



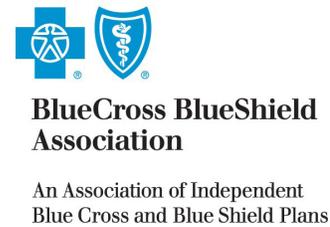
**Council on
Health Care
Economics and Policy**

STATES' ROLE IN HEALTH CARE: OPTIONS FOR IMPROVING ACCESS, QUALITY AND LOWERING THE COST OF CARE

The 19th Princeton Conference

Princeton, New Jersey
May 22-24, 2012

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The 19th Princeton Conference, *States' Role in Health Care: Options for Improving Access, Quality and Lowering the Cost of Care* focused on how states are addressing health reform while facing huge economic challenges.

Moderators, presenters, and participants included key stakeholders who had working knowledge of how states are coping and what approaches they are using to address cost, quality, and access. This included barriers and possible opportunities presented by the Medicaid conundrum, high-cost beneficiaries, states' progress in setting up health insurance exchanges, and the role of federal and state regulations. Each session engaged well-informed participants in thoughtful discussion that included supporting and opposing views on how states should proceed with local health reform efforts.

With so many challenges and opportunities ahead for states, each conference session presented potential solutions and considerations that represent credible options as states navigate health care reform while addressing economic realities.

This policy brief presents the major findings from each session at the 2012 Princeton Conference.

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Session I: The Economic Health of States

- Presenter: **Alan Weil, JD**, Executive Director, National Academy for State Health Policy
- Moderator: **Stuart Altman, PhD**, Sol C. Chaikin Professor of National Health Policy, The Heller School for Social Policy and Management, Brandeis University

Overview

For health care reform to be successful, cooperative federalism is necessary. The federal government must establish a framework, provide some funding, and then give the states flexibility in implementation, which is necessary based on the variability in delivery systems across the country. There are models where cooperative federalism has worked well and the Affordable Care Act is a good start on this road. But further cooperative federalism is needed in bringing about payment reform, which is necessary to bring about essential changes in the delivery system.

Context

Stuart Altman welcomed everyone to the 19th Princeton Conference and set the framework for the three-day meeting, emphasizing the important role that states have in implementing health care reform.

"The states are important. . . . In many cases, the action is at the state level . . . and we can learn from the states."

— Stuart Altman



Alan Weil asked if cooperative federalism is possible in health care and shared his ideas on the subject in the form of 10 tweets.

Key Takeaways

- **Some of America's best social policy changes have come from cooperative federalism.**

In considering the role of the states, an important question is whether cooperative federalism is possible in health care, or if the political division and polarization currently being experienced is inevitable. Some of the best examples of social policy changes come from what many have viewed as cooperative federalism. These are programs involving contemporaneous changes in federal, state, and even local policy that have moved the country forward. Two examples are:

- *Welfare reform.* The federal government opened the door for tremendous flexibility, which is generally viewed as successful.
- *State Children's Health Insurance Program.* The federal government created a framework and provided some

funding. States, the federal government, and both Democrats and Republicans love it.

"This is what we can do as a country when we set our mind to it and so it seems to me it's worth asking whether we can have cooperative federalism in health care."

— Alan Weil



- **The likelihood of cooperative federalism for health care reform can be boiled down to 10 tweets.**

Tweet 1: Martians and governors: two perspectives on health policy.

If Martians came to Earth, they would say, "Finally, this [ACA] is what states have been asking for." ACA builds up the Medicaid floor, streamlines the insurance market, and contains income-based subsidies. And, 95% of the cost is paid for by the federal government. Based on these things one would think ACA would be wildly popular among the states.

Yet, governors have a different perspective. Matching funds from the federal government to help states with Medicaid declined in 2011 and the cost to states steadily increased, eating up more and more of their limited resources. Governors would prefer to spend their limited funds on things like education and roads—but have to spend on Medicaid, which isn't what they were elected to do.

Tweet 2: There have always been leading and lagging states, and this time is no different.

With any new policy or program, there are always some states that go first, some that hang around the middle, and some that never get there. The fact that there is divergence isn't new.

Tweet 3: The Triple Aim is more than three times as hard to achieve as the single aim.

Previously, people would say that in terms of cost, quality, or access, you could only have two out of three. Everyone agreed that quality was important. The Democrats focused on access and the Republicans focused on cost savings. Now the reality is that all three are required. Achieving all three requires consensus, which is how people at the state level are thinking.

"We have a new understanding that in order to achieve any of these goals [cost, quality, and access], we have to achieve all three."

— Alan Weil

Tweet 4: Delivery system reform and payment reform: we can't do it nationally and we can't do it locally.

The health care system is inefficient and the reason is that there are lousy financial incentives. To create efficiency requires changing the incentives via payment reform. While everyone agrees on the need to change the incentives, it is much harder to agree on what the incentives should be. People use terms like "value not volume" or "pay for performance" or "pay for quality," yet different people mean completely different things.

Everyone knows payment reform is necessary but the country hasn't developed the operational capacity to do it. The delivery system varies too much across the country, there is no national commitment to payment reform, and there are no national goals. Thus, the federal government can't do it alone.

There are people at the state level who are willing to set goals and make commitments, but they don't have the tools and can't control funding, so they can't do it alone either. Throughout the health care system there is also a shortage of the most important component of payment reform: trust.

"Since we are unable as a country to do this (payment reform) nationally and are unable to do it locally, we have to have cooperative federalism . . . that's what it's going to take to get us there."

— Alan Weil

Tweet 5: There are red states and there are blue states, but keep your eyes on the green states.

Trust can come by putting money into the system, so people don't fear that cost cuts will come at their expense. Money serves as a lubricant; it's the necessary ingredient that enables hard conversations.

Moving forward is not just about political will and is not just about the government playing an activist role. It's not just about red and blue. It's about shaking loose some dollars and being able to go back to the community and saying, "We've got some resources; let's see if we can do this a little bit better." Finding money can make hard conversations easier.

Tweet 6: Delivery system reform may be a necessary but is certainly not a sufficient condition for sustainable comprehensive coverage.

As a nation, improving health care requires a cooperative approach. But a collaborative approach doesn't on its

own get us to near universal coverage. Some people support the approach followed in Massachusetts of "Bring everyone in and then figure out how to make this work [from a cost perspective]." Others agree with the theory but don't believe the costs savings will ever be achieved. However, believing the opposite—that the country can create efficiencies that will then lead to comprehensive coverage—is not realistic.

Tweet 7: ACA may be the closest to cooperative federalism we can achieve when it comes to coverage.

There are two conspiracies under way: 1) A conspiracy of silence. Many state and federal officials claim that the system will easily be ready on January 1, 2014, to add more than 30 million people. They are lying. It will be tough and a mess. 2) A conspiracy among those who oppose the law who say they are doing nothing and will do nothing. They are lying too. They are quietly figuring out how they will get ready to implement the law.

Tweet 8: We're going to know a lot more in two months, but it has nothing to do with the Supreme Court.

We are about to enter the fourth phase of state response to the Affordable Care Act. The phases have been: 1) there was honest deliberation in state houses about whether it was in a state's interest to implement ACA; 2) many legislators around the country decided to oppose the law, which stopped implementation in many states; 3) inertia set in as states that are proceeding continued to move forward and those opposing ACA stopped doing anything; and now: 4) states have to decide what to do after the Supreme Court ruling.

Tweet 9: If ACA doesn't feel cooperative, wait until you see what comes in its place.

As unhappy as many states are about ACA, without it there is no joint federal/state partnership structure and no reason to think that anything better will come along. The result will be spasms of cost containment pushed by Republicans and spasms of coverage expansion pushed by Democrats. There will be an oscillation between these two responses and states will have little say over either of them.

Tweet 10: If we want better health what we really need is to spend less on health care.

Everyone knows that the health care system is grotesquely over-expanded and inefficient. The country is way under the health production function. If the country could get on that function, dollars could be shifted to things like education and economic development that improve people's health and outcomes. The problem is that states lack a clear roadmap for how to act on this.

- **The country needs cooperative federalism, which can harness the capacities of the federal and state governments.**

The country needs a coverage framework from the federal government, because the states can't create this on their own. However, the federal government is not good at setting limits; it keeps feeding an inefficient beast. The states and private payers bring spending discipline. That's what is needed: to harness the capacities of both levels of government. This is an imperfect, messy solution but it is the only solution.

From a state perspective, ACA is a bit heavy on the federal framework and a little light on the spending discipline. Yet, for all of its flaws, it represents a pretty good start. It provides a national framework for dealing with coverage and has led to a national conversation about transitioning from fee-for-service and paying for value.

Participant Discussion

- **Medicare's leadership?** Conceptually, because Medicare is so large, people want Medicare to lead payment reform. However, the larger a public payer is, the less able it is to exercise its clout.
- **Role of comparative effectiveness research.** States view comparative effectiveness research as one of many inputs into the system. Learning about what works is beneficial information, but the country is not set up to put evidence into practice; i.e., lousy financial incentives.

