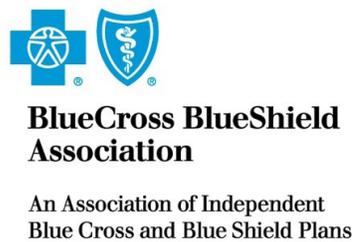


High and Rising Costs of Health Care in the U.S.

The Challenge: Changing the Trajectory



Alliance for Health Reform 20th Anniversary Series Sponsors



20th Anniversary Series

From April through July 2012, the Alliance for Health Reform hosted a series of briefings focused on the key drivers of the high and rising costs of health care and what can be done to control health care costs. These briefings, held at The Kaiser Family Foundation's Barbara Jordan Conference Center in Washington, D.C., were moderated by Susan Dentzer, editor-in-chief of Health Affairs, and involved many of the country's leading stakeholders, health care economists and thinkers in the field of health care policy. The briefings were:

- **Session 1: Health Care Costs: The Role of Prices and Volume.** This session framed the country's health care cost problem and identified the many factors driving health care costs, exploring, in depth, two key factors: health care prices, and the volume and intensity of services delivered.
- **Session 2: Health Care Costs: The Role of Technology and Chronic Conditions.** This session involved examining the role of technology and of chronic conditions in driving health care costs.
- **Session 3: The High and Rising Costs of Health Care: What Can Be Done?** While solutions were discussed in sessions 1 and 2, this session focused squarely on what is working, how successes can be expanded, and what other avenues might be pursued.

Key themes from the series of briefings are summarized below. The complete webcast of each session along with the agendas, presentation materials, and additional resources can be found at the Alliance for Health Reform's website at: http://www.allhealth.org/briefings_summary_prev.asp.

Overview

At 18 percent of America's economy and growing 2 percent faster than Gross Domestic Product, both the level and rate of growth of national health care spending are seen as alarming. While this isn't a new problem, the amount of spending on health care, combined with the country's fiscal challenges, makes the need to contain health care costs a national priority requiring a sense of urgency. High health care spending is exacerbating the government's strained fiscal situation and is hurting the standard of living for many Americans.

There are many key drivers of America's high and rising health care costs. Among them are medical technologies; growth in the number of individuals with and the treatment prevalence of chronic diseases; a fee-for-service payment system that incentivizes volume and doesn't encourage or reward coordination, integration, or management of health care delivery; the high price and high intensity of care; lack of patient engagement; and lack of evidence on the relative effectiveness of various treatment options.

Controlling costs requires decreasing waste; reforming the payment system to change incentives; changing the delivery system to improve coordination and integration; managing costly patients with chronic diseases differently; engaging patients and families in shared decision making, particularly at the end of life; and many other discrete activities.

The good news is that many activities already are underway. These include initiatives by the federal government, by state governments, by private payers, and by local communities. There are numerous pilots underway, multiple successful initiatives taking place, and a great deal of positive momentum. In addition to pushing for payment and delivery system reform, among the key challenges is spreading what works.

Controlling costs while reinventing the health care system is a never-ending pursuit that requires collaboration among all of health care's key stakeholders.

The Problem

In framing this series of briefings, Ed Howard, executive vice president of the Alliance for Health Reform, said that the problem of high and rising health care costs isn't new. He read from a 1932 report from the Committee on Costs that stated, "Many persons do not receive service which is adequate either in quantity or quality, and the costs of service are inequally distributed. The result is a tremendous amount of preventable physical pain and mental anguish, needless deaths, economic inefficiency, and social waste."

Progress Has Been Made

Much progress has clearly been made since 1932. Kenneth Thorpe explained that between 1940 and 1990, the uninsured portion of the U.S. population declined from 90 percent to 15 percent, Medicare and Medicaid were launched, and numerous new technologies and treatment innovations were developed. As a result of countless new technologies,

there has been a significant increase in the treatment prevalence for diseases such as diabetes, hypertension, arthritis, and cancer.

