

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

Altman closed the conference by thanking sponsors, speakers, and guests. He discussed the importance of controlling spending moving forward. Single payer systems in other nations contain spending through global budgets. Altman noted that while this is not always pretty, it brings health care costs and available resources into the same conversation. Currently, there are constraints on the Medicare and Medicaid program, but we are using private insurance like an ATM machine. Cost shifting from public programs is ballooning private payments from employers and employees. States are grappling (to some degree) with system costs and some, in addition to Vermont, are thinking about methods for moving toward all payer systems. Altman asserted that the primary goal is to make delivery systems more efficient and determine methods for moving the entire system forward in a sustainable way. Altman concluded with a charge to the audience to help move the needle. He said that many of these problems happened on "our" watch; solutions are possible on "our" watch. This is certainly enough material to tackle during the 25th Princeton Conference next year.