Session II: Medicaid: Current and Future Challenges

- Presenters: **Andrew Allison, PhD**, Director, Division of Medical Services, State of Arkansas
Stephen Fitton, Medicaid Director, State of Michigan
Kathleen Gifford, JD, Principal, Health Management Associates
Chad Westover, Vice President, State Sponsored Business, Wellpoint, Inc.
- Moderator: **Mary Ella Payne**, Vice President, System Legislative Leadership, Ascension Health

Overview

State Medicaid agencies and private payers are focused on creating a more efficient, cost-effective health care delivery system. This is imperative as states face enormous budget challenges, increasing Medicaid enrollment, high costs from Medicaid beneficiaries, and a coming enrollment surge as part of health care reform.

States and private payers are interested in payment reform, including capitation, bundled payment, and benefit redesign. States are also interested in enrolling more Medicaid beneficiaries in managed care and in collaborating on multi-payer initiatives.

In addition, states recognize the challenges associated with implementing ACA, including the possibility that many states will not be ready to enroll uninsured individuals in Medicaid by the January 2014 deadline.

Context

Kathleen Gifford provided an overview of the financial challenges states are facing related to Medicaid and the solutions they are pursuing. Medicaid directors from Arkansas (Andrew Allison) and Michigan (Stephen Fitton) described what their states are doing. A representative from a private payer (Chad Westover) summarized Wellpoint's experience with its Healthy Indiana Plan.

Key Takeaways

- State spending on Medicaid continues to soar, causing states to look for ways to slow Medicaid cost growth.

Medicaid today is America's largest health program, with an average enrollment of 57 million people. In 2012, 68 million Americans (1 in 5) will be enrolled in Medicaid at some time during the year, and spending is projected to reach \$457 billion. The federal share varies by state and ranges from 50% to 74% and dual eligible beneficiaries account for nearly 40% of spending.

The key issues facing state Medicaid directors are:

- Health reform.** State Medicaid directors are preparing for a significant role in implementing health care reform in an extremely uncertain political environment.

— **Quality improvement.** State Medicaid directors are focused on making Medicaid a more effective, higher-value program.

— **Unrelenting financial pressure.** This is the main issue. A common refrain in state capitals is that Medicaid spending growth is unsustainable. This isn't new. In 1988 Medicaid accounted for 8.4% of state general fund budgets, which was seen as unsustainable. But in 2011, Medicaid represented 17.4% of state general fund budgets, and is projected to rise.

From 2007 to 2011, Medicaid spending grew between 5.4% and 7.6% per year. In 2014 it is expected to grow by 14.8% due to the expansion of Medicaid as part of the ACA. Annual growth from 2015 to 2020 is forecast to average 7.6%.

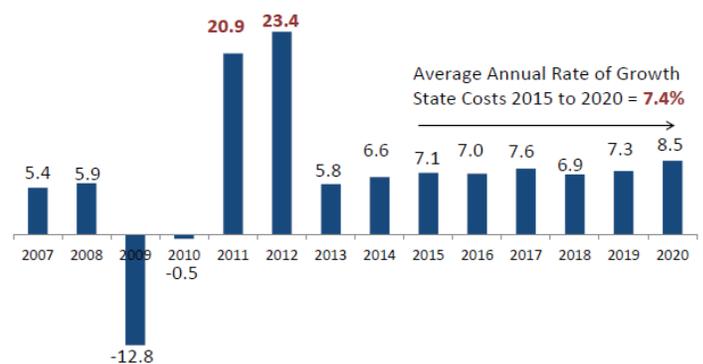
"Medicaid spending has grown much faster than the U.S. economy—and this trend will continue."

— Kathleen Gifford



As the chart below shows, in 2009 and 2010 the state share of Medicaid spending growth actually declined due to federal fiscal stimulus funding. But as these federal funds phase out, the state share of Medicaid spending is expected to grow by more than 20% per year in 2011 and 2012.

State Share of Medicaid Spending Growth Rates, FFYs 2007 - 2020



SOURCE: HMA based on CMS Office of Actuary, March 2012. 2011–2020 are projections.

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Many states expect more financial pressure in 2014 when health care reform adds an estimated 15 million new Medicaid beneficiaries, an increase of almost 26%. (The number and percentage of beneficiaries added will vary significantly by state.) Many question whether capacity exists to provide access to care to all of these new enrollees. There were 19 million beneficiaries added from 2001 to 2011, and in general access has remained good, but this increase in beneficiaries took place over a decade, not one year.

States will continue to look for new ways to slow the growth in Medicaid costs. This is an enormous challenge since Medicaid beneficiaries are sicker than other individuals, costs are already lower than the costs for other payers, and the cost growth for Medicaid has also been lower than for other payers. Also, the easy actions have already been taken, eligibility reductions are restricted by ACA, and cutting provider reimbursement could jeopardize access.

So, many state Medicaid agencies are looking to managed care as a solution. Over the past couple of years, dozens of states have issued managed care RFPs to contract for capitated care management. Also, 41 states are moving ahead with patient-centered medical home initiatives. In addition, states are pursuing new integrated delivery system models (like ACOs), various reimbursement reforms, and of perhaps of most interest, dual eligible integration initiatives.

"Medicaid will increasingly rely on managed care."

— Kathleen Gifford

- **The Medicaid program in Arkansas is engaged in a multi-payer effort to change how health care is paid for.**

To deal with their fiscal challenges, many states have hammered their Medicaid programs. This comes at the same time that there are more people enrolling in Medicaid and that state Medicaid agencies must implement ACA. In Arkansas, administrators must find nearly \$400 million to support the Medicaid program, a front-page issue in the state that is creating significant anxiety.

To address this situation, Arkansas' Medicaid program is participating in a multi-payer effort to change payment. Payment in Arkansas will be based on a three-part approach:

- *Episodes of care.* Incentive payments will be made to—or withheld from—key providers for certain episodes of care based on financial and quality outcomes. Providers will be accountable and at financial risk. The initial episodes chosen were not necessarily the highest-cost

episodes, but were “designed to hit a broad waterfront.” The goal was to engage a wide range of providers and create momentum through quick wins. The plan is to expand the number of episodes over time. Actual payment will be fee-for-service, followed by a retrospective review.

- *Patient-centered medical home.* This is a population-centered approach. In 2–3 years the state wants PCPs to be at risk for care delivered.

- *Managed care for high-cost populations.* This includes those with disabilities and with mental illness.

By collaborating with multiple providers, the initiative has more scale and support. Providers are interested because they view change as inevitable (fear) and because this initiative includes gain sharing (opportunity).

"Arkansas may be at the forefront of pursuing payment reform, but other states are also looking at system-wide cost control."

— Andrew Allison

- **In Michigan, managed care is already used for Medicaid beneficiaries. A key concern is about capacity post-ACA.**

The Medicaid caseload has risen steadily, from 1.1 million in 2001 to 1.9 million today, which is putting enormous pressure on the state's budget.

To manage its Medicaid costs, Michigan has:

- *Cut reimbursement to providers.* There were rate reductions of some type in 2002, 2004, 2005, and 2009. And, there has not been an across-the-board rate increase since 2001. Today Michigan is 44th in the country in provider reimbursement, with providers in Michigan receiving just 54% of the reimbursement that they receive on Medicare patients.

- *Enrolled beneficiaries in managed care.* Currently 70% of Michigan's Medicaid beneficiaries are already enrolled in managed care, meaning this is not a new strategy available to the state to find savings.

Continuing to support the Medicaid program in Michigan requires further scrutinizing reimbursement rates and reforming/reinventing other aspects of the program, including the care delivered to dual eligibles. Also of great concern is increased enrollment as a result of health care reform. Some say there will be 400,000 new beneficiaries, but it could be 500,000, 600,000 or 800,000. While the federal government is providing funding to support new enrollees, it is not clear if adequate capacity exists to care for them.



"The key question is can Medicaid [in Michigan] absorb more lives. I'm not sure. I'm told yes, but I'm not sure doctors will take more Medicaid patients."

— Stephen Fitton

It is clear that cost growth requires not just reducing rates, but decreasing utilization. Aspects of Michigan's Medicaid strategy include:

- *Organizing service delivery systems.* The first part of the strategy involves working with private sector plans and key provider groups on a coordinated strategy for better organizing service delivery.
 - *Capitated financing methods.* This is a financing method that helps control costs and allows flexibility in resource allocation.
 - *Focusing on dual eligibles.* Developing a coordinated strategy with the federal government—which entails rationalizing two misaligned systems—represents a big opportunity for savings.
 - *Developing an effective exchange.* An exchange will allow for seamless transitions and a more market-based approach.
- **WellPoint has used benefit design to decrease utilization among Medicaid beneficiaries.**

As a private payer, WellPoint is extremely interested in the Medicaid population, especially with ACA adding 16 to 20 million more beneficiaries to Medicaid. About 70% of these individuals will be childless adults, and most aren't currently covered.

WellPoint's experience with Medicaid beneficiaries in Indiana has shown that this population has pent-up demand for health care services and higher utilization. New enrollees in the Healthy Indiana Plan (HIP) who were previously uninsured had costs that were 2 times higher compared to typical Medicaid adult members. Claims, on a PMPM basis, for the first 12 months of the program trended more than a 20% decrease annually.

WellPoint sees two primary levers for improving the effectiveness and efficiency of managing this population.