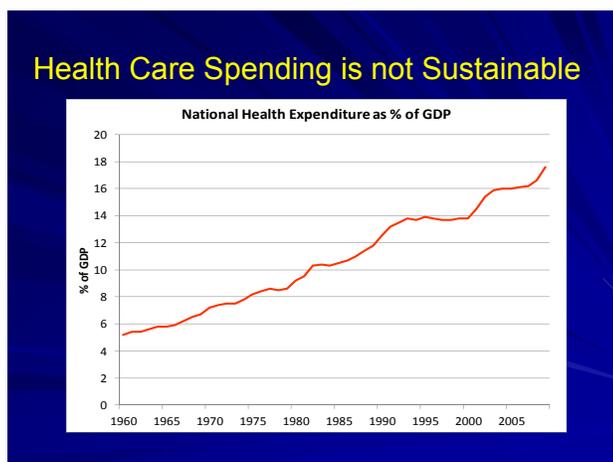
Joseph Newhouse pointed out that just since 1970, life expectancy in the United States has increased from 70.8 to 78.2 years. Jim Fasules of the American College of Cardiology said that in just the past decade there has been about a 30 percent decrease in mortality from cardiac diseases, likely as a result of treatment. And Gerry Shea of the AFL-CIO stated that a sea change has occurred in health care delivery with its current focus on quality, including measurement of quality, changing care delivery based on quality and even increasingly linking payment to quality measures—something that previously would have been unthinkable.

The Costs of Health Care in America Are Unsustainable

While the benefits of improved health care are significant, the costs of health care are immense.

Michael Chernew shared data showing that in 1960, national health expenditures represented around 5 percent of U.S. GDP, and now account for about 18 percent of national GDP. In addition, as Paul Ginsburg stated, the trend for health care spending is growth of 2 percent greater than GDP growth. Multiple presenters and respondents termed the current cost situation unsustainable for all stakeholders: the federal government, state governments, private health plans, employers, and consumers.

Dr. Ginsburg said that because of the major fiscal challenges faced by the federal government and state governments, “There is an urgency for cost containment.”



Source: Michael Chernew

“Any way you look at it, private and public payers have a hard time financing the projected rates of growth [in health care spending].”

– Michael Chernew

Increased Costs Have Significant Consequences

The high amount of spending on health care and the rate of growth of such expenditures have significant potential consequences, some panelists said. Among the consequences they listed are:

- **Higher taxes.** If public health care spending is financed by taxes, marginal tax rates for high-income earners could rise to 70 percent by 2060.
- **Lower GDP.** High health care expenditures and taxes could cause GDP to decline (related to trend) by 11 percent.
- **Decreased employment.** Helen Darling of the National Business Group on Health said private spending on health care is unsustainable. As a result of health care costs, which increase the cost of labor, as well as the impact of the Great Recession, many large employers are not creating jobs. Over the past five years, many firms have reduced headcount and decreased hours. She noted that health care costs are not the only factor driving this trend, but are a major factor.
- **A lower standard of living.** In the 1940s, about 5 percent of per capita income growth was devoted to health care; the other 95 percent could be devoted elsewhere. Even in the 1980s, about 25 percent of income growth went to health care. But from 2000 to 2009, more than 90 percent of “our increase in wealth went to health care,” Michael Chernew said.

Employers have held down wages, decreased coverage, dropped coverage altogether, and/or shifted a greater portion of health care costs to employees. This has affected and will continue to affect the standard of living of Americans.

“The real problem is a living standards problem.”

– Henry Aaron

Why Health Care Costs Are High and Rising

Dr. Chernew defined total national spending as simply a function of price (P) times quantity (Q). Growth in total cost comes from growth of P and/or Q, and controlling costs requires controlling P and/or Q. He said the United States actually has two problems:

1. The **level** of health care spending. This is the total amount of spending on health care at a point in time. Compared to other developed countries, the level of spending by the United States is much higher.
2. The **rate of growth** of health care spending. While the rate of growth of U.S. health care spending is comparable with the rate of growth in other countries, it is a serious problem because the rate of growth of health care spending continues to significantly outpace the rate of GDP growth. Also, this growth is based on an already high level of spending. Dr. Chernew sees the rate of growth as the more significant problem.

