25th ANNIVERSARY

Princeton Conference

Council on Health Care Economics and Policy

THE HEALTH INDUSTRY Forum

Brandeis

Navigating Uncertainty in the U.S. Health Care System

Princeton, New Jersey, May 22-24, 2018

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Conference Opening: Tribute to Uwe E. Reinhardt and Celebrating 25 Years of the Princeton Conference

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

Altman opened the 25th Princeton Conference with a tribute to the late Uwe Reinhardt, who along with his wife, Tsung-Mei "May" Cheng, began the Princeton conference 25 years ago. The impetus for the conference originated from the idea of bringing people from the Clinton administration and Congress together on the eve of the release of the Clinton Health Care Plan in 1993. Altman, who took over running and sustaining the conference, recounted stories of his lifelong friendship with Reinhardt and the skillful way Reinhardt helped build the field of health care economics.

Tsung-Mei Cheng, Health Policy Research Analyst, Woodrow Wilson School of Public and International Affairs, Princeton University

Cheng recounted how Reinhardt became a larger than life phenomenon from a supportive childhood that included economic and physical hardship in Germany after the Second World War. Largely raised by his mother, while his father was at war and work, he grew up surrounded by strong women, including his grandmother. His mother's sense of direct honesty influenced his ability to speak the truth to Presidents and CEOs—and this may be one reason why they kept inviting him back. His father was a university educated chemical engineer, who, like many, in the pre- and post-war economy found it hard to find work. He always explained complex things to his children with the greatest patience and clarity. Reinhardt may have gotten the notion of social justice and economic security through his early life experiences, and his analytical mind and the ability to explain complex things in a simple manner came from his father. Reinhardt's close encounters with war and poverty were primary reasons why he was a life-long strong supporter of diplomacy and universal health coverage.

Growing up, Reinhardt was also the family jester and his sense of humor—along with humanity—became well known later in his life and career. Health care was always available to everyone in Germany, including in a defeated and impoverished post-war Germany. Without the medical care he and his four siblings had as young children, some of them may not have survived childhood. His interest in health care economics and policy, and the larger questions of distributive justice may have developed out of those early personal experiences. He believed that health care is a social good and that all should have it regardless of their ability to pay. Reinhardt influenced many on health care policy, including heads of state and luminaries, as well as people he encountered in grocery stores or on his many travels. This man of the world was like a rare and precious gem whose influence and legacy will live on in the hearts and minds of many from all walks of life, both here in the United States and abroad.

John K. Iglehart, Founding Editor, Health Affairs; National Correspondent, The New England Journal of Medicine

Iglehart reiterated the impact of Reinhardt's work on the field of health policy. He highlighted that when he thinks of Reinhardt, he also thinks of Cheng—discussing how much of a "team" they were. They not only raised a family but also influenced national and international health policy. Together, they supported and guided the development of the health care system in Taiwan. Iglehart noted that Reinhardt was one of the first editorial board members of Health Affairs and made remarkable contributions to the journal and the greater health field. When Reinhardt stepped off the Health Affairs board, Cheng took his spot. To this day, she continues to provide invaluable contributions to the journal.

Chris Jennings, Founder and President, Jennings Policy Strategies, Inc.

Jennings talked about a meeting between the former First Lady and Secretary of State Hillary Clinton and Reinhardt during the Clinton Health Reform era. The meeting took place in the White House Map Room, where FDR oversaw war plans for Germany. Reinhardt was mesmerized by the history and relevance of this meeting place—both under FDR and during this effort to reform the health care system. This story illustrates many of the themes that followed Reinhardt—Germany, health reform for all, social insurance, and equity. He also joked that it was harder to get Reinhardt to deliver information to the First Lady than it was for her to convey information she learned from Reinhardt. Reinhardt entertained as he informed, and this stuck with the First Lady, as it did with the many people he influenced over the years. Jennings discussed how Cheng was always Reinhardt's biggest critic, as well as his collaborator, best friend, and negotiator. Reinhardt's greatest legacy is his wonderful family, the humanity that inspired us all, and his indisputable intelligence, wit, and charm.

Leonard D. Schaeffer, Judge Robert Maclay Widney Chair and Professor, University of Southern California

Schaeffer, a longtime friend and admirer of Reinhardt's, recalled their special relationship throughout his own remarkable career. He originally believed his special relationship was unique because of the individual attention and insight that Reinhardt provided, but learned that part of Reinhardt's charm was that he had this type of connection and relationship with so many people. Schaeffer reinforced the rare skill Reinhardt had of explaining complex things with simple language and examples. He used his wit and good humor as an effective education tool. Schaeffer ended by recognizing how many people Reinhardt touched as a friend, teacher, public policy guru, brilliant economist, and humanitarian.

After each of the speakers shared stories about Reinhardt, many from the audience recalled individual encounters and experiences with Reinhardt. These reinforced the impact, humanity, wit, intelligence, and sense of humor of this luminary who will be sorely missed.

Welcome

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

Altman welcomed the speakers and attendees of the 25th Princeton Conference and thanked the generous funding partners. He recognized the Robert Wood Johnson Foundation (RWJF) for their continued support of the conference from the beginning and thanked RWJF for the use of their conference room and facilities.

Alonzo L. Plough, Chief Science Officer and Vice President for Research-Evaluation-Learning, Robert Wood Johnson Foundation

Adding to the welcome, Plough, said that the theme of this 25th Princeton Conference, *Navigating Uncertainty*, is timely and the agenda is keeping with the work of RWJF. RWJF is working to foster a culture of health, which links social determinants of health with efforts to transform the health care system. Foundation efforts focus on healthy children including healthy weight, physical activity, social and emotional health, and a reduction in health disparities. Changing the culture also requires collaboration across the public, private, and non-profit sectors, and the increased use of data as an impetus for action. Plough noted that the foundation is also working with states to fund promising

interventions to improve health and reduce costs. It is supporting safety net providers and is committed to facilitating diverse leadership to help bring about necessary change.

Washington Update

Sheila P. Burke, Strategic Advisor and Chair, Government Relations and Public Policy Group, Baker Donelson; Research Faculty, John F. Kennedy School of Government, Harvard University

Altman introduced Burke as the moderator for the session, noting her history and ability to effectively work in a bipartisan manner. Burke suggested that uncertainty in Washington creates a major challenge for navigating the health care system. Agreeing with Altman's suppositions that bipartisan work is disappearing, she lamented that while there have always been disagreements on policy, there had been a common understanding of data and assumptions. She discussed current trends and potential areas for concern playing out in Washington, including the opioid crisis, insurance market instability, declining insurance coverage, rising premiums, and unstable Medicare costs. Burke noted that the reduced primacy of the committee process is one cause of the frayed legislative process. Further, while not new, the administration is increasingly using administrative rules to circumvent the legislative process. She commented that while the public is politically divided, there is strong support that everyone should have insurance coverage, but not if it is attached to tax increases. The upcoming midterm election will determine who controls Congress. Regardless of the outcome, we need to work toward a shared understanding of the problems and potential solutions that impact health care in the United States.

Wendell Primus, Senior Policy Advisor for Budget and Health, Democratic Leader Nancy Pelosi (D-Calif)

Primus suggested that the largest health concern is poor preparation for the retirement of the Baby Boomer generation, which will double the number of retirees between 2010 and 2035. Solutions, he stated, are difficult, in part, because of increasing debt caused by massive tax breaks. Primus noted that one big difference between the Democrats and Republicans is that "Democrats pay for their priorities." Retiree demographics will account for 80% of the 3.0 percentage point increase in Federal outlays as a percent of total GDP between 2018 (20.6%) and 2028 (23.6%), according to the Congressional Budget Office (CBO). The recent tax cuts cannot survive given our country's demographics, and all of this is difficult in a highly partisan environment.