- *Providers.* One lever is changing the incentives for providers from fee-for-service to capitation. This could involve ACOs, capitated models, and pay-for-performance. In markets where there is great room for improved efficiency (i.e., high penetration of brand drugs, high utilization of unnecessary facility visits, disproportionate usage of high-cost facilities versus low-cost facilities) we may see increased savings perhaps in the 10% range, however in other markets where there is less opportunity for improvement, the reduction in costs may be much less.



"When incentives are aligned, costs can be reduced. With the right incentives, change can happen."

— Chad Westover

- *Members.* The lever WellPoint has used with HIP beneficiaries is value-based benefit design. The key components include: free preventive coverage up to \$500; a POWER Account, similar to an HSA, with contributions up to \$1,100 per year funded by the state and participants; and copays for non-emergent ER visits up to \$25.

Results include:

- **Decreased ER visits** among POWER accounts users and those required to pay the \$25 copay. These tools encourage members to utilize care when appropriate. Also, use of generics declined.
- **High satisfaction** among participants as 94% said they are satisfied and 99% said they would re-enroll.
- **Higher preventive scores.** Participants in this program have higher scores on several key preventive measures than the national Medicaid average.
- **Personal responsibility.** Over 98% of participants pay their POWER account contribution on time, 90% return their applications on time to continue their program eligibility, three-fourths are more likely to seek preventive care, and two-thirds are no more likely to seek treatment when needed.

Participant Discussion

- **States are behind.** Several panelists commented that a number of states are not on a path to be able to successfully enroll all of the new beneficiaries expected in 2014. In fact, one panelist has seen a projection that 40 states won't be ready.
- **Eligibility system.** There has never been an eligibility system built fast enough to enable states to implement ACA on January 1, 2014. One participant argued that it was already impossible to implement a new eligibility system on the day that ACA was passed. States must now share their new systems with other states to implement ACA.
- **Lingering opposition.** Governors opposed to the ACA are unlikely to change their position regardless of how the Supreme Court rules. They will then wait for the upcoming election and are likely to avoid implementing the law. The political environment will have to change before widespread progress takes place.
- **Motivating providers.** One panelist commented that it doesn't take a lot of money to get providers' attention. By just taking a little money away from them, withholding it,

and then returning it if they hit certain goals, providers will change their behavior.

- **Philanthropy's role.** One panelist commented that philanthropy played a key role in getting health care legislation passed. The same level of engagement is needed from philanthropy to preserve the legislation, but that doesn't appear to be happening.
- **Cost shifting.** Medicaid's low reimbursement does result in cost shifting to private payers. A concern is that as

employers dump insurance there will be fewer people receiving private insurance and more people insured through Medicaid.

- **Less flexibility for Medicaid.** While private payers have used value-based benefit design to encourage members to behave in certain ways, it is not likely that states will have the same flexibility in creating rewards or penalties or co-pays.

Session III: Managing Costs and Quality of Care in Massachusetts

- Presenters: **Deborah Devaux**, Senior Vice President of Strategic Services, Blue Cross Blue Shield of Massachusetts
Thomas O'Brien, JD, Assistant Attorney General, Health Care Division, Massachusetts Attorney General's Office
Ellen Zane, CEO Emeritus, Vice Chairman of the Board of Trustees, Tufts Medical Center
- Presenter/
Moderator: **Robert Mechanic**, Senior Fellow, Heller School for Social Policy and Management, Brandeis University

Overview

Massachusetts is several years ahead of the rest of the country in passing and implementing health care reform. The state now has near universal insurance coverage and is confronting cost issues. New legislation is being debated to control costs that will impose spending targets and increase the government's role in oversight and enforcement of cost controls. The proposed legislation is ambitious, complicated, and unprecedented.

As future cost-control legislation is taking shape, there has already been a dramatic increase in global payment, and further increases in global and bundled payments are expected. Needed is even greater transparency on costs and quality, efforts to reduce the variation in payment between providers, and more attention on quality standards. While every state is different, valuable lessons can be learned from the experience in Massachusetts.

Context

This panel—providing different perspectives on what has happened in Massachusetts—shared their thoughts on what has occurred and what needs to take place to better control costs.

Key Takeaways

- Having achieved near universal access, Massachusetts policymakers are now focused on controlling costs.**

Mitt Romney signed the Health Reform Bill in Massachusetts in 2006, and as of 2008, 97.5% of the state's residents had insurance coverage. As soon as this legislation was signed, policymakers recognized there would be cost issues. These issues weren't just related to Medicaid spending; they were related to total health care spending in the state.



"We found that covering everybody focuses the mind wonderfully on cost control."

— Robert Mechanic

Several subsequent actions have taken place to try to control costs.

- *Legislation to improve transparency (2008).*
- *A payment reform commission (2009) that called for moving to global payment within five years.*
- *Premium caps in the small group market (2010).*
- *Attorney General's report (2010) showing significant price variation among hospitals.*

Most important are three potential bills dealing with payment reform and cost controls. These include a bill introduced by Governor Deval Patrick and separate bills in the Massachusetts House and Senate. Key areas in these bills include:

- *Annual spending targets.* The governor's bill calls for spending targets but doesn't specify what they are or how they will be determined. The House and Senate bills each call for spending targets linked to the state's gross state product (GSP). The House bill calls for spending equal to GSP in 2012 and -0.5% of GSP in 2016. The Senate bill sets annual health care spending at +0.5% GSP in 2012 and at GSP in 2016.
- *Oversight of spending and delivery reform.* The governor's bill proposed a state-run Health System Coordinating Council to coordinate the activities of existing state agencies. The House and Senate bills call for an independent, quasi-governmental body to oversee spending and delivery reform.
- *Enforcing spending targets.* The governor's proposal would give the government a strong role in disallowing "excessive" provider payment rate increases, while the House and Senate bills are softer in that the government "may" take certain corrective actions.
- *Payment reform.* All of the bills call for public payers to engage in payment reform by moving to alternative payments.
- *Payment differential.* The bills treat this subject differently, ranging from recommending a luxury tax on high-cost care to "studying the issue further."

"The long-term trends are not yet clear, but there has been a movement toward payment reform."

— Robert Mechanic

Rob Mechanic stressed that these bills are all ambitious and complicated, and they include many aspects that have not been tried before in the United States. As Massachusetts moves forward, it is important to provide adequate resources to ensure that the legislation is implemented correctly.

- **Global payment is growing but is not a panacea.**

As of 2008, about 200,000 people in Massachusetts were part of global payment contracts. At the beginning of 2012, more than 1.3 million (20%) of the state's population was part of a global payment contract. Many of these individuals are part of Blue Cross Blue Shield of Massachusetts Alternative Quality Contract (AQC).

Deborah Devaux of BCBSMA reported that global payment aligns the interests of employers, health plans, and providers. The AQC, which is tied to certain measures of quality, has been supported by provider groups because: 1) this is the type of contract they were looking for; or 2) it is a better alternative than the declining fee-for-service reimbursement.



"Previously those at conferences like this were interested in payment models. Now the interest is in how organizations are using models to make changes."

— Deborah Devaux

Ellen Zane described global payment as a tool that better aligns the interests of providers and health plans, but she cautioned that global payment is not a panacea. This payment method is just a tool, and what matters most is how this tool is used. She is concerned that rates are set based on a provider's geography and clout, which results in some providers (particularly those in poor areas) receiving much lower reimbursement than providers in other areas.

- **Transparency is a key to lowering costs.**

Thomas O'Brien was surprised to learn that quality and costs are not factors in how providers are paid. He argued that increased transparency is necessary so payers can better understand exactly what they are paying for.

"Quality is not factored into payment. If you don't change that, there will be no changes in health care."

— Thomas O'Brien

Ms. Devaux said that previously employers were most concerned about providing unlimited access so that their employees could go to the hospitals and doctors they desired. But to control costs, some employers are now considering restricting access to specific providers. Making such decisions requires transparent data on a

provider's quality and costs. (One barrier is lack of agreement on consistent quality measures.)

- **In the view of some, variation in the payment to providers is too high and needs to be addressed.**

The attorney general found significant variation in what is paid to providers. Ms. Zane believes that until this variation is addressed, health care reform in Massachusetts won't be successful.

"If we don't fix [the variation in payment] then in three to five years we will be sitting on another panel discussing what went wrong."

— Ellen Zane



Ms. Devaux explained that when establishing the AQC and other types of payment contracts, employers were most interested in broad access. To secure broad access, health plans pay different rates to different providers. She also noted that not all providers deserve to receive the same reimbursement.

Identical payment is not required, acknowledged Ms. Zane. But in her view payment should be based on transparent and reasonable criteria (such as quality), as opposed to market clout and geography.

- **Efforts to control costs are having some success.**

Some providers that are participating in global payment contracts have invested in infrastructure, trained their physicians to better manage costs, and are trending below national averages. Ms. Zane wondered if these cost controls will last. She compared the current situation to the period around when Hillary Clinton was focused on health care reform. At that time, cost growth slowed—temporarily. It then resumed its growth. Ms. Zane doesn't believe the slow rates of cost growth experienced by some providers in Massachusetts will be sustained.

But representatives from other providers disagreed. They believe that investments in new systems and creation of new processes, along with organizational cultural changes, will change how care is delivered, lowering cost growth over the long term.

Participant Discussion

- **Independence in oversight.** Ms. Zane is skeptical about the supposed independence of the oversight board being discussed. Various industry players will lobby heavily for representation and to influence the board's decisions, making such a board anything but independent.