Which Should the United States Focus On?

In addressing health care costs, participants debated whether the focus should be on reducing the level of spending or the rate of growth.

- **The argument for level of spending.** Ms. Darling emphasized that it has been repeatedly documented that 20 percent to 30 percent of all health care spending is wasteful, harmful, or risky. She felt strongly that efforts should focus on reducing the level of spending by reducing waste, and not just accepting the current level of spending and focusing on controlling the rate of growth.

“We would like to be sure that every conversation starts with reducing the base and also worrying about growing spending; not just talking about growth. It’s not just about growth.”

– Helen Darling

- **The argument for rate of growth.** The majority of speakers and reactors felt that focusing on the rate of growth is more important. Reducing the level—while important—was viewed as a one-time action that might buy time, but isn’t a long-term solution. Even if the level is reduced, if the rate of growth isn’t addressed, costs will eventually become unsustainable. Stuart Guterman said, “A high growth rate eventually leads to a high level.”

“If we don’t change the slope [the rate of growth], we’ll not have corrected anything.”

– Gail Wilensky

Several participants, including Henry Aaron, stressed that attention needs to be focused on decreasing both the level and the rate of growth of health care spending. Dr. Ginsburg commented that the rate of growth is the sum total of changes in levels of all different services. Slowing the rate of growth involves making many discrete changes in levels.

“What is the rate of growth? It’s the sum total of changes in levels of all the different services and their prices, and we summarize it. If we’re going to slow the rate of growth, it’s going to involve many discrete changes in levels.”

– Paul Ginsburg

Drivers of High and Rising Costs

Beyond the basic concept of price and quantity, speakers, respondents, and participants offered several factors responsible for high and rising health care costs. Among them are:

- **Intensity of care.** Gail Wilensky sees the intensity of care as a major driver of cost. While the United States has shorter lengths of stay in hospitals than in other countries, and Americans see physicians less frequently, when an individual does have an encounter with a hospital or physician, the system “goes gangbuster.”
- **Lack of coordination.** The fragmented, uncoordinated delivery system has been comprised of silos, which has increased costs and inefficiency. The historic fee-for-service payment system has not provided any incentive to improve coordination. The lack of coordination has both driven up costs and hurt the quality of care delivered.

One example where coordination has been lacking, provided by Melanie Bella, is for the nine million dual eligibles, who participate in both Medicare and Medicaid. These individuals tend to have multiple chronic conditions (55 percent have 3 or more) and tend to be high-cost, high users of technology. The fragmented, uncoordinated payment and delivery systems exacerbate the costs through inefficiencies, including duplication of service.

“The major areas where we have problems right now in the payment system are in places where we are paying for things but we are inadequately managing the service use.”

– Dan Mendelson

- **Lack of management.** Dan Mendelson sees price times quantity as an incomplete, inadequate framework that perpetuates providers acting in silos. An alternative framework is to look at how patient care is managed (or not managed at all). He believes major cost issues arise when service use is not adequately managed. An example is the transition between acute and post-acute care for a Medicare fee-for-service patient, which is unmanaged.
- **Provider incentives.** The reason that intensity of care, lack of management and medical technology have increased cost is that providers—who direct treatment decisions—have been incentivized to deliver more care, particularly in a fee-for-service environment. Combined with defensive medicine, misaligned incentives have resulted in unnecessary care and overuse.
- **Medical technology.** There was consensus that medical technology is a major driver of increased cost. Technology in health care is defined not just as medical equipment, devices, and drugs, but as new medical knowledge. Important technological innovations have included lab tests and x-rays (in the 1950s and 1960s), Coronary Artery Bypass Grafting (CABG), C-sections, and chemotherapy (in the 1970s), new pharmaceuticals (in the 1990s), and imaging and biologics (in the 2000s). Other technological innovations—which have come at a significant cost—include computerized tomography (CT) functional imaging with positron emission tomography scans (PET), surgery robots, treated stents, and harmonic (ultrasonic) scalpels. Technology also includes major investments by providers in health information technology, such as electronic medical records and new clinical decision support systems.