Primus also discussed widespread support for universal coverage and suggested that modifications to the Affordable Care Act (ACA) are the most effective and least expensive way forward. A single-payer system is not doable as it creates winners and losers, requires huge expenditures of federal outlays that are needed for other priorities, and most health care stakeholders are in opposition to this type of change. ACA successes, in addition to fewer uninsured, include a reduction in the rate of spending growth and improved quality and coverage. He talked about how Republicans sabotaged the ACA by dismantling Medicaid expansion and promoting Medicaid work requirements, and a range of regulatory interventions helped derail implementation efforts. Abortion politics derailed ACA market stability legislation. Work needs to be done to shore up cost-sharing subsidies and to stabilize markets – much of which could be done by States. Primus agreed with Burke that there is an opportunity for bipartisan action on the opioid epidemic, noting that there are currently 70 bipartisan opioid bills. He discussed some recent success in a bipartisan budget act, which substantially increased discretionary spending, extended the CHIP program by 10 years, and provided for increased NIH and opioid funding paid in part by Pharma. For prescription drug pricing, however, the administration is going along on its own with proposals that provide more questions than answers, he said. Real progress requires the ability to negotiate price and require drug manufacturers to publicly release hard

data and information justifying price increases. In the end, these proposals and efforts to improve and strengthen the ACA, Medicare, and Medicaid are likely to be held hostage by new tax policy and tribal politics.

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

Kahn began with comments on the ACA. In 2010, it was thought that the ACA could effectively set up a framework for universal coverage, but this underestimated the political backlash against it and the Supreme Court's decision. Instead of becoming a framework for coverage, it became a personification of political division and polarization. While the ACA assisted many people, it never met its promise.

Kahn stated that the current Secretary of Health and Human Services (HHS), Alex Azar, is a skilled and knowledgeable secretary. Despite his incredible competence, and that of his staff, progress has been a challenge. For instance, HHS was given direction to do what it can to address rising drug prices but to not upset the industry in the process. The result was that drug stocks went up, and HHS is left with no room to truly direct policy. Kahn did note that value-based purchasing might work, but success will be difficult despite solid leadership. Another area is Medicaid re-welfarization, which began before the Secretary took the helm, but has nonetheless continued its forward movement.

Kahn ended with optimism by pointing out likely success in passing the "Right to Try" legislation, the Veteran's Affairs Mission Act, as well as measures to address the opioid crisis. We can hope that some of this will find the center and some level of bipartisan cooperation. In the current environment, however, there is not a clear strategy for progress.

Discussion

The point was made that Congress is bypassing regular order and the committee process, and thereby empowering leadership. This was countered by pointing to the ACA and Tax Bill that both went through the committee process. The underlying problem, Primus and Kahn agreed, is tribal politics and the inability to compromise. It was pointed out that the states with the most to gain from ACA Medicaid expansion were the most likely to vote against it. Politics were so strong in these areas that they overcame the hospital lobby.

The panel was asked if the Democrats have a coherent policy strategy if they take over the House and Senate, and if so, what would their priorities be? Primus stated that the ACA would have been in good shape if Clinton had been elected and added that the ACA was built on conservative principles, which adds its own level of irony. He suggested that the Democratic priorities should be to roll back the tax cuts, address the health and retirement needs of the Baby Boomers, and make other investments in health care coverage.

Another audience question asked how to counter an aggressive administration that might use administrative executive orders to go around Congress? The panel responded that while there have been considerable administrative changes, there are limits to this power. Kahn suggested that the Centers for Medicare and Medicaid (CMS) Commissioner identified limits when she said that she did not have the authority to approve a lifetime cap on Medicaid. One challenge is that currently there is limited pushback from Congress to check executive powers. Panelists lamented the difficulty in achieving compromise and working across the aisle. They expressed hope for more bipartisan cooperation moving forward but were not overly optimistic.

Session 1: Latest Activities in Health Care Spending and the Private Insurance Market

Murray Ross, Vice President, Kaiser Permanente

Ross moderated the panel and introduced the speakers. The goal of this panel was to understand the reasons for persistent health care spending increases and to provide insight into how the insurance market is dealing with uncertainty.

Joseph Dieleman, Assistant Professor, Institute for Health Metrics and Evaluation, University of Washington

Dieleman identified three taxonomies to split apart personal health care expenditures: demographics of the patient, epidemiological health conditions, and types of care. Their research examined how costs within each of these categories changed across time. Dieleman discussed the drivers of spending, which include population size, population age structure, disease prevalence, service utilization, and service price and intensity.

Price is the biggest driver of cost increases, followed by population size, and an aging population. Fewer inpatient bed days helps reduce costs but is generally offset by more intensive care and higher per day expenditures. Results regarding the overall percentage of total costs, by type of care, included 33% of costs for outpatient (ambulatory care), 33% for inpatient care, and 14% for pharmaceuticals. Some of the larger costs, by health condition groups, are diabetes (5%), ischemic heart disease (4%), and low back and neck pain (4%). Combined mental health conditions make up (9%) and cancers (5%).

These results are available on the Institute for Health Metrics and Evaluation website, including various ways to cut, view, and display the data by different categories: https://vizhub.healthdata.org/dex/.

Matthew Eyles, Senior EVP & Chief Operating Officer, America's Health Insurance Plans

Eyles provided insight into what will drive health system change over the next decade. These include affordability, social determinants of health and chronic disease, and the influence of government. Each will affect the health care delivery system, consumers, providers, and clinical innovation. Everything is impacted by advancements in information technology. Eyles agreed with Dieleman that unit prices for health care in the United States are the highest in the world. He added that looming budget deficits influence government funding.

Eyles identified challenges or disrupters to the system, which include new association health care plans and a move toward smaller businesses self-insuring. Small companies are self-insuring with reinsurance and administrative support from traditional carriers to avoid state regulation and get out of the ACA small group market. Short-term plans, which cover people for brief gaps in coverage, will also impact premiums and lead to market inefficiencies. Association plans like farm bureau plans also seek to avoid regulation and will create market instability. The long-term care insurance market is a disaster, with fewer and fewer options available.

Indeterminate and changing federal policy is leading to uncertainty in the Individual market, where individuals receiving the largest subsidies are the most at risk. Moreover, there is an increasing concern for those above 400% FPL, who face the brunt of higher premiums without subsidies. Within this uncertainty, plans will need to make decisions about rates and estimate participation levels for the upcoming year. Some plans are at a point where they may begin thinking about pulling out of certain markets.

Leemore S. Dafny, Bruce V. Rauner Professor of Business Administration, Harvard Business School

Dafny began by describing mergers and acquisitions within the insurance industry. She discussed how most of the recent deals have been vertical and not horizontal. One trend is insurers merging with prescription drug benefit managers (PBMs). Here the goal is to lower costs and maximize health. Another trend is to have a portal to the health care system through Walmart, CVS, or another retail partner with the hope of improving care management. This might increase value, although there is no clear evidence supporting this.

We may yet see growth in mergers between insurers and providers to protect and increase market power. Insurers that own the providers have access to physician organizations and may be able to improve management and administration, which could lead to innovation and a potential for learning. However, this might not work because organized providers have power through market domination and may not be willing to cede control.

Vertical arrangements have more potential to generate value for consumers than do large horizontal mergers. This is a time for great potential and experimentation. Alternative payments and risk sharing can lead to greater efficiency. Multiple models are likely to be necessary within a complex system such as that in the United States; we should expect to see regional variation.

Discussion

An opening question asked if efforts to tamp down on price will lead to increased volume and thus wash out potential savings. One suggestion was that that incentives need to be structured further upstream to reward chronic disease management. A consensus was that while providers recognize the need for change, they may not yet be ready for a change.

