Health Care Costs: The Role of Prices and Volume

Alliance for Health Reform
April 18, 2012

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

[START RECORDING]

EDWARD F. HOWARD: Hi. Good morning. My name's Ed Howard. I'm with the Alliance for Health Reform. On behalf of Bob Graham our board chairman, the rest of our board, and Senator Jay Rockefeller, our honorary chairman we welcome you to this program about high and rising costs of health care in America. We're talking about health care costs in general, not necessarily but certainly including health care costs in government programs. I want to thank all of you for coming. I was looking at the registration list and looking around the room. The health policy talent assembled here is so deep it reminds me of the Washington Nationals Pitching Staff. [Laughter].

I want to just say a few words of thanks first of all to our cosponsors whose names you see arrayed in a variety of screens around you; some long time partners, some new ones who took a flier on our plunge into, which for us is a new format, a new territory. Included in that group, by the way, I want to draw a special attention to our friends at the Kaiser Family Foundation, Drew and Diane, and all the other great folks we have been working with, not just as sponsors but as hosts with the use of the Barbara Jordan Conference Facility and we will be using it for all three of the briefings in this series. I want to thank Jack Ebeler and his colleagues at Health Policy

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

Alternatives for the issue brief you found in your materials that chronically without evaluation most of the things that are cited commonly as potential drivers of health care costs. Thanks to Paul Ginsburg who is here who is now drafting a paper on some policy options that will form the jumping off point for discussion in our final number in this series on June 12th to which all of you, I hope, will repair at the appropriate time.

I want to thank an informal advisory group that we put together to help us think through both the structure and the content of this program. Indeed look at the technology. Folks for logistical reasons are all around Washington, but represent a wide range of views on health policy topics. They helped us both structure the events and try to sort out which items on that long list that Jack Ebeler and his friends put together for us we would single out for some special attention. A special thanks to John Rother who helped by chairing that group.

Quick housekeeping notions. We are not going to take a break in the program. You should feel free to take your own break at your own pace. We are in a relatively intimate setting, at least compared to some of the 300 person briefings that I know some of you have been part of on the Hill for the Alliance. Nonetheless, this is not one of those off the record conversations you are going to be able to use complete

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

deniability. There are even, dare I say it, a reporter or two in the audience and we are web casting. Do not be guarded in what you say, but just know that you will be given proper credit for it. [Laughter].

We would like to call your attention to the blue evaluation form in your materials, which we hope you will fill out that will help us improve these sessions and try to find others that you think would be helpful in considering this list of issues. Let me just conclude the introduction by noting there are a lot of blue ribbon commissions and reporting groups, high level folks who have weighed in on how to lower the deficit, often by dealing with health care costs, other groups that have focused specifically on health care costs. I just wanted to bring your attention to one of those groups. It is called the Committee on the Costs of Medical Care. Permit me to read two sentences. "Many persons do not receive service which is adequate either in quantity or quality, and the costs of service are inequitably distributed. The result is a tremendous amount of preventable physical pain and mental anguish, needless deaths, economic inefficiency, and social waste."

Some might say we're talking about today. Almost. This was a report that the AMA and associated groups issued in October of 1932. Do not get me wrong. I think we have made

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

some progress in 80 years. I am confident that this group can contribute to a big step forward. Here is where I introduce Susan Dentzer, except that she is on 16th Street in a car that is not moving very fast. I will however let her take a sip of coffee. She can frame this discussion later. I do not want to put her under a lot of pressure.

You have seen the agenda. We are very grateful to Mike Chernew for taking on the job of framing this issue. The nice part is that he knows that you know that he doesn't have to eschew obfuscation. He can use acronyms and not worry about this audience not understanding them. I will tell you that the speaker's pre-conference conference call in which our assembled formal presenters talked about what they were going to talk about, informed me as much on the topic of health care costs and health care spending as anything I have ever heard. Henry Aaron suggested that we should have just taped that and played it back for you because it was extremely revealing and very insightful.

Therefore I know that Mike Chernew's conversation with you this morning is going to fall in that same category. Most of you know him. He is going to give a very brief introduction from me. He is a professor of health care policy in the Department of Health Care Policy at Harvard Medical School. He is a member of MedPAC. He is a member of the Commonwealth

Commission on a high performance health system. He is our keynoter. Michael, thanks very much for getting this brief started. Susan, you can come up at this point.