“It’s the growth in technology that’s been differentially applied to groups; that’s what’s really driving spending growth. . . . There’s just more stuff we do.”

– Michael Chertow

Joe Antos described how technology has resulted in better care, using cataract procedures as an example: What was a primitive and painful procedure for hundreds of years became an inpatient procedure in the 1960s with a long recuperation period, followed by what is now a safe, effective outpatient procedure.

Kenneth Thorpe estimates that about 60 percent of the growth in health care spending from 1987 to 2008 is linked to increases in treated prevalence of certain conditions. Treated prevalence increased as the clinical incidence increased for some diseases (like diabetes), but also because new treatments were developed, and have become widely used, for conditions such as hyperlipemia, hypertension, and mental disorders.

- **Chronic diseases.** Several speakers described how 5 percent of patients represent around half of costs and 20 percent of patients account for 80 percent of costs. Kenneth Thorpe said that five chronic conditions are key drivers of Medicare spending growth, accounting for about one-third of growth since 1987. These conditions are: diabetes (8 percent of growth); arthritis (7 percent); kidney disease (6 percent); hypertension (6 percent); and mental disorders (5 percent).

The obesity epidemic also contributes to cost growth, speakers said. The Congressional Budget Office has estimated that 8 percent of the rise in health care spending since 1987 is attributable to obesity. Obese workers spend about 40 percent more on health care than normal weight adults and the lifetime costs of obese Medicare beneficiaries are 20 percent to 40 percent more. As the obese population increases, they projected, costs will continue to rise.

“We have an epidemic going on in terms of chronic conditions. It is a system-wide problem, but it’s particularly a problem in Medicare.”

– John Rother

- **Unhealthy consumer behaviors.** John Rother pointed out that consumers are constantly engaging in unhealthy behaviors—in addition to poor diets and exercise—that increase the use of health care services. This includes smoking, using alcohol and drugs, not wearing seatbelts, and having poor dental health habits. By changing behaviors, expenditures from the treatment of resultant chronic diseases could be prevented.

- **Lack of patient engagement.** In many instances, particularly at the end of life, patients and family members are often not engaged in shared decision making with their care provider. Providers may not do a good job of asking or understanding what individuals really want, which is often not more tests and procedures. As a result, services are rendered and costs are incurred while not providing the care and comfort that patients actually want.
- **Thinking medically, not functionally.** Providers often view patients only in medical terms, seeing a patient based on his or her disease and treatments. An individual usually thinks about his or her daily life and how to have an independent, dignified existence rather than about medical interventions. Bruce Chernof stressed that a medical approach can lead to excessive costs and inappropriate care versus thinking about individuals functionally.

“Functional [impairment] is a really important cost driver in the lives of those with chronic illness, regardless of the number of chronic conditions that they have.”

– Bruce Chernof

- **Medical education.** Former American Medical Association President Nancy Dickey said that medical education teaches new physicians how to use various medical technologies, but fails to teach when to use these technologies—and when not to use them. She views the focus of medical education as driven by the historical incentives and culture of health care. Changing the education and behavior of new physicians requires changing the incentives so that doctors will know not just how to use new medical technologies but when and when not to use them.
- **Lack of evidence.** A driver of increased costs is a shortage of evidence regarding which technologies and interventions are effective and provide value. While the basic concept of generating evidence through comparative effectiveness research is appealing, Joe Antos argued that: effectiveness is not the same as value; research can’t move fast enough to keep pace with continual change; research at best reflects average patients and providers, not real-world situations with significant variation; and often glamorous drugs and devices get attention before other, perhaps simpler and cheaper methods. For these reasons, he sees lack of evidence contributing to increased costs and doesn’t see effectiveness research as a real solution.

“Effectiveness research is not enough. It is unlikely to have real impact on how we spend the money.”

– Joseph Antos

Other drivers of cost that were mentioned were prices, the aging population, the case mix (with sicker patients in hospitals), an increased administrative and regulatory burden, rising incomes, and more generous insurance coverage.