Rob Mechanic, Brandeis University, noted that while Medicare has moved toward alternative payments, the private sector seems to lag behind. He asked why private insurers are not quickly moving to alternative payments. Eyles responded that some private insurers are innovating, but there is significant geographical diversity. Areas like California are leading the way with alternative payments, but in other areas providers with significant market power stifle innovation. Market and regulatory uncertainty make change difficult. States, however, can be effective in creating movement, although most have not yet acted. Competition could lead to future change. This is challenging, however, because big steps are necessary for real change, and they come with significant risk and uncertainty. One hope is that large employers are increasingly cognizant of the cost issue and may become catalysts for action.

Altman said that Massachusetts is the only state taking on total healthcare spending. He reiterated what Uwe Reinhart stated for years, “It is the price, stupid.” Efficiency is not enough, he argued, and savings from efficiency typically go back to those who make the change and do not reduce total costs. Altman asked whether some of the recent innovations would succeed in reducing price. Eyles was not optimistic; he said that insurers can focus on price and will leverage this if they can, but that negotiations alone will not control system-wide costs. Global budgets would work, but movement is still slow in this area. Dafny reported that driving down price without consideration for quantity will not work and that efficiency is only realized if there is enough competition. Dieleman added that understanding the data in a sophisticated way is critical. Data by payer would be helpful to examine price on a state-by-state basis and this state data could be used to identify trends. Insurers use a variety of tools, Ross noted, but mostly focus on utilization. Unless we change overall policy, insurers are not likely to make dramatic changes.

Session II: The Employers Strike Back: Toward a Real Market in Health Care

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

Feinstein opened the session with the idea that an employer awakening has the potential to transform the health care delivery system. We are deep in a system with 35% to 40% waste, and a new infusion of ideas and innovation is essential to creating and sustaining a high-quality health care system.

Robert S. Kaplan, Senior Fellow and Marvin Bower Professor of Leadership Development, Emeritus, Harvard Business School

High healthcare spending in the United States comes from an inefficient health care system. Employers' health insurance premiums can range up to 5% of their total operating expenses. Kaplan noted that employers bear additional costs, to their out-of-pocket spending, from absenteeism and lower morale of ill employees. Further, presenteeism, or low productivity of workers with chronic conditions, can decrease productivity and quality. Employers benefit from a motivated, healthy workforce. Even though most employers are self-insured, either explicitly or implicitly through annual experience ratings, they continue to use health benefit plans that have markups as high as 15% to 20% above claims. Kaplan added that corporations are increasingly wary of spending this amount of money without control or accountability over the final product.

Most companies run their health insurance programs through their benefits or human resources departments, with the goal of keeping employees happy. Kaplan asked, "What if health benefits were run through the purchasing department instead?" How might this transform the system? The purchasing department has existing quality and accountability standards for all their suppliers. Extending this discipline to the purchase of health care services has the potential to revolutionize the way we understand health insurance.

Employers have extensive discretion and power in how they design plans. They can form alliances and be more efficient purchasers. The question is why aren't employers transforming this system? Some are. Kaplan discussed how Walmart and General Electric both set up Centers of Excellence to address several high-volume, expensive conditions prevalent in their employee population (e.g., back pain, joint problems, maternity care). They collaborated with providers based on quality; they set up bundles and paid for value. As these examples illustrate, employers have a lot more they could be doing to improve health care outcomes for employees at a considerably lower cost.

David A. Asch, MD, John Morgan Professor, University of Pennsylvania

Asch discussed the possibility of employers becoming models of change in health care. He noted that health care can certainly learn from outsiders. Employers can impart lessons for the health care system, particularly through their competitive threat and business process innovation. Provider organizations vary widely in their ability to innovate, however, and tools like financial incentives are often not enough to facilitate change.

Asch is optimistic, however, and discussed how health care can learn from industry. For example, using the Jiffy Lube experience can help reduce hypertension, the leading cause of mortality worldwide. The current model for managing hypertension includes having a primary care physician monitor the patient and make periodic adjustments. The result is that many patients have poorly managed hypertension. At Jiffy Lube, they concentrate on one thing and they do this efficiently. Asch described hypertension clinics with focused systems, like that of Jiffy Lube, that achieve nearly 100% control within their patient population in just six months.

Another example is how companies like Amazon, Dominos, or Netflix use their websites to suggest other products for consumers based on recent purchases. The health care system can use similar tactics to promote generic drugs over

brand names. Companies are also increasingly offering products on websites that have not yet been developed to see how much interest exists, a so-called "vapor" test. Health care can use this type of idea to see what demand looks like before they put resources into operationalizing or changing their systems. Asch's examples demonstrated the potential for business innovation in health care systems.

Vivian S. Lee, MD, Verily

Lee spoke about innovation at the University of Utah health care system, an integrated academic medical system. The system includes a large catchment area, across multiple states, and is an employer with over 20,000 employees, trainees, and students. The system is committed to population health with considerable success. She criticized the movement toward consumer-driven health care, and the shift of responsibility onto employees. While price transparency sounds good, it has not had a positive impact on health. She cited research that shows that consumer-directed health care, including higher consumer cost sharing, often leads to a reduction in necessary and unnecessary care. For instance, people may forgo free preventive health visits if other kinds of appointments require copayments.

Alternative approaches like disease management and wellness programs can save money and improve health, although the data in this area are mixed. Much of the literature seems to suggest better success with efforts focusing on population health upstream, like disease management programs. Lee offered an example from the University of Utah system to illustrate improved population health and cost savings. One laboratory diagnostic company within the health system uses health assessment questionnaires for all employees. They run this data through a risk calculator and use it to create specific care pathways for employees based on their risk profile. This has led to better health and lower costs for employees with specific diseases.

Lee offered another case example. She discussed innovation at Virginia Mason in Washington State that was spurred by four large employers. These employers threatened to drop Virginia Mason coverage because of high costs, which led the health system to examine enrollee data to see avenues to transform care and become more efficient. They identified what worked and what did not. Employers asked for better customer satisfaction, same day services, rapid return to function, as well as affordable prices. Guided by the employee data, Virginia Mason developed centers of care to address particular care pathways. They developed care protocols for the most common health care services (different by employer). Some services were delivered on site, some in hospital, and some in clinics, including a comprehensive spine clinic. The lesson, Lee noted, is the opportunity for employers and clinicians to learn from each other and align around better, more efficient care for patients.

Discussion

The first question considered how employers are attempting to control rising drug costs. The panel suggested that employers have different levels of sophistication in how the health care system works, and how involved they will become. Many are increasingly engaged and interested in obtaining utilization data from health plans. While they are using this data to assess high costs and risks and educate enrollees, there has not been large-scale movement in this area.

The conversation next shifted to the role of brokers and consultants, which serve many employers. The panel suggested that consultants can provide necessary services, as well as have conflicting relationships with providers and insurers. Many employers put too much trust in brokers, Lee noted. Brokers need to be able to show the value they might bring.

The panel was asked about the role of data sharing. It is often challenging for employers and providers to access data or sift through and understand the data. While quality data is becoming increasingly sophisticated, it may not be

enough to facilitate change. Other challenges are that health as an outcome is only partially under the control of the medical system and with data comes significant privacy challenges.

Some in the audience presented a pessimistic view of what employers can actually do. While certain employers may be innovators, for real change there must be something that will bring the majority to the table and provide concrete examples. This does not seem to exist, and most employers are not yet active players in health care.

Session III: Medicaid at a Crossroads

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

Doonan shaped the panel by describing the polarization and competing views of the Medicaid program. Conservatives see the program as a welfare service program. This view believes that benefits should be reserved for the truly needy and the program should be hard to get on and easy to get off. Work requirements, time limits, and drug testing would help provide incentives for people to work and target benefits to those most deserving. The view on the left is that Medicaid should be part of a larger system of universal coverage. It should serve as a safety net, covering all individuals and families below a certain income threshold. The program should be easy to get on and hard to get off. Doonan also suggested that there could be a third way, which might include state flexibility to operationalize different options. He cautioned, however, that conservatives use national government power as much as liberals do and that state flexibility to test universal coverage options is very creative when using federal money.