SUSAN DENTZER: What have you done in the way of an overview?

EDWARD F. HOWARD: I have done nothing in the way of an overview. You can see that some aspects of this we did not have planned. You can either do it here or there.

SUSAN DENTZER: I have to say good morning, everybody. The cost issue may have been talked about in the 1930s, but I bet you the traffic in Washington DC wasn't quite as bad in those days as it is now. I apologize for my late arrival. My job is just briefly before turning it over to Mike, who's already been introduced, is just to tell you what the plan is for the next several briefings.

Today we're going to be talking about really this overview that Mike is going to give us of health care cost drivers. Then we have two presentations focusing on volume and pricing. We're then going to move on, on our next briefing, which is on May 29, to two other drivers, technology and poor health, specifically chronic conditions. Then our third briefing on June 12th is going to focus on real world examples of successful techniques at driving down costs.

As anybody who's been involved in these conversations know, it is virtually impossible to have a conversation about one of these things without very quickly moving on to the other. We imagine, even as we try to talk about overviews today as well as volume and pricing, inevitably the conversation will suddenly seize upon technology or chronic conditions. It's just the way it goes in this arena. As an editor I think I've spent almost most of my career changing the words costs to spending and spending to costs. It's also very confusing often to move from that one issue, costs, to the spending issue. We imagine that we'll be doing a fair amount of that as well as we sort through these three topics.

Nonetheless, as I say, we're going to try as much as possible to keep today's conversation focused on volume and pricing, and hold off our intense desire to discuss technology, poor health, etcetera to the next briefing.

With that finally let me turn things over to Mike for our overview.

MICHAEL E. CHERNEW, PHD: Thank you. I'm thrilled to be here. I look around; I see that most of you could give my talk. I should have had Susan give my talk. I will give an overview. I'm mostly going to start with something that I know you know, and then move on to things you probably know, and then I'll talk about technology and chronic illness. I do want

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

to start with some basic definitional issues to lay the groundwork for at least the vocabulary.

Again, as Susan said, I think in general the discussion needs to focus on spending at the population for example national level, which is by definition price times quantity. That's not the same as spending per unit of service, which economists typically call price. What are we paying for an MRI? That's a price. The real question is the price times the number of MRIs we do. That's the quantity. The cost of producing units serviced, the notion of cost, is also not what I want to focus on because the spending is more than the cost. There are other things that go in the profits and other types of things like that.

I really want to avoid having a discussion about spending for a particular cohort of people. Almost any NIH grant that's going to go to an institute will talk about spending for people with diabetes, people with mental health conditions, people with whatever your grant is about. That's all very important. That doesn't roll up to national spending at the population level. I think the broader policy question is about spending for the broad population.

That leads to another important point which is distinguishing between total spending and government spending. Often there are two different conversations going on. One part

of the conversation is talking about how much we spend as a country. I'm going to say something about that in a minute which you know. The other part of the discussion is really not focused on that. They're concerned with the budget, particularly the federal budget. Those are different conversations. They're related. Obviously having a more efficient national system would help with the federal budget problems.

There are things that the federal government does that might drive the entire system, but they're different in a number of ways. Most importantly, if we were to spend 17-percent of our GDP on health care the economics of that are different if it's financed by a bunch of individuals making private choices about what they want to buy, as opposed to if we tax people and then spend 17-percent of GDP. Normally if people are going out and purchasing products and we're spending more on flat screen TVs or iPads or whatever it is, that's a good thing. It's distortions in health care that make it problematic.

Some basic data. Every slide if go over you have to show some doom and gloom-type slide. I will tell you in case any of you did not know or you were just coming here for the lights and the environment, health care spending has been going on; it is a share of GDP. What's interesting is one way to

think about that is every year, and I say that somewhat facetiously, most years we're richer than the previous year. The key question is what share of that increased income do we devote to health care. Historically it was a relatively low share, 5, 10, 15-percent. In the 80s when health care was growing quickly you got to 25-percent.

In this most recent decade over 90-percent of our increase in wealth went to health care. Some of that's because our wealth wasn't growing all that fast. Understood. As health care becomes a bigger share of the economy mathematically the gap in spending growth between health care and income overall has bigger consequences. You have to devote a greater share of your annual increase in income to health care if health care is growing more rapidly. We haven't been accustom to devoting that much of our income to health care. It might not be bad. If we were getting great health care that would be wonderful, but it does create a lot of problems.