Additionally, in April 2012 the Alliance for Health Reform commissioned an issue brief entitled *Cost Drivers in Health Care*, by Jack Ebeler. It presents the factors within three broad categories, recognizing that it is the interactions that are critical and that any categorization is dependent on judgments about placement.

Key Elements of Addressing Health Care Costs

Just as the increase in the level and rate of growth of health care costs is based on multiple factors, several concepts were presented as ideas to better control health care costs. Many of these ideas aim to address specific drivers of health care costs.

- **Use payment reform to change incentives and drive delivery reform.** The idea mentioned in all sessions by numerous speakers was the need for payment reform to change provider incentives. Bundled payments, global payment and capitation, and ACOs with shared savings are among the payment methods mentioned. The theory is that altered incentives—with payment linked to quality—will cause providers to reinvent and redesign the delivery of health care, increase coordination and integration, and deliver care as teams. Payment reform was seen as necessary and was supported by virtually all speakers.

“Payment reform is a means. The end is better care through delivery reform.”

– Andrew Dreyfus

- **Decrease waste.** To reduce the level of health care spending, a key step is to reduce the amount of waste and services that are provided that have indeterminate value.
- **Impose a budget constraint.** Henry Aaron and Stuart Butler see need for a firm overall budget for health care spending, which Aaron referred to as “brute force.”

Respondents Andrew Dreyfus and Dan Mendelson see an integrated delivery system with budgets set at an appropriate level for groups of patients and physicians as a preferred approach.

- **Expand the use of HIT and data.** For payment reform to work at driving greater coordination and integration, providers must have an interoperable health information technology infrastructure with patient information and clinical decision support tools to help them make evidence-based decisions. Also, data mining is needed both to identify and target specific patients and to better understand the situation and care needs of patients.
- **Think of and manage different groups of patients differently.** Diane Rowland described the importance of identifying different sub-groups and then treating these groups differently. She explained that the costliest 10 percent of Medicare beneficiaries are different from the costliest 10 percent of Medicaid beneficiaries. The costs of these Medicare beneficiaries are driven by acute episodes, while the high costs for Medicaid beneficiaries come from long-term care in nursing facilities. This shows that even though people are termed chronically ill and high cost, different approaches are required for different groups.

“We found that the top 10 percent [most costly] Medicaid and Medicare beneficiaries are different people. Sub-group analysis is key.”

– Diane Rowland

- **Increase the role of primary care.** Several speakers mentioned the importance of primary care and of patient-centered medical homes that help coordinate care. Importantly, in determining the services provided, medical care is not the only consideration, they said, noting that the most appropriate care might focus on functionality and consist of various social services.
- **Better incentivize, engage, and listen to patients.** Health care providers need to better engage and listen to patients to understand what they want and involve them in decisions about their care. Providers need to coordinate care across space and time, understanding that patient preferences often change with age and gravity of illness. In many situations, especially at the end of life, individuals want less intensive care, which is less costly. The word cloud (shown in next column), provided by Bruce Chernof and referenced repeatedly during the second session, shows some of what people really want—social engagement, independence and community.



Source: Bruce Chernof

“[Patient] preference needs to be part of the process. It is not part of the fee-for-service system; it needs to be part of coordination.”

– Kenneth Thorpe

Multiple tools and policies can be used to incentivize consumers to choose more efficient care, such as value-based insurance design. Employers are focused on programs that not only place greater financial responsibility on patients but also encourage employees to engage in healthier lifestyles.

- **Spend more wisely in generating evidence.** Joe Antos asked, “Can we spend better?” Among the many ways that Medicare can spend better is by using coverage with evidence development (CED), which would approve a new treatment conditioned upon developing evidence about its effectiveness. While he acknowledged that this seems like a good idea, CED is easy to phase in, but hard to phase out.
- **Increase transparency.** Jim Guest of Consumer Reports believes that tools that provide consumers with greater information about cost and quality are of great importance to inform their decision making. However, he doesn’t see consumers as the key to cost savings. Instead, transparency will allow providers to see information about other providers, which will drive change. Paul Ginsburg argued that consumers need to know the difference in out-of-pocket cost of choosing one provider over another. He also noted that consumers will choose the most expensive provider if the cost differential does not come out of their pockets.