Matt Salo, Executive Director, National Association of Medicaid Directors

Salo spoke about the ideological differences playing out in Medicaid programs around the country. These are not so much of a divide, but different views on how to run Medicaid. States are not sitting idly by, but are active change agents, thinking about creative methods for managing Medicaid programs. Discussing the current debate on whether it is appropriate, legal, or ethical for Medicaid to allow work requirements for eligibility overlooks the fundamental questions and debate taking place in states. Instead, he asserted, it is important to look deeper at what states are trying to do. It is vital to support state flexibility, and multiple pathways for Medicaid are the best policy options. Given the current political uncertainty, Salo also discussed the importance of making sure that continued stability for the program is available.

Nina Owcharenko Schaefer, Senior Research Fellow, The Heritage Foundation

Schaefer suggested that Medicaid has always been a complex program, and in recent years has grown even more that way. Medicaid has outpaced its original purpose, she asserted. There have been several demographics, financing, and administrative changes in recent years. Recent expansion to newly covered groups was not the intention of the program. The program, which used to be viewed as a program primarily for children is now about income where adults and children are treated equally in terms of eligibility. As Congress and others evaluate eligibility requirements, they are not looking at the structure of eligibility. Instead, they are laying one thing on top of another. The Children's Health Insurance Program (CHIP) is layered on top of Medicaid, then the ACA layered in expansion adults, and so on. The primary question is how do we create the right priorities and balance these across the Medicaid program? Schaefer also supported the need for increased state flexibility to return to covering the core groups.

Other changes and shifts that Schaefer discussed included structural and fiscal challenges for the program. Medicaid managed care and waivers have further changed the structure of the program. Policy is lagging in this area as well. There is a need to look at the underlying structure of the program. Moreover, fiscal changes to deal with skyrocketing

costs (e.g., dual eligible costs, expansion adults) are needed to streamline the program. Finally, Schaefer noted that while the current Administration has a lot of authority, it is limited. There is a need for Congress to make statutory changes for Medicaid or else the program will remain messy in the near future.

Sara Rosenbaum, Milken Institute School of Public Health, The George Washington University

The divide between the states concerning Medicaid is an issue that we have struggled with since the inception of the program. Rosenbaum noted that even when the program began, states were divided in what groups should be eligible for Medicaid. For example, approximately 30 states included working adults and funded these individuals with state dollars; almost 20 states did not. These roughly 20 states are largely the same states that are currently not expanding Medicaid. Reviewing the ideological divide that erupted during the ACA, Rosenbaum discussed some of the policy questions that were considered. For instance, how much latitude do you give states over Medicaid design and administration? She pointed to some of the hazards on recent increases in state flexibility and discussed the work requirement waiver requests as an illustration. The problem with the work demonstrations, she noted is that they are net losers. They point downward, and states are not using them to expand Medicaid, but rather to move people off the program. The goal of the Medicaid program is to cover the uninsured and waivers that role back or take away coverage should not be accepted.

Discussion

The discussion began with a question regarding 5-year time frames of Medicaid waivers and the high turnover rate of Medicaid Directors. Salo agreed that this is a problem area and that leadership turnover is considerable. For waivers to succeed, they need to be public-private partnerships. The limited resources put into leadership in state governments impacts the success of these initiatives. Tiffany Gavin, from Boston Medical Center, who is running one of the Medicaid waiver programs added that it is more of a 15-20-year investment than the five-year life of the waiver.

The conversation turned to how Medicaid and ACA marketplaces can better work together. Salo pointed to a proposal under consideration in Idaho where Medicaid beneficiaries would have been covered through the marketplace; those with high needs would have remained in the traditional Medicaid program. While the proposal was not implemented, Salo noted that examples like this show how states think differently about the intersection and interaction between Medicaid and Exchange coverage. Rosenbaum added that Medicaid is the best place for people who need more health care services and that it removes more costly people from marketplaces. Attention needs to be taken to ensure that people get access to the care they need in the most appropriate setting. Schaefer cautioned that it is also important to forgo the idea of getting all 50 states to expand Medicaid as this overlooks the original goal and focus of the program.

Audience members discussed the impact of Medicaid on state budgets and how this competes with other priorities. Solutions for dealing with rising program costs, however, were not evident and Salo cautioned that it will likely get worse before it gets better.

The panel closed with final words from each panelist. Schaefer discussed that the tension we are seeing at the state level will also become a tension at the federal level as the states “ring the fire alarm” and demand that the federal government gets more involved. Rosenbaum observed that the current debate demonstrates just how indispensable this program is to people across the country. Salo highlighted that Medicaid is large, complex, and the biggest payer of many important health care services. While this was not the original vision of the program, we got here because other components of the health care system failed, he asserted. To help preserve Medicaid, we need to make other parts of the health care system relevant again.

Session IV: Prescription Drug Spending Trends

Cybele Bjorklund, Distinguished Visitor, Georgetown University Law Center; Senior Fellow, McCourt School of Public Policy, Georgetown University

Bjorklund introduced the panel and acknowledged a quote by Uwe Reinhardt about hospital charges being "chaos behind a veil of secrecy." Prescription drug spending and prices can be similarly characterized.

Murray Aitken, Executive Director, IQVIA Institute for Human Data Science

Aitken dissected data on prescription drug costs and spending trends. While there have been many years of high growth, recent trends are below general medical inflation. The Medicine growth rate slowed to just 0.6% in 2017 on a net manufacturer sales basis. In 2012, sales revenue dropped precipitously as several big sellers went off patent. This was followed by a steep climb between 2012 to 2014 as new Hepatitis C drugs came onto the market. Aitken noted that a full third of prescription drugs are non-retail and often administered in the hospital. Retail sales, while high in 2014, declined by 2.1% in 2017.

According to Aitken, the growth of prescription drug prices on a net basis is much less than perceived, though notably patients often do not experience this trend due to insurance design. Outliers continue to exist, but their aggregate impact is small. Manufacturers have reduced their net price increases and the pharmaceutical industry appears to be committed to single-digit increases. Out-of-pocket costs for patients have been rising so quickly—for brand name and generic drugs, despite rebates—that patients feel like overall prices have increased. Coupons are becoming key aspects to help patients afford prescription drugs.

Rhys Williams, Executive Director of Global Health Economics, Amgen

Williams focused on the costs associated with innovation, or research and development, for prescription drugs. Making the case that the risks of bringing new drugs to market are incredibly high, Williams noted that the U.S. pharmaceutical industry spends the most in the world for research and development. This accounts for more than 8 million jobs, and 3% of the population is connected directly or indirectly to the pharmaceutical industry. It costs over $2.6 billion over 12 years to get a drug approved, and to market, and only one in 10 drugs are approved. Phase three trials are the most expensive element. In total, only 35 drugs or biologics are approved each year and less than 50% of drugs on the market make money. One of the biggest challenges is that a drug receives a patent for only 20 years, and with the long approval process, there is limited time to recoup high development costs.

Williams described how medications can save money by treating some of the costliest diseases and helping lower overall health care costs. Further, prescription drug innovation holds the potential to reduce future such illnesses like cardiac disease, cancer, and Alzheimer's. He noted that for every additional dollar spent on medicine for congestive heart failure, high blood pressure, diabetes, and high cholesterol, there is a $3 to $10 savings generated from reduced emergency room visits and inpatient hospitalizations. AIDS treatment has been one of the major pharmaceutical industry's success stories, with new medications resulting in a 90% reduction in death rate. A final point Williams discussed is the importance of value-based pricing but cautioned that this needs to be achieved without reducing innovation.