Largely the federal portion of this plays into the issues of the debate. There's some work by Kate Baicker and Jon Skinner that suggests that if you look at the CBO long-term spending growth projections and ask what tax rates would be needed to finance that in a budget neutral way, and there's a lot of different assumptions, but their baseline estimate was marginal tax rates would have to rise to 70-percent by 2060.

That's not a forecast. I don't think that will happen. The point is over time the burden of financing health care becomes greater and the tax rate implications of financing the historic rates of growth and even the CBO projected rates of growth are remarkable. That financing portion of it has economic consequences with GDP declining relative to trend by 11-percent. The magnitudes of these numbers depend on the exact assumptions that you make, but there's simply not a reasonable set of financing options that will allow us to finance the spread between health care spending growth in income growth going forward. I wish I was here giving the possible solutions talk. That's going to fall to Paul and others, but I am not.

Apart from the federal portion, I see Helen is here. Private employers have a similar type burden. The gap between wage growth and health care spending has become unsustainable for employers in a number of ways and they have responded in a series of ways. Holding down wages is of course one, but there are other actions that they're taking; dropping coverage, buying down coverage. There are a lot of issues with the viability of retiree benefit covers for example. Any way you look at it private and public payers have a hard time financing the projected rates of growth.

Why is spending growing? The first point I want to make again to help the debate is to draw a sharp distinction

between the level of spending and the rate of growth in spending. The level of spending is sort of—and I apologize for being an economist, I do that a lot actually—it's the intercept. It's how high is spending. The rate of growth is how steep is the curve. As my rudimentary PowerPoint skills illustrate, they're different. You can have a high intercept and a flat curve. You can have a low intercept and a steep curve. The real problem we face I think is the slope, the rate of growth.

If I knew my colors I could really walk you through this graph. I wish we had our Harvard versions. The Dartmouth map shows the different health referral reasons broken into whether or not their level of spending was above the median or their rate of growth was above the median. It turns out that they're not correlated. Areas with low spending are not systematically those with low spending growth. Areas with high spending are not systematically those with high spending growth. In fact, if you look at different periods of time, areas that were high spending growth at one point are not necessarily high spending growth at the next point. We all seem to have this spending growth problem. When you look at drivers or solutions there's a difference.

Many of you know that if you were to look at these different areas and categorize spending by the share of the

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

physician population that are primary care physicians, those areas that have more primary care physicians would have lower spending. That's not my result and I think it's mostly associated with Barbara Starfield, but a lot of people have made that realization.

This is a chart of spending growth. The horizontal axis is the number of primary care physicians in the workforce. The vertical axis is not the level but the rate of growth in spending. There's no relationship. More primary care seems to be associated with lower spending but not slower spending growth. There's a whole series of drivers of the level of spending that aren't drivers of the rate of growth in spending.

What do I think drives spending growth; the slope of my curve? Susan's introduction, if she would have been in traffic this would have sounded perfect. Every time I give this talk someone says it's obesity. I need to say a few things about obesity. I do believe that obesity contributes to spending growth. The key point is the effects of obesity interact with medical technology. If health care spending grew faster than the income for every 10 year period since World War II, even before what we now consider to be the obesity epidemic. If you look at some of Ken Thorp's numbers, who's associated with a lot of this work, and you were to take the spending for individuals in 1987 by weight class and simply shift the

distribution across weight classes, put more people in the obese category, fewer people in the other categories, if you just shift the distribution but keep spending within each category the same the spending goes up by about 1-percent per year. It's actually less. It's about 1-percent total. It's much less than 1-percent per year.

The reason that it matters is because what's really going on is there's an interaction between obesity and technology. We've seen a lot of technology applied to conditions associated with obesity, heart disease, diabetes. It's not that we're spending the same for a person with diabetes or heart disease as we were in 1987. There's tons of technology in those areas. It's that growth and technology that's been differentially applied to groups that's what's really driving spending growth.

I define medical technology very broadly; new knowledge and associated stuff. There's a whole series of less important factors, prices, aging, rising incomes, more generous coverage, inefficiency, inappropriate use and liability. Many of these things relate to the level of spending; inefficiency, inappropriate use. I believe very strongly that they relate to the level of spending. I would say it is clear. We're not spending more now because we're that much more inefficient than we were in 1932. There's just more stuff we do. In fact in

many ways I think we're more efficient if you look at length of stay in hospitals and various things like that.