- **Migration from HMO to PPO.** Panelists noted that in the past few years several Massachusetts employers have moved from HMOs to PPOs. PPO plans don't offer global payment or some of the other methods to control costs.

One conclusion is that by moving to PPOs, some employers don't have the same appetite to control costs and aren't willing to use the same methods (such as the AQC) as HMOs.

- **Federal funding for Massachusetts?** One participant expressed the view that reform activities in Massachusetts have been largely paid for by the federal government. Stuart Altman strongly disagreed. Yes, Massachusetts has a waiver, as do many other states.

Massachusetts didn't receive new funding; it simply reallocated how the waiver funds were used.

- **Health care jobs.** A participant asked if controlling costs in Massachusetts could hurt job growth in the health care sector, which employs about one in five people in the state. Ms. Devaux replied that making insurance affordable for all of the state's employers, particularly small employers, is the best way to help the state's economy.

Session IV: High-Cost Beneficiaries: What Can States Do?

- Presenters: **Melanie Bella**, Director, Medicare-Medicaid Coordination Office, Centers for Medicare and Medicaid Services
Cathy Schoen, Senior Vice President for Policy, Research, and Evaluation, The Commonwealth Fund
Bruce Vladeck, PhD, Senior Advisor, Nexera, Inc.
- Moderator: **Murray N. Ross, PhD**, Vice President, Kaiser Permanente

Overview

High-cost beneficiaries represent 30% of national health care expenditures. These beneficiaries include people who are dually eligible for Medicare and Medicaid and others with high needs for medical care who are disabled and have multiple chronic diseases. Because spending for these sick and vulnerable beneficiaries is so high and because care is so fragmented, improving care management and coordination with teams that are patient-centered presents a significant opportunity to improve outcomes and care experiences and decrease costs.

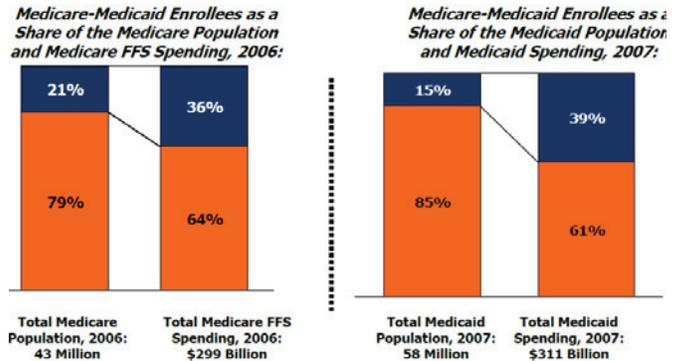
But it won't be easy. This is a longstanding problem with multiple obstacles, including differing incentives and poor coordination between Medicare and Medicaid for those eligible for both programs. The care system needs to be redesigned using a team-based care approach across a care continuum, and IT investments are needed to assure that information flows with patients and informs care. Previous efforts to improve care for these beneficiaries and lower costs have yielded some promising results but have not yet spread or been scalable. Redesigning care and developing teams to innovate also takes time. The challenge for the nation is how to learn from success and spread while safeguarding and/or improving the health of very vulnerable populations.

Still, the focus on these beneficiaries provides the most optimism in many years. CMS has created an office to coordinate activities between Medicare and Medicaid, multiple states are pursuing demonstration projects, and numerous success stories show that progress is possible.

Context

The panelists discussed the highest-cost Medicaid beneficiaries and shared ideas and strategies for improving the outcomes and lowering the costs of caring for these individuals.

Medicare-Medicaid Enrollees Account for Disproportionate Shares of Spending



Key Takeaways

- High-cost beneficiaries represent a huge proportion of national health care spending.**

There are nine million “dual eligibles” who are covered by both Medicare and Medicaid. These beneficiaries represent about 38% of total Medicare and Medicaid spending.

But high-cost beneficiaries include more than just dual eligibles. They include non-dual Medicare beneficiaries with five or more chronic conditions, disabled Medicaid beneficiaries, and chronically ill and disabled individuals covered by employers. In total, spending on the disabled and chronically ill is \$635 billion, which is 30% of national spending on health care.

These high-cost beneficiaries tend to have multiple conditions, which makes caring for them complex and expensive. But costs are increased because of:

- *Differing incentives.* For dual eligibles, where some aspects of care are paid for by Medicare (such as hospital expenses) and other aspects by Medicaid (such as nursing home costs), there has been a lack of coordination and often differing incentives between the two programs.
- *Lack of care coordination.* The care for high-cost beneficiaries with multiple chronic conditions is extremely fragmented and delivered in silos. Beneficiaries usually see different providers, who each care for one particular condition. Instead of a comp-

prehensive care plan, beneficiaries often receive uncoordinated care, too much care, and too many medications. This can be harmful and drives up costs.

"There is fragmented care delivered in silos, not by a team along a continuum of care."

—Cathy Schoen

▪ **Multiple CMS initiatives focus on improving care for high-cost, high-need beneficiaries.**

CMS' overall vision includes: better health care, better health, and lower costs. Consistent with this vision, three examples of these CMS initiatives to improve care for high-cost, high-need beneficiaries are below:

- *Partnership for Patients.* This is a public-private partnership focused on reducing hospital readmission rates by 20% by the end of 2013.
- *Community Care Transition Program.* This program provides support for high-risk Medicare beneficiaries following a hospital discharge. CMS estimates that potential avoidable rehospitalizations of dual eligibles cost approximately \$8 billion. A demonstration project aims to reduce unnecessary rehospitalizations among these beneficiaries.
- *Independence at home.* This is a test of a new service model that uses primary care teams directed by physicians and nurse practitioners to provide services to high-cost, chronically ill Medicare beneficiaries in their homes.

In addition, as part of ACA, CMS has created the Medicare-Medicaid Coordination Office to improve the coordination between the federal government and the states. The goal is to eliminate financial misalignments and develop innovative care coordination models, while ensuring that beneficiaries have full access to the services to which they are entitled. Initiatives being pursued by the new CMS Coordination Office focus on:

- *Program alignment.* Medicare and Medicaid bump up against each other in numerous areas including enrollment, eligibility, appeals, and more. CMS has created an initiative to identify and address conflicting requirements between the Medicare and Medicaid programs to achieve greater alignment.
- *Data and analytics.* One way to improve care coordination is to provide states with access to Medicare data. Currently, 22 states are actively seeking Parts A and B data, and 20 states are seeking Part D data.
- *Models and demonstrations.* CMS has announced plans for federal-state demonstration models that include: 1) a capitated model; and 2) a managed fee-for-service model. The idea is that improved financial alignment will promote a more seamless experience for beneficiaries. Demonstrations of one or both models

are being pursued by 26 states. Enrollment of beneficiaries in these demonstrations will begin in 2013.

"Some say we are moving too fast. When you see the beneficiaries, you realize that they need us to move even faster."

—Melanie Bella



▪ **The keys to rapid progress in caring for the chronically ill are redesigned care systems and team-based care.**

Cathy Schoen shared findings from The Commonwealth Fund about caring for high-cost, chronically ill beneficiaries. Keys to success in caring for this population include:

- *A team approach.* A consistent element of successful programs is a foundation of patient-centered primary care teams. Teams can take multiple forms and have multiple members in different locations, including members who are embedded as part of the community and who deliver care over the phone and via email. What matters is that the team is accountable for care and that team members collaborate and communicate.
- *Care-system redesign.* Instead of care delivered in a fragmented nature in numerous silos, care is redesigned to treat the entire patient. This entails clinicians working together in new ways, and can include reskilling and cross-skilling personnel, particularly nurses. When care is redesigned, it includes home care and other home-based services.

"Where there has been success, there has always been a team approach and a care-system redesign."

—Cathy Schoen



- *New payment models.* The most effective models are not fee-for-service and payment does not occur based on a visit. Payment is for value and for the care delivered by the entire team. This can include bundled payment with accountability for transitions. Keys are that payment provides shared savings and allows some flexibility in how the team delivers care.
- *IT enabled.* For team-based care, IT systems are needed to track patients and supply information to clinicians in real time.

Multiple models across the country have demonstrated success in caring for groups of chronically ill patients. These successes were data driven, using analytics to identify high utilizers, such as asthmatic children in specific neighborhoods; involved redesigning care using a team-based approach; and used various methods

including tele-health, electronic communication, caregivers in the community, and a focus on planning and coordinating handoffs at discharge. These successes improved the care and outcomes delivered, reduced readmissions, and lowered costs.

- **While the timing for addressing this population is ideal, there are serious questions about institutional capacity.**

Bruce Vladeck agreed with the other panelists that there is a significant opportunity to improve the care delivered and lower the costs of caring for high-cost beneficiaries. He views the current conversation about this population as “the most exciting and substantive conversation about these people and services we’ve had in the last generation.” And, he believes that in principle, we should have “a once-in-a-lifetime opportunity for thoughtful, diverse experimentation.”

But he is skeptical that this conversation and this opportunity will translate into success. His skepticism is based on:

- *Serious questions of institutional capacity.* He doesn’t see the skills or experience among providers to care for complex, chronically ill beneficiaries. He also doesn’t see necessary capabilities in health plans or state governments.



“There is a big opportunity here . . . but I don’t think we have the capacity to tackle it in a systemic way.”