Steven D. Pearson, MD, President, Institute for Clinical and Economic Review (ICER)

Cost-effectiveness analysis should play a role in drug pricing, Pearson noted, particularly for specialty drugs. Currently, most people do not believe that prescription drug pricing is fair and feel that price should reflect manufacturing costs plus a reasonable profit. Rising drug prices impact States and Medicaid programs, which feel

particularly underwater with specialty drugs. Managing specialty pharmaceuticals is an increasing challenge. Moreover, the costs of professional services for administering drugs is rapidly increasing and there is a considerable concern about the launch prices of new drugs.

It is important to examine the total budget impact of a drug. Pearson suggested that the dominant approach should be to link price and the added value of the drug to patient and health care systems. He described the basic structure of cost-effectiveness analysis and the use of quality-adjusted life years (QALYs) to help understand value. These assessments, done by ICER, are increasingly used as an independent evaluation for policymakers. Provider groups and payers are using these assessments to negotiate price. Pearson provided an example of how New York Medicaid is using ICER reports and cost-effectiveness analysis to help the program secure deeper discounts for the Cystic fibrosis drug Orkambi.

Pearson closed his presentation with information about next steps for ICER and value-based plan designs by outlining three options. Option one, for private payers, would include a special tier, step therapy, or exclusion for drugs where the negotiated price remains above the value-based benchmark. Option two, which might be used by public or private payers, would include drugs on the formulary, but only pay up to the value-based price benchmark. Any residual gap between the charged price and the reimbursement amount is the responsibility of the patient/manufacturer. A final option, option three, would be for public payers to include drugs on a formulary but only pay up to the value-based price benchmark. In this option, the manufacturer is forbidden from balance billing and has the choice to list or not list the drug at a price not exceeding the value-based price.

Discussion

The discussion opened with a conversation about pharmaceutical spending on research and development. Williams noted that the average spending on research and development is about 16% of sales. Even with the pharmaceutical growth strained, it was suggested that the industry continues to invest in research and development. Where is the breakeven point where the industry will no longer continue to innovate? It is hard to quantify, but approximately 15% to 20% on research and development is likely the preferred range.

Other questions and thoughts supported the work of ICER and the need for increased information on cost-effectiveness and value-based pricing. One comment noted that the net price in the United States is much closer to world prices when rebates and discounts are considered. However, there is a marked difference between what the patients feel and what pharmaceutical numbers seem to show. Prices go up after launch, sometimes even many years later. The conversation ended with a call for further price transparency at the provider level, but there were concerns about the best way to convey this information.

Session V: Future of the Health Care Workforce: Where Are We Going?

Michael Tutty, Group Vice President – Professional Satisfaction and Practice Sustainability, American Medical Association

Tutty began the session with a discussion on the physician shortage, which is caused by increased demand, physician retirement, and burnout. An aging population and increased incidence of chronic illness are further driving physician demand. While the United States is producing more medical students, there is a cap on residency training. Moreover, physicians are retiring at a higher rate and experiencing increased levels of burnout—double the stress level of the general population—for a variety of reasons. Recent studies suggest that elevated stress on physicians is due in large part to administrative burdens and less time with patients. Physicians also report having less ability to

manage workloads and control their work environment. Tutty noted that because of physician burnout, one in five physicians intends to reduce their workload over the next year and one out of 50 physicians intends to leave the profession altogether.

Peter Buerhaus, Professor, and Director, Center for Interdisciplinary Health Workforce Studies, Montana State University

Buerhaus discussed the nursing workforce, which is growing with more nurses completing graduate and bachelor's degrees. The nursing profession has steadily increased and enjoys strong public perception. The nursing shortage of recent years has mostly been addressed as the Millennial generation moves into nursing and will be able to replace the 1 million retiring baby boomers. However, there are still some regions experiencing shortfalls, primarily along the coasts.

With a physician shortage and concerns over rising health care costs, physician assistants and nurse practitioners can play an increasing role in the healthcare system. There is mounting evidence on the positive contribution that nurse practitioners play in primary care, Buerhaus noted. Many states have placed restrictions on the scope of practice for physician assistants and nurse practitioners, however, which could decrease access to primary care. Buerhaus' conclusion was that there are different workforce issues at play now than in recent years, but how best to use available workers in the most efficient way is still a primary concern.

Gail W. Stuart, Dean, College of Nursing, Medical University of South Carolina; Board President, Annapolis Coalition on the Behavioral Health Workforce

Stuart opened with statistics about the behavioral health workforce around the country. She reported that 55% of counties in the United States have no behavioral health provider and three-quarters of the counties have unmet behavioral health needs. The behavioral health workforce is plagued with shortages and this is at crisis levels in various regions of the country. Stuart described the behavioral health workforce, the types of practice settings and activities they are engaged in, and the challenges and needs moving forward.

Her conclusion was that the specialty behavioral workforce will not be able to meet the behavioral health needs of the country. Instead, the workforce needs to be redefined. For instance, there are 100,000 nurses working in mental health settings, 275,000 primary care physicians, and 3.8 million general practice nurses who can help expand the reach of behavioral health. Moreover, police, peers, community health workers, and family and friends have roles to play in supporting patient care. There is a strong need for better data collection and a database of behavioral health workers to plan for future needs, which will help with recruiting and retaining workers. New Mexico is doing this extremely well on a state level. Also, loan forgiveness and training programs need to be enhanced.

Stuart concluded with a call to allow for the full scope of practice across a broader array of practitioners, which includes providing reimbursement for all licensed/credentialed providers. Success will require rethinking what treatment is and where it is provided, including further development of telehealth.

Jay Komarneni, Founder and Chair, The Human Diagnosis Project

Komarneni agreed that the physician shortage is exacerbated by burnout. He described documentation and administrative burdens, which reduce physician autonomy and time with patients. The Human Diagnosis Project is a worldwide open intelligence system to map the steps necessary to provide optimum patient care. Here, physicians collaborate along with information technology and artificial intelligence to support best practices. This type of a system could also facilitate billing and serve as a worldwide resource.

This design and interaction can increase provider capacity and address shortages by empowering providers to work more efficiently, expand the scope of practice in a safe way, and provide decentralized tools to support patient self-assessment and self-management. Quality decision support software would be driven by physicians, which would help expand the scope of practice. Systems can even be designed to support value-based payment incentives. Today, electronic medical records are often viewed in a negative light by physicians. Team-based care, along with artificial intelligence systems, could increase physician engagement in this arena and lead to better patient health outcomes.

Discussion

The initial discussion centered on how the time burden of electronic medical records compares with paper files that physicians used to take home with them. It may be less about the method of documentation, and more about electronic medical records not aligning with clinical workflow. More data is needed to fully understand what is going on. The discussion then moved to the importance of addressing social determinants in health care, which may be causing moral distress to some providers. The panel agreed that clinicians report moral distress when they cannot help their patients. Moreover, the system is riddled with misaligned incentives. People show up at the emergency room to try to receive treatment, and physicians often feel like they need to game the system to get patients the care they need. Often, they must also figure out how to care for a patient despite insurance challenges. A concern was raised about the lack of a behavioral health career trajectory and the response was that this is essential to attract and retain quality providers.

The conversation then turned to the role of technology in providing more health care in the home. Home-based care can be both dangerous and time-consuming, and advances in technology and telemedicine will allow providers the ability to go into the home without physically being there. Furthermore, to bend the cost curve requires increased labor productivity. Fewer workers need to take care of more people. Using artificial intelligence and technology will be important in this way. These systems, however, need to involve the user in designing an interface. A motivated workforce, which will involve developing and utilizing technology with the end user in mind, is critical in meeting changing health care needs.