Over time the type of technologies change. I had several comments from people saying we need to put these other technologies on. I agree completely, but I'm probably going to be over my time anyway. In the 50s and 60s it was lab tests and x-rays. Those used to be high-tech things. In the 70s it was things like open-heart surgery, CABG, c-sections, and various types of cancer treatments. In the 90s we went through a period of just really berating the pharmaceutical industry. There were a lot of medications that came online and health care spending for drugs was really rising dramatically. In fact many of these are going off patent now and so it's a really important issue to understand that we're now reaping the gains from those blockbusters.

In any case, recently we have focused on imaging or biologics. It seems to be the case, and I'm not a physician, but people get sick and we don't like it. There are different types of technologies that people apply to those conditions over time. That has changed. The one thing that's constant is medical technology has progressed.

A few myths I want to discuss. The most important one; I often here, in other industries technology lowers spending. How come that doesn't happen in health care? I think there's a

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

basic definitional problem. In other industries technology lowers price. If you look at the most rapidly growing industries they're all high-tech industries. When I grew up we had one TV. It was connected later by a cord. Now I have six TVs. They're all wireless. We spend way more on information technology stuff than I ever did as a kid, even though the unit cost of all this stuff has really gone down quite a lot. There's a big distinction between the notion that prices are going down and spending is going down. Most high-tech industries actually have seen an increase in spending by and large.

I am sensitive to this because people don't like economists and think all we care about is money. The benefits might justify the costs. That's the crucial question. If we're going to slow spending we have to slow either price or quantity. Technology generally fits into the quantity side. Although as Gail has pointed out, she may say quantity and price depends on how you define the product. Point taken.

The key point is most technology is generally in quantity. The key question is knowing when to apply that technology. The average value of technology, which generally there's work by David Cutler and others would say, on average the technology has been great. We've been blessed with a lot of the medical technologies that have been developed. That

doesn't mean that we're applying them officially at the margin for the incremental patient, that we're not using them too much. We have to understand and develop strategies that help us understand when to apply the new technologies. We don't want to stop technological progress or the application of new technologies. We just want to use them in the most efficient way possible.

Our goal in the end has to be to promote value as opposed to simply spend less or have one group spending less. As we pointed out as we go forward the technology itself reflects the system, the insurance incentives, the cost containment incentives. The question is how can we change the system to allow technology and allow us to manage it more appropriately.

My basic implications. Everybody knows, I hope it's clear. Reductions in the level of spending are important. Maybe they're very important. Our basic problem is the level of spending growth. The determinants of spending growth may differ than the determinants of the level of spending. Our strategies in the end are going to have to be continual one-time improvements or some fundamental change to the environment which lowers the slope of health care spending growth, their trajectory. It is the case that we can control the public portion of this and therefore the debt and some of the other

tax issues by shifting spending to beneficiaries. That does solve a particular and very real problem. It raises other particular and very real problems. Thinking through how we're going to divide the spending and with the economic consequences of that become important.

With that I will turn it over to a more detailed discussion with Henry and Gail. I'll stay up here.

SUSAN DENTZER: We are actually happily just a bit ahead of schedule. Maybe we'll just take a moment and if there are any questions specifically for you we'll address them. I'll seize the moderator's prerogative to ask you one. You said the real problem is the slope, the rate of growth of spending. You also said when you started out that an additional problem is the distortions in health care that come about as a consequence of the fact that we're tax financing so much of it, and also we have tax related distortions.

I wonder if you would just say a little bit more about that because in addition to this concern about public spending or I should say in tandem with the concern about public spending growth, those two issues are also front and center.

MICHAEL E. CHERNEW, PHD: Right. I think that that's right. Maybe I have the tendency to say that everything is the biggest problem; not when I'm not in DC. The problem with taxing is the burden of taxing rises disproportionately as you

tax at a higher rate. We could handle the taxing that we're doing now and probably handle the taxing to fund the level of spending we have now. The Baicker Skinner analysis points out that we can't handle that if spending grows. We could solve the taxing portion of that by shifting to individuals. Then you have a lot of individuals that can't afford their health care. We have access problems and a whole bunch of other problems.