- **Continue to use pilots and demonstrations and expand successes more quickly.** Several speakers emphasized the importance of pilots. Paul Ginsburg said that current pilots are important because they are much larger in scale than has previously been the case; they refine approaches to payment; they engage provider leaders; and they point a direction for future payment to the provider and payer community. However, one challenge of pilots is transitioning from temporary pilots where participation is voluntary to permanent programs that are implemented on a widespread basis. Gail Wilensky commented that CMS's history in replicating and expanding successful pilots is not great.
- **Place greater importance on prevention.** Society has chosen to allocate significant resources to diagnosis and treatment of disease and caring for individuals at the end of life, often with intensive technology-driven interventions. In contrast, relatively few resources are devoted to disease prevention and health promotion, even though many prevention programs have demonstrated excellent results and positive returns. Several speakers felt strongly that part of lowering costs entails allocating more resources to prevention.
- **Build trust and cooperation among the stakeholders in health care.** In Scott Serota's view, payment reform, coordination, integration, and better aligned incentives won't occur without first having trust, leadership, collaboration, integrity, and innovation.

Efforts Underway to Control Costs

Most speakers and presenters were in general agreement about what needs to be done. The key question is how to do it. Susan Dentzer said, "There is much in the performance improvement tool box." Questions included how to prioritize the tools that exist and how to spread what is working.

Acting CMS Administrator Marilyn Tavenner described several ways that CMS is focused on using money more wisely. These activities include:

- Elevating the experience for beneficiaries.
- Incenting care that is less fragmented and more coordinated, and that results in a decrease in unnecessary services. This includes using the ACO model, bundling payments, penalizing readmissions, and better managing transitions.
- Emphasizing strong primary care.
- Focusing on prevention and wellness.

- Correcting spending distortions and keeping per beneficiary cost growth low.
- Piloting improved coordination for dual eligibles.
- Paying for quality, which entails aligning the many measures of quality.
- Taking advantage of the wealth of data held by CMS. CMS is working to modernize its approach to storing, analyzing, and disseminating data. CMS has established a "data shop" and plans to use data to decrease costs.

Other activities that speakers, respondents, and participants described that could make a difference in controlling costs include:

- **Federal programs as part of the health reform law.** Ms. Tavenner mentioned bundled payments, focus on primary care, and ACOs. In addition, Karen Davis indicated that already underway, due to the Patient Protection and Affordable Care Act (ACA), are value-based purchasing; efforts to provide more transparency on quality and cost; and "meaningful use" of HIT.
- **Various Medicaid/state government innovations.** Karen Davis also mentioned numerous Medicaid/state government initiatives in states such as North Carolina, Vermont, Montana, Missouri, Illinois, and Indiana. These innovations are targeting high-cost Medicaid patients with innovations such as teams of providers sometimes including community health workers. These programs are already producing positive results.

State action is also being taken in Michigan, Massachusetts, and Washington to improve care transitions and reduce rehospitalizations through closer coordination between hospitals and subsequent providers. Federal efforts also are taking place to reduce rehospitalizations by improving nursing home care through enhanced on-site services and supports to nursing facility residents.

"There is lots of evidence that things are working."

– Karen Davis

- **Patient-centered medical homes.** Early evidence from multiple patient-centered medical home (PCMH) initiatives is encouraging. The PCMHs have shown fewer ER visits, fewer hospital admissions, and lower total costs. Anne Weiss described how successful patient-centered medical home initiatives are being developed at the local level. Among those she mentioned was a PCMH program in Cincinnati that began small, at a grassroots level, and

grew to include more practices. Patient-centered medical homes can start small and locally, and still be extremely successful.