Uwe Reinhardt Memorial Lecture: Changing Mortality Patterns in Working Class America

Stuart Altman welcomed everyone to the Prospect House dinner and discussed how this dinner and lecture will be named in honor of the late Uwe Reinhardt moving forward. Altman introduced Constance Horgan, Professor and Director of the Schneider Institute for Behavioral Health, The Heller School for Social Policy and Management, Brandeis University. In her introduction, Horgan briefly spoke about the formation of the new Opioid Policy Research Collaborative at the Heller School for Social Policy and Management. She then went on to introduce the keynote speaker for the evening and commented on how wonderful it is that the first Reinhardt Memorial Lecturer, Anne Case, is a Princeton professor and colleague of the late Uwe Reinhardt.

Anne Case, Alexander Stewart 1886 Professor of Economics and Public Affairs Emeritus, Princeton University

Case spoke about her ground-breaking work with Nobel Prize colleague and husband, Sir Angus Deaton, on rising mortality rates among white non-Hispanic Americans in midlife. In the 1960s, health changes—including a reduction in smoking and medical advances particularly around heart disease and cancer—led to significant gains in life expectancy for all Americans. While these gains have continued in Europe, something very different has been taking place in the United States. After decades of improvement in health, mortality rates among white non-Hispanic men

and women have slowly begun to rise. In fact, 2017 will likely be the third year in a row when life expectancy falls in the United States. Mortality rates among blacks and Hispanics have continued to fall, however, with life expectancy improving among these populations, although there are still gaps between black and white mortality. This gap, however, has been shrinking in recent years, in large part because white mortality is rising.

Older whites are living longer, and child mortality rates continue to decline. The problem is with middle-age. The group most at risk is white Americans without a college degree, representing approximately 70% of the white population. In every state, mortality rates from drug overdoses, alcoholic liver disease and cirrhosis, and suicide rates have increased. This holds true for the inner city, suburbs, and rural communities. It is true across genders. The number of prescriptions for pain medication has quadrupled and there is easy access to opioids. These "deaths of despair" are large factors at play in rising mortality.

Other factors are also at play. The United States has stopped making gains against heart disease, in part due to increased levels of obesity and uncontrolled hypertension. The rate of smoking is creeping back up. The number of people who report excellent or good health has gone down for all groups except the elderly and the incidence of mental health problems is up. These trends cannot be blamed on economic downturn. They began long before the Great Recession, and we do not see the same trend in the European countries hardest hit by the financial crisis of 2008.

One hypothesis is that these trends have to do with economic change combined with a weak safety net and decreasing social connections. The pillars that have supported people in their lives appear to be eroding. Marriage rates have fallen and fewer men are living with their children or playing a role in their lives. Religion has become more individualistic providing less communal bonds. Economic opportunity and a hope for a better future have vanished for most people without a college degree. The social contract between business and labor has eroded. Automation, outsourcing, and a lack of unskilled well-paying jobs contribute to this despair. Moreover, courts ruled that employees cannot band together in class action suits against their employers. Many are unable to find work that pays a living wage, and they are less likely to be able to afford to buy a home. There has been some positive movement for black Americans, however. Black kin networks and churches seem to have provided some protection against these changes.

The presentation ended with a conversation on what action steps might be taken to reverse this trend. What are the policy levers to combat a crisis of despair? There was hope expressed in the focus on income disparities and suggestions for labor and market efforts to more equitably distribute resources. It is also critical to invest in children and empower the next generation.

Session VI: The Future of Medicare

Gail R. Wilensky, Senior Fellow, Project HOPE

Wilensky introduced each of the panelists and noted that the session will center on Medicare delivery issues.

Michael Chernew, Leonard D. Schaeffer Professor of Health Care Policy, Harvard Medical School; Director of The Healthcare Markets and Regulation Lab, Harvard Medical School

Chernew discussed pathways for Medicare payment reform. He reiterated earlier findings that price is driving costs and that fee-for-service (FFS) payments and incentives fuel the system. Risk needs to be appropriately transferred to providers to promote better value, and the overall system should be accountable for cost. Efficiency requires flexibility

and the ability to substitute inputs to deliver efficient outcomes. The structure of FFS discourages flexibility of substitution and the problem is that we pay for inputs and not for outputs.

Current physician payment reform is complex and likely unsustainable. Under the current design, the average physician will not see increases in Medicare reimbursements. Chernew suggested that value-based payment could be the sugar that makes the medicine (i.e., value-based cost control) go down. An increasing number of Accountable Care Organizations (ACOs) hold promise for doing this. The Medicare ACO program saved an estimated 5%, but more importantly, created an infrastructure for flexibility and future savings. Moreover, the Medicare Advantage program has great potential, but shifting dynamics have complicated the program over time. It started out promising big savings—some of which would be used to fund additional benefits. Ultimately, add-on benefits were dropped, and arguments were made for increased funding over FFS.

Episode payments also hold great possibility and have shown 4% savings. However, there is incredible variation in the ability of systems to take value-based risk payments. The primary goal should be to move toward efficiency and away from FFS even if the savings are not as profound as predicted. It is important to continue working to improve the regulations and models to steer the system moving forward.

Mark E. Miller, Vice President of Health Care, Laura and John Arnold Foundation

Miller started by noting that there are multiple factors outside of Medicare's control that affects the program and its trajectory. This is particularly true with prescription drugs where Medicare drug spending continues to rise because decisions with respect to patents, market exclusivity, and price setting are outside Medicare's control. Drug market innovation is financed by profits, with prices justified by research and development but the evidence does not support that explanation. The supply chain also adds to cost. For instance, it is not always in the interest of PBMs to do what will benefit their clients. Within hospitals, the cost of off-patent basic drugs is rising, which is a problem that needs to be addressed by developing more competitors or directly restraining prices. Without intervention, these problems are likely to increase over time with even greater challenges on the horizon as the use of more expensive biologics grows.

Miller suggested that we reformulate support for drug innovation. This can be done in multiple ways, including finding alternative methods to fund innovation (e.g., NIH funding, tax credits), reexamining intellectual property rights, and developing value-based pricing. It is also critical that patent law and potential abuses of exclusivity terms are reviewed and revised. For instance, the *pay for delay* bill that almost passed Congress recently would have reduced the power of industry to maintain high prices. States are important to the drug price control process and they are looking at ways to control drug costs. Miller also thought that examining state laws around generic and biosimilar substitution was important. Miller agreed with Chernew that Medicare and Medicaid need to move more expeditiously toward payment reforms that incentivize efficiency.

Miller then discussed the impact of vertical and horizontal integration among and between hospitals and physician groups. With these consolidations, the evidence suggests that prices will increase with no changes in quality. Consolidation also makes it more difficult for insurers to negotiate price, which in turn pressures Medicare to increase payment rates. Medicare costs are also increasing because patients are being seen in more expensive settings, like hospitals and emergency rooms, instead of the physician's office. Areas for reform include movements toward site-neutral payments and learning from state experimentation such as laws that limit out-of-network billing. Finally, Miller stated that we need to think through a public option insurance possibility, which has the potential to take people out of the current, high price commercial options and move them to options that incorporate lower pricing structures.

Paul N. Van de Water, Senior Fellow, Center on Budget and Policy Priorities

Van de Water noted that one of our biggest challenges is to fill the gaps in the Medicare benefit package and provide strengthened protections for all low and middle-income beneficiaries. We spend more of our GDP on health care, and still, do not cover everyone and are left with considerable gaps in quality. For instance, the Medicare program lacks dental, hearing, and vision coverage and the traditional Medicare program does not provide catastrophic coverage.

The traditional program and Medicare Advantage should be operating on a level playing field. The traditional program is available throughout the country, with wide provider choice and well-established cost structure. Medicare Advantage provides a choice of plan design and care coordination. Some Advantage plans are overpaid, however. Measuring and paying for quality remains a major challenge and there is a need to facilitate better competition between the two Medicare options. Currently, there is little competition and switching between the options—in part due to inertia and the complication of switching.