The challenge we face is if we finance the projected rates of growth with taxing we have a whole series of tax distortions that would be a broader subject of an economic discussion. If we try and finance the projected rate of spending by out-of-pocket spending we have a whole series of other access and health-related concerns. If we simply had the spending level that we have now I think we could find the mix of taxing and private spending that we could live with. If we have the spending that the CBO had projected in say 2060 I don't think there's going to be any set of tax and out-of-pocket spending options that we really like. Of course, if we had a lot of out-of-pocket spending requirements I don't think we would have the spending that is projected in 2060, but that doesn't mean the world would be a better place.

We're constantly trying to figure out how to balance both the financing and then managing the overall rate of growth.

SUSAN DENTZER: Are there other questions for Mike at this point? Yes? Back in the rear?

BRAD STEWART, MD: Hi. Brad Steward, Sutter Health and Coalition to Transform Advanced Care. As a physician, and taking for granted that 5-percent of the population that accounts for 50-percent of our spending in those people who are really sick, I'm puzzled as to why it's a given that we seem to think that public spending growth, i.e. Medicare in particular, could be controlled by shifting spending to patients because old, sick people, we're just going to see them in the hospital. Shifting them out of the hospital makes sense. I don't get that having individuals pay would even be feasible to consider.

MICHAEL E. CHERNEW, PHD: I will not comment on the feasibility of what we're willing to consider. I'm certainly not the expert on that. There are a number of ways which you could change the system. In fact I think you're going to find even under the existing system because of retiree coverage there's going to be a much greater burden on individuals. The question is how will they respond to that burden. Some of it is if they go to the hospital can they afford to pay. Some of it is they won't get the care that they need. They also won't

get the care that they don't need. There are a lot of complicated things going on.

The point remains there's a whole number of ways that you could shift the burden to those individuals. There's a whole host of problems that arise if you do. If you simply take the point of view, we're going to protect you no matter what you spend there's all these other problems. It's easy to find any solution. Maybe if you wait until June, Paul will tell you the best. There's a whole number of problems with almost anything we do, but it hinges on being able to control the overall rate of spending growth in a system that we think is more efficient in a way that we can handle.

JOHN ROTHER: Good morning, Michael. John Rother with the National Coalition on Health Care. You noted that some of the improvements in technology had relatively small marginal value. Most of these decisions to use that technology seem to be provider-driven. Could you comment on the incentives behind the choice of technologies? What's the factor there in driving cost?

MICHAEL E. CHERNEW, PHD: Susan made the mistake of allowing you to ask your big, broad questions before everyone else spoke. I'm going to try and be particularly brief in this. You're 100-percent correct. I think most of you when you're not here listening to us or around trying to figure out

how to change providers that is in fact I think the big debate that we're going to have going forward is how much of the incentives are we going to deal with on the provider side. I've done a lot of work with—Andrew will talk later about Blue Cross Blue Shield's alternative quality contract where we're trying to bundle payments. I don't want to get too far there.

There's a whole other group that want to think about consumer incentives and how the consumers have to pay out-of-pocket. I think the preceding question pointed out there's challenges to do that. I think I'm going to go with yes.

SUSAN DENTZER: We'll also note that this is a big part of the assignment that's been handed to Paul Ginsberg to tell us the entire set of solutions for all of this. Yes. Let's take two more and then we'll go to our panel.

DAVID NEXON: David Nexon, Advanced Medical Technology Association. Your slides are very interesting in showing that the drivers of level of spending aren't correlated with the rates of growth in spending. What is correlated with the rates of growth in spending?

MICHAEL E. CHERNEW, PHD: Surprisingly little geographically. There are certain things; income. You get slower health care spending growth in the areas where people are poor. I don't think lowering everybody's income is the policy lever we want to latch on to. Managed care slows

spending growth, although not by a huge amount. Those are the main ones that I could point to. We haven't yet figured out what's well enough correlated with growth. I think the standard economic story would be there's general medical knowledge driving growth. That goes to McAllen as well as Minnesota. You see growth at the same level you saw a whole series of studies in the past about HMOs and non-HMOs.

There's this common factor driving growth. Much of it, as I said, we want access to, but it does seem to be broad. There's no place in this country you could say that's the Mecca for controlling spending growth. You could find a place and have a nice photo op in saying they've controlled the level of spending. We spend much more here than there. Odds are at least 50/50 that if then you come to me and say, is that place controlled the rate of spending growth; they wouldn't have. Even if they had, if we wait another 10 years and went back to the same place they may well not have controlled over the next 10 years because every place has seen spending growing because medical technology diffuses.