—Bruce Vladeck

- *Lack of proven success.* The track record of states in caring for non-elderly disabled beneficiaries is hardly the basis for optimism. Overall, the success stories in caring for high-cost beneficiaries are few and far between.

- *Lack of scalability.* When there has been success, programs have remained small and haven’t scaled. They haven’t been expanded and haven’t produced compelling data.

Mr. Vladeck favors a small number of learning opportunities that are based on experimentation with new service delivery and financing models, which can then be scaled. Just because the current system is bad, racing to put beneficiaries into something new won’t necessarily be better and could in fact be worse.

Participant Discussion

- **Change or experiment.** In general there were two lines of thought: 1) the current Medicare/Medicaid system is badly broken and we need to move quickly to a new system, which can’t be worse than the current system; and 2) just moving to a new, unproven system for dual eligibles could be worse. Such a move should come only after experimentation, data showing success, and creation of necessary institutional capacity.
- **Keeping Medicare’s promise.** Several participants worried that enrolling dual eligibles in some sort of a new coordinated program would remove them from Medicare. They then might not receive the benefits they expected and that were promised to them. Ms. Bella emphasized that anyone enrolling in such a program would have the ability to opt out at any time, as they do today, and the benefits would be equal to what they would have received in Medicare. Her hope is that a new, better coordinated demonstration program would have such obvious benefits that beneficiaries would opt in.
- **Size of demonstrations.** Mr. Vladeck would prefer six to eight demonstrations that were experiments designed to produce learning. He believes a higher number would be considered a waiver of existing policies and not a true demonstration. Ms. Bella said that the 26 states where demonstrations will be conducted have just 22% of dual eligibles, which provides a good group for a demonstration.
- **Clinical imperative.** One participant argued that it is imperative to move to a more coordinated system for dual eligibles and other chronically ill individuals not just because it will save money, but because it is clinically necessary. Today, these individuals aren’t treated by any sort of an organized “system.” The care they receive is highly fragmented and ineffective. A new approach is needed not just for financial reasons but for clinical ones.
- **Terminology.** One participant argued that the term “dual eligibles” is alienating and fails to take into account that the people being cared for are human beings. This is a bad way to speak about a group of people.
- **Measurements.** There is currently a lack of standard metrics to measure outcomes and progress among high-cost beneficiaries, but work is under way to create a set of standard measures.

Additional Resources

Additional information and resources are available on the Commonwealth Fund and CMS websites.

Session V: States' Varied Approaches to Managing Costs

- Presenters: **Joseph Antos, PhD**, *Wilson H. Taylor Scholar in Health Care and Retirement Policy, American Enterprise Institute*
Ann Monroe, *President, Community Health Foundation of Western & Central New York; Member, New York State Governor Andrew Cuomo's Medicaid Redesign Team*
Anya Rader Wallack, PhD, *Chair, Green Mountain Care Board*
- Presenter/
Moderator: **Robert Murray**, *President, Global Health Payment LLC; Former Executive Director, Maryland's Hospital All Payer Rate Setting System*

Overview

States are considering and pursuing different strategies and approaches to contain costs, including all-payer rate setting for hospitals, a single-payer system with significant regulatory authority, and a hard cap on Medicaid spending. While the approaches in each state differ, consistent themes include wanting to move away from fee-for-service, emphasis on primary care and care coordination, and looking broadly at health care costs and not just at costs from one group of providers, such as hospitals. Lessons can be learned from each state's activities, but it is not yet clear what can be replicated and scaled.

Context

These panelists described the approaches used to manage costs and the lessons learned in Maryland, Vermont, and New York.

Key Takeaways

- Hospital rate setting in Maryland has lowered the growth in cost per case, but rate setting may be an artifact of the past.**

Maryland hospitals operate under an "all-payer" rate setting system, with prices set by a state agency for public and private payers. The intent is to constrain hospital costs, ensure access to hospital care, improve equity and fairness of hospital financing, provide financial stability, and require public accountability. Rate setting recently has been pointed to as a way to moderate price growth in markets that are dominated by large hospitals or hospital systems, but Maryland's experience demonstrates the difficulty of accomplishing that goal.

Key elements of Maryland's rate-setting system:

- Rates set for all payers.* In concept, Medicare, Medicaid, private insurers, and self-payers all pay the same price for a given service at a specific hospital. However, due to state budget issues, Medicaid pays less. Rates are adjusted to account for uncompensated care and other hospital-specific costs. Inpatient payment rates are "per case," using cost-based all patient refined (APR) DRGs.

- A federal waiver* (since 1977) allows rate setting to apply to Medicare-covered services.
- Active hospital and insurer participation.*
- An independent agency*—the Health Services Cost Review Commission (HSCRC) with broad regulatory authority and in-depth expertise.

Results include:

- Access to hospitals is ensured*, but rate setting finances nearly \$1 billion per year in charity care and bad debt.
- Equity across payers is achieved* by eliminating price discrimination and cost shifting, but Medicaid cuts shift costs to hospitals and private payers.
- Financial stability has been enhanced.* Bond-rating agencies consistently refer to Maryland's rate-setting system as a "credit enhancer."
- Cost results are mixed.* Maryland's growth in cost per case has been well below that of the U.S.; in 1976 Maryland's cost per case was 25% above the national average and as of 2010 was 3% below the U.S. average. That translates to a savings of \$48 billion for Maryland payers from 1976 to 2010. Even though growth in the cost per case has been lower than elsewhere, the state's cost per case in 2011 was \$12,620 compared to a national average of \$10,632.

"Had we been successful in controlling costs the way some thought, the system wouldn't have lasted."

— Joseph Antos



Other important lessons from Maryland's experience include:

- FFS payment promoted volume growth.* The use of fee-for-service payment kept providers focused on volume. As a result, as of 2007, Maryland had 360 hospital discharges per 1,000 Medicare enrollees compared to a national average of 336.
- An overly narrow focus.* The rate-setting system focused narrowly on inpatient hospital cost per case; not the full cost of care, not on patient outcomes, and not on the performance of the entire health system.

Maryland is now looking to move from being totally hospital-centric to having a broader focus, with a broader waiver.

▪ **Vermont is using ACA as a platform that helps the state move toward a single-payer system.**

Vermont governor Peter Shumlin ran for office promising a publicly funded health insurance system (a “single payer”) that covers everyone in the state. In addition to universal coverage, goals included controlling costs, paying for value, and making financing simpler and more equitable.

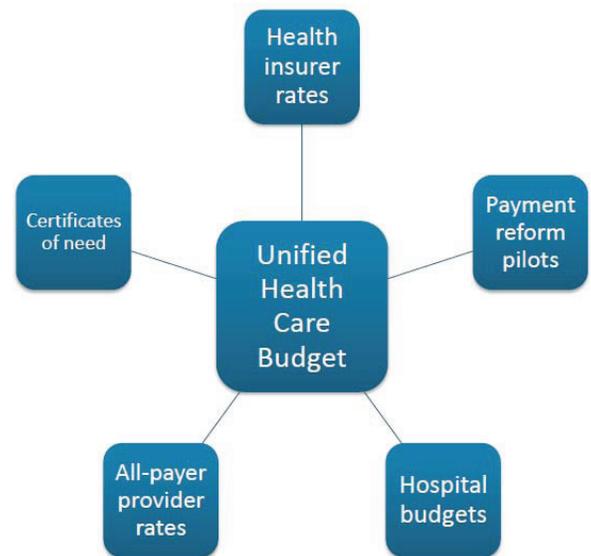
When he was elected, the question became how to deliver on this promise. A state health reform bill was passed to deliver on the governor’s vision. Health reform in Vermont has three key components:

— *Creation of an exchange.* The idea is that in 2014 the Vermont Health Benefit Exchange will be a single portal for non-group, small-group, and public insurance programs. It will be expanded; so, in 2016 larger employers also will get their insurance through the exchange. The exchange is housed in the state’s Medicaid agency and will seek to minimize gaps between public and private coverage (“churn”) and maximize the use of federal tax credits under the affordable care act.

— *Development of a plan for single-payer financing and operations.* As part of the state’s health reform legislation, the governor’s office is committed to devising a plan for financing and operating a single-payer system, to be submitted to the legislature. This plan is being developed.

— *Establishment of the Green Mountain Care Board.* GMCB, which Ms. Wallack chairs, was given broad regulatory authority for cost containment and payment reform. Payment reform goals include moving away from fee-for-service, building on a foundation of an advanced primary care medical home, and including performance measurement.

GMCB is creating a unified health care budget for Vermont and has the authority to set all-payer provider rates, hospital budgets, health insurer rates, and Medicaid payment, and can establish payment reform pilots. The state is developing pilots involving bundled payments, global payments (in an ACO-like system), and physician/hospital budgets with prospective payments. The question for GMCB is, can it (through planning, policy, and regulation) contain cost growth and improve health.



“We thought about how ACA can be a platform for a single-payer system.”

— Anya Rader Wallack



Vermont is actively pursuing “cooperative federalism” by thinking about ACA as a platform that will make possible the single-payer system envisioned by many in the state.

▪ **Through a collaborative, transparent process, New York is seeking to redesign Medicaid to improve quality and significantly reduce costs.**

New York is the nation’s largest Medicaid program both in terms of beneficiaries (5 million) and spending (\$53 billion). New York’s Medicaid program has provided uncoordinated care with significant variation. There has been little focus on reducing the cost of care, making the program financially unsustainable.