Another movement, Medicare for All, looks to leverage Medicare and expand it. Van de Water expressed concern that this could subsume the existing Medicare program, which might result in lower payment rates across the system and potential unintended consequences. Medicare is in a difficult place. On one side, the program is facing fiscal pressure and issues with the Trust Fund and on the other end, a battleground for those seeking to expand the program and advocates arguing for drastic "savings" and cuts.

Discussion

Concerns were expressed about the value of mergers and acquisitions and the ability to further reduce Medicare reimbursements, which are already considerably lower than private payers. Spending is about demographics, and even if ACOs yield cost savings for the program, demographics will likely still lead to considerable program growth. Skepticism about bundled payments, which may have the unintended consequences of protecting high-cost specialties, was also voiced in the discussion.

The panelists stressed that the problem with Medicare is not the lack of innovation, but the patience to test the various models. Some believe that creating a public option based on Medicare and its price structure will lead to more affordable options and spark competition. Several people suggested looking to the states for innovation in cost, particularly while the federal government appears to be in gridlock. Other comments suggested building a better balance between traditional Medicare and Advantage options.

One question posed noted the potential for Medicare to use its purchasing power to negotiate lower prices. The response was that ACOs offer opportunities for savings. However, it was acknowledged that only a small portion of Medicare providers are put at risk, even in Medicare ACOs. Chernew stated that what matters is managerial mechanisms and that this could still be desirable even with underlying FFS payments. He pointed to the many changes included in the ACA that are still in process and need to be tested. Instead of 6000 different models, he argued that a few select innovations should be provided with the time and opportunity to work.

Altman shared a concern that with the various discussions on expanding Medicare, and Medicare Advantage growth, these trends may leave to the program's inability to meet the goals established in 1965. For instance, there may be limited access to physicians and hospitals. He also mentioned a concern about the gap between private payment rates and Medicare. Moreover, MACRA does not provide a real increase for physicians, and this is likely to become a significant concern down the road. Concierge medicine and providers choosing to take or not take Medicare payments could become a real problem, he commented. The final warning of the panel was that if we are not careful, we could overleverage Medicare and, in the process, ruin it.

Session VII: Addressing the Social Determinants of Health: Is there an Economic Case to be Made?

Audrey Shelto, President, Blue Cross Blue Shield of Massachusetts Foundation

Shelto noted steady progress in discussing the importance of the social determinants of health. The need is to now move beyond discussing the issue and making the case for identifying and implementing evidence-based interventions. In this process, it is essential to consider the potential economic benefits of addressing social determinants of health.

Shelto provided two examples of success. First, a community health center in Springfield, MA partnered with a local housing organization to mitigate asthma triggers in the home. With an average cost of $1,400 per family/home intervention, it appeared to be a cost-effective way to prevent emergency room visits and hospitalizations. A second example discussed a medically specific meals program versus traditional Meals on Wheels deliveries to dual eligible Medicare and Medicaid recipients. The focus of this program was on addressing food insecurity and repeat emergency room visits among an elderly dual eligible population. The results supported statistically significant differences in using medically designed meals to address food insecurity and reduce emergency visits. Through examples like these, Shelto reported, there is growing support for both health and economic benefits to addressing social determinants of health.

Romana Hasnain-Wynia, Chief Research Officer, Denver Health

Hasnain-Wynia asked what role should the health system play in addressing social determinants of health? The CMS evaluation of ACOs will be helpful in seeing how health systems can shape and address social determinants, she stated, but this is only one piece of the issue. Many people still question whether social determinants should be the role of the medical system. The economic and health benefits are obvious, but payment models for addressing social determinants are unclear to health care systems and hospitals. Issues like childcare, homelessness, and poverty can seem like bottomless pits of need, and it is unclear how money should be diverted from direct medical care to address social needs like these. Hasnain-Wynia argued, however, that if medical systems and hospitals hope to improve overall health outcomes within their populations, they must help address social determinants.

Every provider understands that patient care is impacted by food insecurity, housing instability, and poverty. This can be overwhelming for providers, and success requires offering support and direction. Hasnain-Wynia suggested that as we move to models of shared decision-making and empower patients to be active decision makers in their health care, social needs are often at the forefront of what is most important to them.

The challenging question Hasnain-Wynia suggests is—should the health care system be tasked with addressing social determinants? It is not an effective system and there is tremendous waste. Currently, we spend significantly more money on health care than on other social services, and this money could be more efficiently used to achieve better health outcomes for patients by addressing social determinants. Other service sectors in our society do not have the same level of resources that the health care sector has. Moreover, in the current political environment, the resources in the health care sector may be the only resources available to fill necessary gap areas. Partnerships between the health care system and other service sectors will be necessary. Hasnain-Wynia concluded her remarks with the idea that more evidence is needed for knowing where and how best to intervene; we are, hopefully, getting closer to figuring this out.

Allison Bovell-Ammon, Deputy Director of Policy, Children's HealthWatch

Bovell-Ammon described the work of Children's HealthWatch, a research network committed to improving the health of young children and their families by informing policies that address and alleviate economic hardships, including housing instability. She reported that families with housing instability move frequently, are often behind on rent or mortgage, may be doubled up with friends/families, and often spend time in shelters or even on the streets. The lack of affordable housing exists across the country and carries with it numerous health risks.

Like in the health care system, the top 5% of the most housing insecure individuals account for a majority of public resources. These individuals and families are chronically homeless. The Boston Medical Center looked at the top 3% of high utilizers of health care services and found that most were homeless, and 80% had mental health comorbidities. To address the needs of these patients, they put together a care team, which also included a housing specialist. In the first three months, the program participants significantly decreased emergency room use. More information will be available from the program evaluation, which includes a comparable control group, but the early data is extremely positive. Bovell-Ammon ended with the idea that more work needs to be done upstream to assist people who are at-risk of homelessness before they become high-cost utilizers to the system.

Sandra L. McGinnis, Senior Research Scientist, Center for Human Services Research, University at Albany

McGinnis spoke about the evaluation of using Medicaid funding to address housing instability for high-cost patients in New York state. This Medicaid redesign sought to use affordable housing interventions to reduce costs by improving recipient health. Once again, a small group of beneficiaries—approximately 5%—are responsible for 50% of health care costs for New York Medicaid. The idea of this program is to provide affordable housing to select beneficiaries, paired with supports such as case management, with an overall goal of reducing emergency room visits, long-term care services, and hospital admissions. In partnership with seven state agencies, the focus was on individuals who were homeless or in unstable housing situations. It served 20,000 people across 20 programs and was delivered by over 120 community providers. Participants had complex needs—a large percentage with behavioral health comorbidities, multiple complex medical programs, and other risk factors.

The initiative was evaluated using mixed methods and examined implementation, targeting, outcomes, cost, and access. Evaluators examined pre-period utilization and found high uses of the emergency room (60% with at least one visit) and inpatient stays (44% with at least one inpatient stay). The intervention decreased these visits significantly. Pharmacy, transportation, and case management utilization and costs increased, but everything else decreased. In the post period, emergency room visits dropped by 18% and inpatient visits by 12%. While this research is preliminary, and more time is necessary to better understand important components (e.g., impact of specific interventions, understanding costs, adding in comparison group), the early findings are promising.

Discussion

The discussion demonstrated strong backing for the need to support population health and affordable housing. However, there were also concerns that the health care system not be used as a piggy bank for larger societal ills. The New York Medicaid intervention was highlighted as a targeted waiver program with great promise for replication. Some in the audience supported the idea of upstream solutions and the need to think geographically about communities and policies that create substantial returns on investment. Medical care is on the individual level, but it is critical that we begin to think about how to use the health care system on household and community levels.

A series of comments focused on the need for better coordination of health and social services. The lack of coordination leads to re-traumatizing homeless and other disadvantaged people as they are forced to retell their story and situation multiple times. Terry Fulmer, from the John A. Hartford Foundation, suggested the need for age-friendly housing and age-friendly health care system and detailed some of the work they are involved with.