SUSAN DENTZER: We also know, don't we, by virtue of the national health spending numbers of the last couple of years that a great way to slow health care spending is having the worst recession since the Great Depression. That has been

a very effective mechanism in slowing the rate of growth in spending.

Okay. I promised one more question here back in the back and then we'll move to our panel.

DANIEL CALLAHAN: Daniel Callahan from Hastings Center. I hope we'll come back to the question value for money. It seems to be a terrible trap in saying that if something is worth it we should continue doing it. It seems to me a Rolls-Royce is a very good investment, good value to the money, but we can't afford it. You talk value for money at the time when we're trying to reduce cost seems to me a fundamental clash.

MICHAEL E. CHERNEW, PHD: Yes. Economists would incorporate if you can't afford it it's not giving you a lot of value for money. As you spend more and more and more the clinical benefit has to be greater and greater and greater to justify the extra spending. That's a longer discussion. I agree with you that there's a lot of semantics that go on, and we can't be in a world we say this is good for people. We just have to decide to pay for it. Again I apologize for being an economist, but you have to take into account the budget constraint when thinking about how to define value for money. I try not to sink budget constraints here. You left me on way too long.

SUSAN DENTZER: Alright. Sit down then, Mike. [Applause]. Thank you very much. That was great. As you heard, Mike said there are only two real avenues for slowing spending which is that you have to slow or lower the price or you have to slow or lower the quantity, which gets us to our next panel on pricing and volume. Henry Aaron and Gail Wilensky are here to address those two topics. I think Hank we're going to start with you.

HENRY J. AARON: Okay. I like speaking with Gail because if you ever go by alphabetical order I win hands down. I have to say that the most frightening statistic that I heard in Mike Chernew's presentation is that he has six television sets. The reason I'm frightened about that is one is terrified to imagine how much work he would do if he only had one.

I wasn't going to say anything about this, but I want to introduce one reference inspired by Mike's reference to the Baicker Skinner projections of what tax rates would have to be, as high as 70-percent in 2060. Nobody likes really the idea, but I would like to call your attention to a recent article in the *Journal of Economic Perspectives* by two pretty fair country economists, Peter Diamond who holds a Nobel Prize and Emmanuel Saez who won the Clarke Prize, which in some ways is almost as much of an honor. Using the analytical tools of economics they concluded that the optimum marginal tax rate for top high

income individuals was probably in the range of 50 to 70-percent.

I'm not recommending that, and I don't think any of us want to see very high tax rates necessarily, but I want to throw a little bit of cold water on the idea that the world in which those tax rates applied is somehow unsustainable. It is sustainable. We've had them in the past, even during periods of very high economic growth. It's something that needs to be considered as we move ahead.

What I'd like to spend most of my time on, maybe being a bit of a skunk at the picnic, is I'd like to pose a question. Suppose we could figure out what portion of the high level and/or the rapid growth of health care spending is attributable to increased quantity of service and how much of it is attributable to increased price per unit of service. The question is how would that inform public policy. In a hypothetical situation where we really could nail it and we discover that 100-percent of it was excess price; that accounted for the high level and maybe the price excess was increasing over time. In economist jargon it would mean that resources were being paid more than you had to pay them to get them to perform the services that they are currently performing; what economists call rent. Not an intuitively obvious use of the term, but that's what they're called. Then

maybe that would direct public policy in a certain direction. You'd focus on DRGs or some other private regulatory mechanisms to hold down prices.

Or in the opposite extreme, suppose you were able to identify that 100-percent of the problem was an excess level of services. By excess level of services I mean services that produce no or low benefits per unit of cost. Maybe then you'd direct policy toward protocols for treatment of various conditions to discourage over use. I'm going to assert those conditions are not going to be satisfied. We are never, ever going to know exactly how much of the high level or rapid growth of spending is attributable to excess provision of services or to paying resources to make those services possible, more than is necessary to entice them into their current use.

Of equal importance, we don't have any effective way currently of shifting the incentives that are responsible for excess quantities or excess prices. Now, the key word in that last sentence was currently. One of the objectives of the Affordable Care Act is that it was driven primarily to extend coverage to more individuals. Those extensions of coverage are the very ones of course that are now under court challenge and may or may not be sustained by the Supreme Court. I don't want to minimize the importance of coverage extensions and the

Affordable Care Act. They're what a lot of us live and breathe for. I think fundamentally they are not the most far reaching and in the long run important elements of the Affordable Care Act. It's much more than a weigh station on the way to universal coverage.