- **Choosing Wisely campaign.** Several speakers and participants hailed the new Choosing Wisely campaign that involves nine specialty societies (including the American College of Cardiology) as well as Consumer Reports. The campaign involved each specialty society designating five widely used procedures whose efficacy was questionable. That generated a great deal of media attention. The campaign encourages patients to ask questions of their physicians and choose wisely when contemplating tests to be conducted or procedures to be performed. This campaign has the potential to reduce unnecessary tests and procedures, according to speakers.
- **BlueCross BlueShield of Massachusetts' Alternative Quality Contract (AQC).** BCBSMA recognized that most of the decisions about care are made by physicians and wanted to reinvent payment in a way that physicians would embrace. The goal was to create a new payment model that drove significant changes in delivery, with better quality and cost results. The AQC is a deep partnership between the plan and physicians, according to Andrew Dreyfus. Structured as a five-year commitment, it avoids adversarial negotiations, provides adequate time to invest, and involves a significant health status adjustment. Practices are being redesigned, referral and care patterns are changing, quality is up significantly, and resource use is down.

"I think it's [AQC] a demonstration that when we work together in a collaborative way between physicians, hospitals, plan, and customers we can achieve some of the savings that seem to be so elusive."

— Andrew Dreyfus

- **Other BlueCross BlueShield Programs.** In addition to BCBSMA, BlueCross BlueShield plans around the country are undertaking medical home initiatives (in 39 states) and ACO initiatives (in 26 states). BlueCross BlueShield is providing technical assistance to providers and is sharing best practices across plans. In general, BCBS plans are following three strategies to bend the cost curve:
 - *Changing payment incentives.* At Highmark in Pennsylvania, reimbursement based on quality and outcomes has resulted in preventing 42 wrong-site surgeries, has decreased hospital-acquired infections,

and has saved \$57 million from decreased central-line infections and fewer MRSA cases, according to Scott Serota of BCBSA. BlueCross BlueShield of Michigan, with responsibility for 850,000 patients, has focused on chronic conditions. Results have included decreasing inpatient admissions by 17 percent and decreasing readmissions by 6 percent.

- *Partnering with clinicians.* Blue of California is involved in an ACO initiative involving 40,000 CalPERS members. Among this group, this plan has decreased inpatient stays of more than 20 days by more than 50 percent and has decreased readmissions by 15 percent. This has been done with no premium increase. Another success is at CareFirst in Washington, D.C. where the plan's patient-centered medical home initiative has produced costs 1.5 percent below expectations.
- *Engaging patients.* By engaging patients, Blue Distinction centers have decreased bypass readmissions by 32 percent, decreased angioplasty readmissions by 21 percent, and realized cost savings of \$2,200 to \$2,500 per procedure.

BCBS is focused on spreading what is working, developing and sharing standards with providers, and looking at institutions based on performance versus standards.

- **Pre-diabetic prevention programs.** Kenneth Thorpe described a program targeting pre-diabetic individuals which he said has been shown to decrease those becoming diabetic by 34 percent. This program could be expanded nationally and could prevent millions of individuals from becoming diabetic for just \$80 million. This is just one of many proven programs that could improve health and wouldn't require an enormous investment. Other inexpensive actions that Professor Thorpe recommended were building care coordination into Medicare fee-for-service and including preventive services as part of the essential benefit package.
- **"No brainers."** David Pryor sees some interventions as no brainers. These are activities that improve quality and lower costs, such as scaling up patient safety initiatives.

"Lots of great programs work and can be scaled for little money . . . we need to take things that we know work and target at-risk populations."

— Kenneth Thorpe

Other Important Points

- **Impact of the ACA.** Henry Aaron argued that the ACA legislation was a national statement that the status quo in the financing and delivery of health care is unacceptable. He believes it will lead to changes in the financing and delivery of health care in basic ways. While some criticize the ACA for doing too little to control spending, it contains many ideas for slowing the growth of spending, some speakers said.

Gail Wilensky disagreed. She views the expansion in coverage as the most important aspect of the ACA and is less impressed with the law's attempts to constrain spending and bring about delivery reforms.

- **Additional policy considerations.** John Rother said there are four topics dominating discussions among policy-makers, which received little attention at these briefings. These four topics are: premium support, prevention, prescription drugs, and medical malpractice.
- **Globalization of health care.** In response to a question about whether consumers will increasingly go abroad for lower-cost health care services, most panelists see international medical tourism as small in the near term. More likely is domestic medical tourism. However, Dan Mendelson believes that certain health care services, such as radiology and lab tests, could change due to globalization.
- **Health care workforce.** The role of nursing and allied health professionals as part of a care team is getting increasing attention but has to be even more in the conversation about primary care, care coordination, and controlling costs.