Analysis shows inefficiencies in how New York’s Medicaid funds are spent and whom they are spent on.

— *How spent:* New York is above the national average for spending in all service categories (hospitals, long term care, drugs, clinics, etc.) except for spending with physicians.

— *Who spent on:* High-cost enrollees, who account for 20% of Medicaid beneficiaries, represent 75% of New York’s Medicaid spending.

Money is being spent on bricks and mortar (hospitals) to care for high-risk populations. But money would be better spent on primary care and prevention. Also, New York ranked 50th nationally for avoidable hospital use and cost.

In 2010 the governor appointed a Medicaid Redesign Team (MRT) charged with making recommendations to save \$2 billion in the state's 2011-12 Medicaid budget, and for long-term reform.

The process used total transparency and invited extensive participation from all stakeholders. More than 1,000 people spoke at a series of regional meetings and over 4,000 suggestions were received. In the end, the MRT offered 79 proposals for short-term savings to the state legislature. Of these, 73 were accepted, resulting in budget savings of \$2.1 billion.

But the short-term recommendations were just the beginning. Other major recommendations were made to dramatically reduce the costs of New York's Medicaid services while improving care. These cost-related proposals included:

- *No reduction in eligibility or benefits.*
- *A statutory global Medicaid spending cap.* This was viewed as a hard, firm annual cap, with an annual increase of 4% per year. The cap could be raised in an economic crisis, but not if enrollment increased, which could be a significant challenge. The cap was actually supported by hospitals, which viewed this as better than other alternatives. Every month there is to be a report published showing how the state stands compared to the cap.
- *Elimination of the Medicaid FFS payment system.* The idea is to pursue sub-capitation and ACOs.
- *Integrated care and financing for dual eligibles.*

"Cost was a big driver but quality was never off the table."

— Ann Monroe

Proposals to improve care included:

- *A care-coordination program.* The recommendation required that by 2013 all Medicaid enrollees will be in some form of a care-coordination program.

- *A standard assessment tool for long term care services.* This will provide a standardized tool to determine what long term care services a person should receive.
- *Creation of mandatory "health homes" for Medicaid enrollees with complex needs and high costs.* The MRT thought far outside of health care, looking at the many factors that affect a person's health. Examples include access to supportive housing and behavioral health services. The idea to create health homes, which will be implemented in all counties in a phased way, will focus initially on populations with chronic conditions and with mental health or substance abuse issues. Eventually, the health home will also cover developmental disabilities and long term care.

The experience of the MRT in New York show the importance of the collaborative, transparent process; the importance of strong leadership; the need to "cross boundaries" by not just looking at health, but also at housing, education, social services, and mental health; the importance of communication; and the importance of focusing on beneficiaries and what matters most for them.

Participant Discussion

- **Primary care emphasis.** The approaches in New York and Vermont both emphasize the need for primary care to play a critical role, and Maryland realizes that it needs to go from being hospital-centric to a more holistic approach. Together, these states recognize that primary care is a key lever to decrease cost and utilization. But issues exist regarding primary care capacity, coordination, and enforcing PCP responsibility.
- **Waiver criticality.** Having a waiver has been critical to Maryland's ability to engage in all-payer rate setting for hospitals, and will be critical for Vermont to do what it hopes to do. New York is also applying for a waiver to implement the full system and bring the "duals" into New York Medicaid.

Session VI: A Two-Tiered Health Care System: Are We There Yet?

▪ Presenter: **Uwe Reinhardt, PhD**, *James Madison Professor of Political Economy, Professor of Economics and Public Affairs, Princeton University*

Overview

Professor Reinhardt was clear: America will not have a two-tiered health care system. However, he does believe we could be headed toward a three-tiered system that rations care by income class. This would entail a public system for the lower class, a tiered system with reference pricing for the working middle class, and boutique medicine for the upper class. This system—which could take 20 years to develop—is the result of high health care expenditures, growing income inequality, and a huge national debt.

Context

Professor Reinhardt shared his thoughts on what the future may hold for America's health care system and the major factors affecting health policy.

Key Takeaways

- **High U.S. health care expenditures are due to high prices.**

Everyone knows the U.S. spends twice as much per capita on health care as almost every other developed country. In the future, 50% of spending will come from the government and the other 50% will come from private payers. While there is much talk of reducing health care spending, what some view as health care costs are "health care income" to others. And those whose income is threatened do a good job of preserving their income. So don't expect cutting costs to happen with ease.

One theory of cost containment is to have high deductibles so that consumers will have "skin in the game," which will cause them to decrease utilization. However, the cost problem is not related to excess utilization. In fact, the U.S. has the lowest international utilization, with fewer hospital days, fewer visits to the physician, and lower use of medications.

The problem is that health care prices in the U.S. are very high. Providers demonstrate significant pricing power, which can be seen as prices in the U.S. for services such as delivering a baby or having an appendectomy are far higher than in other countries. Health care spending grew at twice the rate of inflation during the economic crisis, even as patients consumed less medical care.

- **Income inequality in the U.S. has increased in recent years.**

Following the Great Depression and World War II, America was more of an egalitarian society. People knew that luck determined whether they were poor or got killed in the war. And they favored policies that helped everyone. This is no longer the case. Today there is tremendous income inequality, with a growing separation between the rich and poor. Consider the following:

	Income Growth (1992-2007)
Top 1%	4.4%
Other 99%	0.6%

	Approximate Annual Income
Median family income	\$50,000
Mean family income	\$64,000
Top 25%	\$85,000
Top 10%	\$135,000
Top 5%	\$200,000

With the median family income at around \$50,000, this means that 50% of all American families make less than \$50,000 per year. Meanwhile, health care spending for a family of four is \$20,000 per year. The result is that for those who are employed, all wage increases have gone toward health care, and for those who are unemployed, health care is unaffordable.

- **The enormous national debt is unsustainable and will require hard decisions by future generations.**

In the last few decades U.S. national debt has exploded. The debt by presidential administration is as follows:

Presidential Administration	National Debt
When Reagan took office	\$900 billion
When Reagan left office	\$2.6 trillion
When H.W. Bush left office	\$4.0 trillion
When Clinton left office	\$5.6 trillion
When W. Bush left office	\$10 trillion
2011	\$15 trillion

Currently about 50% of the debt is owed to foreigners, particularly China, allowing China to hold the United States hostage on economic and foreign policy.

Our children will have to raise their taxes and redeem the maturing bonds with cash paid to foreigners. The foreigners can then use this revenue to buy American goods and services—if there are things they want to buy from us—or use that cash to buy Americans assets, (e.g., General Motors or Hewlett Packard or IBM or Boeing) including patents to our technology. Either way, our kids will be poorer for our reckless behavior. To think about this concretely, recall the Medicare Modernization Act of 2003. It bestowed a whole new entitlement on the nation's elderly, which seemed a humane thing to do. But instead of financing it with added taxes (or cutting federal spending elsewhere), the cost of that entitlement was simply added to our federal deficit, in perpetuity. Thus we give our elderly today hugely subsidized prescription drugs that will be paid by our children and grandchildren.

Despite the outcry of many in the U.S., Americans are not overtaxed compared to other developed countries. Americans are taxed in an odd way, with taxes on income, but Americans aren't taxed too much. America should consider a value-added tax as is used in many other countries. To those who believe that increasing taxes will hurt economic growth, the evidence shows no correlation between tax rates and growth rates.



"I don't think we can continue on like this forever. We have to do something."

— Uwe Reinhardt

Director of the CBO, Doug Elmendorf, has said, "The U.S. faces a disconnect between what people want and what they are willing to pay for." Professor

Reinhardt sees American voters wanting: a smaller deficit, no increase in taxes, and no cuts to Medicare or defense. Long term, defense will be viewed as sacred, and education and health care will compete for limited funds.

- **The implications of high health care expenditures, income inequality, and massive debt are not clear for the health care system. A multi-tiered market that rations care is possible.**

It is not clear how this will all work out and what the implications will be for the health care system. A single-payer system like Canada or Vermont is possible, but it will be politically difficult. An all-payer system like Switzerland or Germany is possible. But more likely is a multi-tiered market-driven health care system that rations care by income class. The tiers include:

— *For the lower class, public hospitals and clinics.* These providers would give the lower class access to health care, funded by the government. Limited government budgets to support these providers would essentially ration care.

— *For the working middle class, a tiered system with reference pricing.* The way this would work is that health plans would say to members, if you go to hospital X, we will pay 90% of your costs. However, you can go to any hospital you want. If you go to a more expensive hospital, you must pay all of the difference in cost. This will result in a price-sensitive middle class. By competing to attract these customers, providers' prices will be driven down. Some say that consumer-directed health care (CDHC) is the way to go, but CDHC will just be part of this tiered system.

— *For the upper class, boutique medicine.* Upper-class citizens will hire their own providers directly. This is already beginning to take place.

Currently the country's educational system and the justice system are tiered, with different levels of service provided to individuals in different income brackets. In this scenario, health care would be no different. Evolving to this model won't take place overnight; it could potentially take 20 years.