Richard Besser, RWJF President and CEO, noted that none of the presentations discussed structural racism and disparities. He asserted that in supportive housing studies, it is critical to look at how different groups are treated. Are services provided in a culturally relevant manner? Social determinants and health equity are intertwined, and systemic injustice has played out in the housing system for a long time. He went on to discuss the community strength and resilience that is needed to effectively intervene in this arena.

Session VIII: U.S. Pathways for Achieving Universal Coverage

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

Hernández started the panel by noting that the United States has been arguing about universal health care for over a century. During this time, the real dilemma continues to be about how best to get there. Other countries took distinct paths toward universal coverage, but in the United States, the body politic seeks something that is simpler, universal, affordable, and uniquely American. While the federal government has been indecisive on the issue, the states are beginning to act through ballot initiatives and other measures.

David Blumenthal, MD, President, The Commonwealth Fund

Blumenthal provided historical background on the issue of universal care. He noted that the Nixon plan was one of the most creative and would have gotten the country closest to universal coverage. Blumenthal identified three roads to universal coverage and provided country examples of each: single payer coverage (e.g., United Kingdom), regulated private health coverage (e.g., the Netherlands), and mixed public-private coverage (e.g., France).

The United Kingdom, ranked number one in the Commonwealth Fund's ranking, spends 9.7% of GDP for comprehensive care with no payment at the point of service. All residents receive care, and the system is financed through taxes and pays providers directly. The Netherlands, ranked second, spends 10.5% of GDP and the system is organized by competing private health insurance companies. The government defines the set of benefits, with cost-sharing for certain services. All residents are required to have insurance unless they qualify for an exemption. People pay premiums for regulated private coverage and the insurance companies pay the providers directly. France, ranked 10th, spends 11% of GDP and operates a mixed system of public and private insurance. The public plan provides a wide range of services with some cost sharing, and voluntary private insurance fills in the gaps. Government finances non-profit funds that pay providers and most people also buy a supplemental private insurance plan. Private insurance accounts for about 14% of coverage.

Amy Downs, Vice President, Colorado Health Institute

Downs described the Colorado experience from the Colorado Health Institute perspective, which provides evidence-based analysis in political context. She said that recent movements toward universal care began with a constitutional amendment on the ballot in 2016 that would have created Colorado Care, a system of universal coverage. The measure did not pass, however. The law would have created an independent cooperative with a 10% payroll tax. While it would have required a waiver to bring Medicaid funds into the system, it would not have initially included Medicare. The measure would have covered all people, including those without documentation. Private insurance

would still have been legal to fill in gap areas, however. The analysis of the plan, which was estimated to save $5.3 billion, showed that it would have led to greater administrative efficiencies and lower prices overall.

While the program would have initially been financed by the payroll tax, because of the annual health care cost growth, more resources would have been necessary down the road. Cost and taxes were huge obstacles. Additionally, there were also concerns that if reimbursements were too low, providers might leave the state, the oversight board could be too strong, employers might invest in other states, and that individuals with high health needs would flock to Colorado.

Ultimately, the uncertainty over the taxes and unresolved questions led to the initiative's defeat by a wide margin (79% to 21%). While this defeat has quieted the universal coverage movement, for the time being, there is a Governor's race in November 2018, which has the potential to reignite the discussion. Public support for universal coverage remains high in the state. However, like national public support, public opinion often erodes quickly when conversations of financing and implementation play out for universal coverage.

Chris Hoene, Executive Director, California Budget and Policy Center

Hoene began by discussing progress made in California under the ACA where California reduced the number of uninsured in the state from almost 19% down to 6.8%. Currently, Medi-Cal, the state's Medicaid program, covers 13 million Californians and Cover California, the state's marketplace has 11 plans providing coverage to 5 million people who previously did not have health insurance. A challenge for the state is how to cover those that remain uninsured (6.8%), half of which are undocumented adults. Additionally, there is still considerable uncertainty over marketplace policy and potential changes from Washington, D.C. Federal funds account for more than one-third of California's state budget, and if there were a reduced federal contribution, this could gravely impact the overall system.

Meanwhile, there is still strong political support in California for a single payer system, although tension exists between moderate and more progressive Democrats surrounding this issue. The nurse's union was a leading force in pushing for single payer in the recent election, but their bill lacked an adequate financing mechanism. In 2017, single-payer legislation passed in the State Senate only to be tabled in the Assembly, but a commission was convened to look at pathways toward universal coverage. The major problem is financing. At the outset, a single payer system in California would require an additional $100 billion, although this could be potentially offset by efficiency in the long run. To put this in perspective, the total state budget is under $200 billion and while the upfront costs are real, how long it would take to realize efficiency gains is unknown.

One option would be for the counties to roll out a plan. Counties in the state are already responsible for running the state's Medicaid program. Any funding mechanism, however, would require state revenue and spending limit changes in the state constitution, and constitutional changes require a ballot measure. This funding could quickly dwarf the percentage of budget spent on other priorities like education and transportation. While there is still a lot going on in the state surrounding this issue, there are not currently any legislative pathways for the issue in 2018. Activists, however, are looking ahead to 2020.

Discussion

Questions were asked about the various pathways toward universal coverage, including expanding the ACA and/or creating new systems. Three principles were identified as necessary for progress toward a system of universal coverage. First, there needs to be an extended transition/crosswalk from the current system. Second, a financing mechanism and revenue plan must be in place before taking the measure to voters. Finally, there should be a gradual phase-in of the new system. Moreover, it is critically important that the voters weigh in throughout the whole process.

The panel suggested that governor races might provide other policy avenues for movement. For instance, Lieutenant Governor Gavin Newsom, the current frontrunner in California's election, endorses universal coverage. Furthermore, there are resources in the system that could be leveraged for further reform. A UCLA study in 2016 found that 71% of all spending is in some form of government spending and the state reform commission is also looking at cost containment measures (similar to what is going on in Massachusetts).

The discussion moved to the tradeoffs between public funding for health care and other priorities. In Colorado, there was a strong belief that new revenue was necessary for major health reform. California's measure did not include a financing mechanism, however, which may be one reason why it only passed through one of the legislative chambers. If a financing mechanism were included, it would have likely faced substantial opposition from anti-tax groups.

If roads to universal coverage are built off the ACA, what might be the best steps forward? The panel suggested that cost control needs to be a priority. Furthermore, there needs to be a coverage pathway for people without documentation to help stabilize marketplaces. The Commonwealth Foundation has modeled other potential steps for building off the ACA. See www.commonwealthfund.org/ for more information.

Another topic of interest was the interplay between health care reform and the overall economy. Does health reform create or kill jobs? In California, health care spending stimulated the economy and ACA expansion created jobs. Universal coverage, however, also provides a pressure to control costs. Another question considered the role of employers. Employers opposed Colorado Care and supported current ERISA provisions exempting self-insured employers from state regulation. The panel responded that while employers complain about health care costs, they also do not tend to favor government takeover of health care, in part, because they like that idea that the benefit creates employee loyalty. The session ended under a theme of complexity and competing needs and pressure regarding U.S. pathways toward universal care.

Closing Remarks

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

Altman closed the 25th Princeton Conference by remarking on themes from the final session, and methods for improving the ACA. He noted that while there was incredible uncertainty during past year conference planning surrounding whether the ACA would even continue, he has high hopes that this will be a large focus area for the 26th Princeton Conference. Altman discussed highlights from the 8 sessions, the Washington Update, and the two dinners. He again pointed out the extraordinary work, accomplishments, and life of Uwe Reinhardt. The problems are very real and persistent though, and it is important that we steadily move forward in our efforts. This should all lead to interesting conversations for next year's conference. Altman ended the conference with another thank you to the sponsors, speakers, and attendees for making the 25th Princeton Conference a successful event.