"The challenge is how to spread what works so there aren't isolated islands of success, but a connected archipelago."

— Susan Dentzer

Where to Go From Here

There was general consensus on what should be done broadly to lower health care costs. This includes payment reform and delivery reform, with payers working together to bring about changes and greater coordination and integration of the delivery system. Primary care also must play a greater role. But there was also recognition of the practical and political barriers in bringing about these changes. Some thoughts on practical steps that can be taken now include:

- **Focus on quality and value.** These are seen as relatively safe topics where it may be easier to secure broad support among most stakeholders.
- **Increase patient engagement.** Patient health literacy and overall engagement in health care decisions need to increase. Providers need to take patient preferences more into account. In discussing how to message to individuals the need to control costs, focusing on "limits" or "budget constraints" is unlikely to be well received. A better approach may be getting the greatest value and impact from the money that is spent on health care.
- **Place greater emphasis on prevention.** Despite proven success, not enough resources are devoted to prevention programs.
- **Spread what works.** There are numerous programs across America that appear to be working. The challenge now is to spread and scale these programs, speakers said.

While the scale of America's health care cost issues may be unprecedented and these problems may be increasingly urgent, concerns about health care costs aren't new. In wrapping up the series, Susan Dentzer noted the importance of closing "the rather considerable gap in public understanding of what is at work with some of these innovations and payment and delivery system reforms, and the current state of consumer awareness and knowledge about the realities of the health care system. ... How do we help them understand more about what is actual quality and value in the health-care system, but also how do we listen more clearly and cleanly to them about what it is that they want?"

She reminded all participants that dealing with health care costs is never-ending work. Now more than ever, stakeholders must come together, agree on priorities, and agree on a path forward to control the country's health care costs.

The Alliance for Health Reform 20th Anniversary Series

Moderator (all three sessions): Susan Dentzer, Health Affairs

Session 1: Health Care Costs: The Role of Prices and Volume

Keynote: Overview of Cost Drivers, **Michael Chernew**, Harvard Medical School

Panel on Pricing and Volume, **Henry Aaron**, The Brookings Institution and **Gail Wilensky**, Project HOPE

Reactor Panel:

- **Helen Darling**, National Business Group on Health
- **Nancy Dickey**, Texas A&M Health Science Center, former AMA president
- **Andrew Dreyfus**, BCBS Massachusetts
- **Teri Fontenot**, Board Chair, American Hospital Association
- **John Rother**, National Coalition on Health Care
- **Dan Mendelson**, Avalere Health

Session 2: Health Care Costs: The Role of Technology and Chronic Conditions

Health Care Costs: The Role of Technology, **Joseph Antos**, American Enterprise Institute

What Accounts for the Recent Rise in Health Care Spending, **Kenneth Thorpe**, Emory University

Reactor Panel:

- **Melanie Bella**, Director of the Medicare-Medicaid Coordination Office at the Centers for Medicare and Medicaid Services (CMS)
- **Bruce Chernof**, The Scan Foundation
- **James Fasules**, American College of Cardiology
- **Joseph Newhouse**, Harvard University
- **Susan Reinhard**, AARP
- **Diane Rowland**, Kaiser Family Foundation

Session 3: The High and Rising Costs of Health Care: What Can Be Done?

Efforts Promoting Good Health, Good Care, Lower Costs, **Marilyn Tavenner**, Acting CMS Administrator

What's Working—Evidence from the Field, **Karen Davis**, The Commonwealth Fund and **Scott Serota**, Blue Cross Blue Shield Association

Policy Strategies to Help Change the Cost Trajectory, **Paul Ginsburg**, Center for Studying Health System Change

Reactor Panel:

- **Stuart Butler**, Heritage Foundation
- **Jim Guest**, Consumer Reports
- **David Pryor**, Ascension Health
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