Participant Discussion

- **Opportunity cost.** In the 1980s, Professor Reinhardt and most health policy wonks (including, notably, Stuart Altman) believed that spending 10% of U.S. GDP on health care was the upper limit. But now hitting 20% seems just a matter of time. His conclusion is that the total level of spending is not an issue; the issue is the opportunity cost of that spending. Those same funds could be spent on infrastructure or education. Spending them on health care is hurting the productivity and competitiveness of the country.
- **Non-medical drivers of cost.** A population's health is greatly affected by the level of education. Therefore, to improve a country's health, investing in the education system and teaching about nutrition may be a better investment than investing in the health care system.
- **Innovating for foreign markets.** The health care technologies and processes used in industrialized countries won't work in lower-income developing markets. China doesn't want a \$5 million MRI; they want an MRI for less than \$100,000. Companies like GE are innovating to create low-cost technologies that work in these markets. Perhaps, when the so-called emerging market economies (Brazil, China, India, etc.) demonstrate empirically that very good health care can be had from better industrial processes of health care delivery and supported by cheaper equipment, Americans may then climb off their high horse and adopt some of those lower-cost practices. There is hope in that.

Session VII: How Are States Progressing in Setting Up State-Based Exchanges?

- Presenters: **Stan Dorn, JD**, Senior Fellow, Urban Institute
Jennifer Kent, Principal, Health Management Associates
Jon Kingsdale, PhD, Managing Director, Wakely Consulting Group
- Presenter/
Moderator: **Jay Himmelstein, MD**, Director, New England States Collaborative for Insurance Exchange Systems, University of Massachusetts Medical School

Overview

Health insurance exchanges at the state level are a key vehicle for expanding health insurance coverage. ACA gives states a great deal of flexibility in whether they choose to create an exchange, what the objectives of the exchange are, and how the exchange operates. An exchange might be an active buyer that focuses on getting the best rates for participants, or an exchange might be a facilitated marketplace like “Expedia for health insurance.”

In any scenario, there are multiple issues that must be dealt with in implementing an exchange, including budget and political issues, tight deadlines, and technical complexity, particularly in integrating the exchange with multiple systems to determine eligibility for Medicaid and tax subsidies. But, as significant as the short-term implementation issues are, there is optimism that in the longer term, exchanges can help states achieve their health care goals.

Context

The panelists shared their firsthand perspectives regarding the progress being made in different states in creating health insurance exchanges.

Key Takeaways

- **State-based health insurance exchanges play a central role in health care reform, but face significant challenges related to timing and technical complexity.**

Jay Himmelstein set the context for this session by providing an overview of the role of health insurance exchanges (HIXs).

- *HIXs play a central role in health care reform.* They are a key mechanism for implementation of coverage expansion. They have responsibilities in determining eligibility for Medicaid and tax subsidies, enrollment in qualified health plans, risk adjustment, and reinsurance.
- *States have significant flexibility in the design and operation of their exchanges.* States have multiple options. They can create their own state-based exchange; can create a partnership model; or can decide not to have a state-based exchange, hence

electing to participate in a federally facilitated exchange. For states that create their own state-based exchange, there is significant latitude in its objectives and operations.

- *States have extremely tight deadlines to launch their exchanges.* Blueprints must be submitted for approval by November 2012, must be approved (or conditionally approved) by January 1, 2013, and must be in operation by 2014. While there are significant federal funds to assist states, the deadlines are incredibly tight.
- *Integrating a state's HIX with other systems is complex.* State exchanges are required to determine or assess eligibility for and coordinate enrollment in Medicaid, CHIP, and state health subsidy programs. This will involve interfacing through a federal data services hub with multiple IRS systems, the Department of Homeland Security, and various other agencies—a hub which is still under development. States will also need to connect to other, state-based information potentially relevant to eligibility determination. For states who have yet to begin their technology development, it is hard to imagine how current timelines can be met.
- *Funding is available to help “early innovator” states to transfer their work.* Three states—Maryland, New York, and Oregon—and a collaborative of New England States led by Massachusetts—have been deemed “early innovators.” They are charged with designing and implementing technology that is transferable and potentially reusable by other states. The ability of other states to “reuse” these technology components to accelerate their HIX development is uncertain, however, and is currently being tested.



“Don't go it alone! We are all trying to meet the same deadlines and deliverables.”
—Jay Himmelstein

On the one hand, the creation of exchanges represents a once-in-a-generation opportunity for states to leverage federal funds to modernize their Medicaid eligibility systems. The federal government is offering 90 percent matching payment for IT investments through the end of 2015 and full funding of exchange-

specific IT development through the end of 2014. But the timing and complexity are daunting.

▪ **States have different approaches and visions for exchanges.**

Jon Kingsdale led the development of the exchange in Massachusetts and now helps other states develop their exchanges. He grouped states into three categories:

- *Drive to implement.* Perhaps 10-12 states are actively working to create an exchange.
- *Wait and plan.* Perhaps another 10-15 states are contemplating how to do an exchange if ACA is upheld by the Supreme Court and their government and legislature decide not to resist this legislation.
- *Wait and pray.* This represents the majority of states—perhaps 20-30—that are hoping ACA is overturned and aren't supporting it. They have made no effort to actually implement an exchange.

Among those states that are implementing an exchange or are contemplating one, Mr. Kingsdale sees two general visions;

1. *A streamlined portal for subsidized coverage for the low-income uninsured.* In this vision, the state is an active purchaser that focuses on getting the best deals for exchange participants, on new eligibility systems, and on maximizing coordination. This is the primary model in Massachusetts where the rate of uninsurance is the lowest in the country, where more than 400,000 residents have become covered since the state launched its exchange, and where being an active purchaser has resulted in a cost trend that is well below market.

"The goal [for this type of an exchange] is to make the market work more effectively."

— Jon Kingsdale



2. *A competitive marketplace for commercial activity.* In this vision, an exchange is a marketplace (like Expedia) where the state is merely a passive purchaser. The focus is on decision-support tools and consumer engagement so that the shopping process is easy and pleasant, with price transparency. A goal is to minimize the state's risk.

Findings from Massachusetts indicate that the 35,000 who use this unsubsidized marketplace are price-conscious shoppers. About 61% buy low-priced "bronze" plans or catastrophic plans. And price matters more than brand. Blue Cross Blue Shield, which has over 50% market share outside the exchange, only gets about 20% of the sales made through the exchange.

▪ **State-based exchanges face a host of implementation challenges.**

Jennifer Kent was involved in thinking about and creating the health insurance exchange in California. She now consults with other states that are planning exchanges. Through her experience she has seen five major implementation challenges.

1. *Budget issues.* Revenue for most states continues to be below fiscal 2008 levels. So, governors must implement ACA while dealing with small general funds and competing budget demands, which will hamper or slow implementation of exchanges.
2. *Politics.* The political gridlock at the national level is contagious and is being seen at the state level. Because this is such a hot-button issue in an election year, it is safer for politicians to sit on the sidelines and do nothing.
3. *IT systems.* The IT complexity is immense and the deadlines for IT systems are incredibly aggressive, as are the many IT vendors hawking their solutions. Few policymakers understand the magnitude of this complexity and are unfamiliar with IT vendors, whose promises may exceed their performance.

"The complexity [of the IT systems required] can't be overstated."

— Jennifer Kent

4. *Managing expectations.* The expectations of consumers and advocates will be high. But exchanges are not a magic solution. Health care costs will remain high and won't be solved by an exchange, and more consumers in the system will strain access. There is a risk that once an exchange is built no one will show up to use it, or even worse, no one healthy shows up.
5. *Market forces.* Exchanges will have to adapt within a specific market based on who they intend to serve. Are they friendly to consumers or to plans? What is the relationship with Medicaid? Answers to these questions and more will shape how an exchange evolves.

▪ **Churning represents a real potential problem under ACA.**

Churning is the forced movement of consumers from one health plan to another when changing circumstances affect eligibility. The magnitude of churning under ACA could be significant. One study projects that 29.4 million people will change eligibility status from year to year, representing 31% of all enrollees in insurance affordability programs. The largest group to churn will be Medicaid enrollees who become ineligible when their income rises; this is estimated to be almost 20 million people.

Churning matters because those who are affected run the risk of becoming uninsured or having their treatment disrupted. Insurers who know of high churn rates will have decreased incentive to invest in members' long-term health. Churning also has high administrative costs.



"Churn matters . . . but there are policies that can address each component of churn."
—Stan Dorn

Policies are needed to:

- *Reduce the magnitude of churn.* There are steps that could be taken to reduce the amount of churn. These include looking at each type of churn and then employing strategies to reduce it. For example, a strategy to reduce churn if a person becomes ineligible for subsidies is to encourage or require the same plans to offer products inside and outside the exchange. That way, even if a person loses eligibility for subsidies, he or she can still keep the same plan. And using the Basic Health Program option to move the threshold for transition between Medicaid and exchange plans from 133 to 200 percent FPL would reduce churning between the two systems by 16%.
- *Reduce the harm from churn.* Regardless of efforts to reduce churn, some churn is inevitable. Therefore, efforts should be made to reduce the harm from churn. Strategies to lessen the harm include intensive consumer assistance to help people navigate transitions, implementing policies that preserve the continuity of care when people are forced to change health plans, and making coverage on both sides of the transition affordable and appealing.
- **Much of the vision for eligibility determination in ACA is being realized.**
The vision for eligibility determination in ACA included the ability for potential beneficiaries to apply for any program via any modality (which is being realized); multiple programs served through one common application (being realized); and using data matches to verify eligibility (being largely realized).

What is missing from the vision in ACA is that some states may not want a federally facilitated exchange to quality people for Medicaid or CHIP, and some public employee unions may not want a non-profit corporation or quasi-public entity to determine Medicaid eligibility. The likely result is an option for bifurcated eligibility determination. There are potential state and federal solutions to this issue that could provide the safeguards that would be necessary, but these solutions add some costs and complexity.

Participant Discussion

- **Execution realities.** While many parties like to discuss policies and strategies, the reality is that states are expected to have functional exchanges that are operating in early 2014. Decisions must be made and actions must be taken to ensure that some form of an exchange is working by then.
- **Short and medium term.** In the short term, the focus at the state level in creating exchanges is largely on execution and overcoming the massive IT challenges. But in the medium and long term, exchanges have great potential to help states reform health care. They can be used to help a state achieve its vision for health care, whether that is a single-payer vision (as Vermont is doing), or a vision for consumer-driven health care that involves a more competitive marketplace. Exchanges have great long-term potential.
- **Inside/outside exchanges.** There is some talk about the need to protect those inside an exchange from adverse selection. But one participant said this might be premature and overreaching by policymakers. The reason is that ACA is transformative, bringing about massive amounts of change in the overall insurance market, such as guaranteed issue, no medical underwriting, and one risk pool. These changes make it impossible to predict what will happen outside the exchange. Therefore, it doesn't make sense to take further action at this time to "protect the exchange." Others view protecting the exchange against adverse selection as essential to its long-run viability.

Session VIII: States' Barriers to Innovation

- Presenters: **Dan Crippen, PhD**, Executive Director, National Governors Association
Michael Doonan, PhD, Assistant Professor, The Heller School for Social Policy and Management, Brandeis University
Sanne Magnan, MD, PhD, President and CEO, Institute for Clinical Systems Improvement
Ann Torregrossa, JD, Executive Director, Pennsylvania Health Funders Collaborative; Former Director, Pennsylvania Governor's Office of Health Care Reform
- Moderator: **Karen Wolk Feinstein, PhD**, President and CEO, The Jewish Healthcare Foundation

Overview

States, along with other purchasers, need innovation in their payment and delivery systems. While states can have tremendous impact over the delivery of health care, they don't routinely take advantage of their position to improve health care. Numerous barriers hinder states' innovation. These may include lack of leadership in both the public and private sector, lack of structures to advance innovation, lack of resources and funding, and entrenched provider interests as well as state bureaucracies in areas like purchasing. Some states, such as Pennsylvania and Minnesota, have had success overcoming their barriers and pursuing innovation. This success can be attributed to the collaborative relationships between stakeholders.

Context

The panel discussed the importance of innovation at the state level, the barriers to innovation, and some ways to overcome these barriers.

Key Takeaways

- Examining the implementation of previous federal/state programs (like CHIP and HIPAA) provides a roadmap for thinking about ACA. Every state is unique in at least some aspects of its health care system.**

Policies are translated into action through relationships between the federal government and state governments. Understanding how innovation occurs requires understanding these relationships. These relationships play out in three phases:

- *Policymaking.* Sometimes laws can afford states great flexibility and at other times are highly prescriptive.
- *Rulemaking.* At times, when rules are made, policies intended to be flexible become prescriptive, and at other times, prescriptive policies have rules that increase flexibility.
- *Implementation.* In reality, the implementation of policies and rules is a process of trial, error, and learning.

Factors that affect whether the federal government is prescriptive or provides much flexibility to the states include:

— *Resources to implement.* If the federal government lacks resources, states will likely be given more latitude. So, for implementing exchanges, the federal government lacks the expertise and resources, which could likely mean that the federal government's enforcement will be lenient.

"What is the penalty if a state doesn't have an exchange? Based on history where the federal government lacks capacity, it will be minimal."

— Michael Doonan

— *Expertise.* If states have expertise and capacity, the federal government will likely be more flexible. In dealing with insurance issues, states have expertise, which is likely to increase the amount of flexibility.

— *Clear reporting requirements.* If standards and reporting requirements are clear, so the federal government can measure performance, states will likely be granted more flexibility. For ACA, the reporting requirements for states will hopefully give the federal government confidence to allow more flexibility.

Looking at the relationship between the federal government and states with CHIP and HIPAA, it would suggest that with ACA states will be given flexibility.

- States have tremendous influence over health policy but don't often take advantage of it.**

States, in particular governors, have a tremendous ability to influence how health care is delivered and financed. Ways that states control health include:

- *Purchase of Medicaid, employee, and retiree benefits.* States are big purchasers and can use their purchasing power to drive change.
- *State regulation.* Health insurance has been regulated at the state rather than the federal level. States have great expertise and power here.
- *Supply of providers.* States set rules about the scope of practice, which determines which professionals can provide what services. States also control the supply of providers by virtue of controlling medical education (how many people are educated and licensed in which fields) and the number of beds in hospitals and nursing homes, and overseeing certificates of need.

- *Transparency.* States could require greater transparency of pricing and of quality results in their own contracting and from insurance companies and providers.
- *Health risk assessments.* More states are adopting assessments, but they could be more uniform, and evidence-based.
- *Behavioral health.* In most states, behavioral and physical health are treated through separate systems. However, research shows that physical and behavior health are linked, and the health costs for those with behavioral issues are much greater. States could better integrate physical and behavioral health systems.
- *Public health.* Many of the innovations with the greatest impact on Americans' health and life expectancy come from improvements in public health. Yet public health at all levels of government doesn't receive adequate recognition or funding. The positive effects of public health are often realized in the future, well beyond budget and election cycles, and therefore easy to discount. Obesity is an example of a critically important health challenge that should be addressed through public health.



"States have lots to say about the delivery of health care . . . and could do a lot more."
—Dan Crippen

▪ **Experience from within state government highlights some of the key barriers to innovation.**

Having been an advocate that prodded state government for 30 years and then an advisor to Pennsylvania's governor charged with innovation, Ann Torregrossa has experienced the barriers that inhibit innovation. They include:

- *Lack of time and resources.* Those within state government see administrations come and go, and keep doing what they do. They are consumed by day-to-day activities, wear many hats, are spread thin, and don't have the time or incentive to innovate. In Pennsylvania, this barrier was overcome through strong *leadership* by Governor Rendell, who was committed to innovation; a *structure* that supported innovation—this was small, with just four people; and *money*, mainly through grants.
- *Medicaid waivers.* While Medicaid waivers are supposed to lead to innovative demonstration programs, a barrier tends to be inflexibility by CMS. So, waivers can be a way to innovate but Ms. Torregrossa doesn't see them as the future of innovation within states.

- *Concerns about antitrust.* Innovation is often hindered by states that due to fear of antitrust fail to bring together stakeholders such as multiple payers. However, these concerns are unfounded and can easily be overcome. The solution is the Power of State Exception to Antitrust, which allows states to convene multiple parties, as long as such meetings are carefully supervised by the state and have the purpose of improving public health. Pennsylvania was able to overcome this barrier.
- *The medical guild system.* Reengineering the health care workforce is extremely difficult because providers zealously protect their turf. The challenge is finding politically possible niches for other health care providers that are acceptable to doctors, and getting the other providers paid. While challenging, there was success in Pennsylvania in addressing this challenge. (Other panelists agreed that getting providers to allow services to be performed by other health care professionals is extremely difficult.)
- *Procurement processes.* Entrenched state procurement processes are a major barrier to innovation. Ms. Torregrossa's advice is to learn these processes and make friends with people who understand them well who can help you navigate them.

"The biggest barrier to innovation [in Pennsylvania] was the state procurement process."
— Ann Torregrossa



In taking these barriers into consideration, the kinds of innovations that states want to implement are those that improve quality while reducing the cost of care, especially for Medicaid or employee health programs. These include innovations that eliminate perverse financial incentives, target expensive populations, and do not have political opposition, such as patient-centered medical homes.

▪ **Health reform in Minnesota shows that public/private collaboration can overcome barriers to innovation.**

Health reform in Minnesota was based on bringing public and private stakeholders together, agreeing on a set of principles, deciding to use the Triple Aim as a guiding framework, and creating an unprecedented degree of public/private collaboration.

The reforms enacted and being implemented include the Statewide Health Improvement Program (SHIP); payment reform, e.g., health care homes; greater transparency of quality results and costs; workforce changes, e.g., dental therapists; and development of a plan to improve consumer engagement.

During its health reform efforts, the state also explored the concept of "accountable health communities" to address the Triple Aim and the social determinants of

health. Sanne Magnan views significant keys to the state's success as leadership and relationships in the public/private sector.



"It's all about relationships; that's how to get things done."

—Sanne Magnan

Participant Discussion

- **Gubernatorial commitments.** When candidates are running for governor, they often develop a blueprint for how they want to improve health care, if elected. When they are elected, some work to implement their blueprint and others ignore it. Those interested in health care at the state level are encouraged to ask candidates to develop a blueprint and then to keep this blueprint in front of whoever is elected governor.
- **Scope of practice.** Activism is required to convince policymakers to expand the scope of practice. AARP supports a broadened scope of practice at all levels.