I will bring this back to the topic at hand, most importantly that legislation was a national statement that the status quo in the financing and delivering of health care is unacceptable. If it survives court challenge it's going to lead to changes in the financing and delivery of care in very basic ways. The law is not going to be in the long run implemented and sustained in exactly the form in which it's currently on the books, for a whole host of reasons; because of guerilla warfare against the law as it stands because there will be unanticipated effects, glitches, failures that were not foreseen and partly because it's pretty damn messy piece of legislation.

The Affordable Care Act has been criticized for having done too little to control the growth of spending or to reign in the level of spending. In my view it in fact contains virtually every idea for slowing the growth of spending that analysts have come up with, including I might add some of which Mike Chernew is if not the father than at least a guiding light.

Some of these cost control provisions are introduced timidly. Notably for example the limits on the tax breaks for employer sponsored coverage. They're virtually all there in at least embryonic form; pilots and demonstrations, which I have to admit have a habit distressingly often of not succeeding or not working out as their authors hoped. Even if they do they're very hard to take to scale.

If the Affordable Care Act survives and is changed over time it's going to be a weigh station along a road to the transformation of the U.S. healthcare system. That process is going to be driven by a recognition that cost control requires—and here I am going to use the words that Mike shied away from—is going to require a budget constraint; something that is lacking in current arrangements.

There are those who think the budget constraint is going to come from individuals exercising market power. In general I personally think this strategy is doomed because well insured individuals cannot exercise market power and will not want to exercise it at the time of care. It is a fact that the typical market-based high deductible health insurance plan, if it contains good stop loss coverage, actually reduces the marginal cost sharing on more medical spending than it increases the marginal cost sharing on. Therefore is not likely to have a material effect on the ability of the market

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

to control the growth of spending. Furthermore, there is just too much of a gap between the purchase of insurance, that decision that you make when you buy insurance, and the actual point of health care use for the first decision in the end from a social and political standpoint to govern the latter. Imperatives will influence the actual demand for care that will override provisions that may have been agreed to insurance.

I think that in the end the budget constraint is going to have to come from a collective decision by a politically constituted and legitimated body within the framework of the Affordable Care Act. It is possible to imagine a process by which health insurance exchanges become such a body, provided that their enrollments gradually expand over time to include a critical mass of the population. Without such a political entity I think we're going to be holding meetings like this forever.

My overall message is that however interesting, and it really is interesting, I'm not minimizing it. However interesting it is to sort out whether high and rising outlays are attributable to excessive prices, rents in the economists jargon, or quantities; that is, care at the margin that produces no or low benefits per dollars spent. The practical policy debate and the challenge of policy formulation is going to have to deal with the totals, not with what is driving them.

That leads me to suggest that the real payoff from this trio of meetings is going to come in the third session.

SUSAN DENTZER: Okay. Thank you. Gail?

GAIL WILENSKY, PHD: Thank you, Susan. It's always fun to follow Henry because I get to change mid-course when I was going to say in response to some of what he said. We've been doing this for a lot of years now.

I'm going to start off by making a comment with regard to his optimal marginal tax rate, which is relax, Henry, because as of next year we will be at and over 50-percent for the highest income, even if the Bush tax cuts are extended. That's clearly a question. We get 35-percent plus 10, 12, 13-percent state and local depending on where you live plus 3.8-percent now that the social security tax has been extended to all income, not just wage income. That probably puts us in the low 50s, even if we don't revert back to 39-percent. You can take a deep breath. We will be in that optimal margin like it or not.

Let me go on to what I was asked to speak about. I've been one of the people in the, is it quantity is it price debate, which is probably not the most useful debate to have. I will grant that. Of saying that we are attributing too little to quantity and too much to price for the following rationale. Excuse me, Susan. I'm going to wander into that

other territory we weren't supposed to touch, which is that it is very difficult to look at quantity if you don't bring intensity. What we are all about in the U.S. is actually not quantity in the mindless definition of only days or visits, but rather what happens once you encounter the healthcare system.

Now you might say yes, of course, except this of course changes how you look at this. We have all seen reports how we actually have lower lengths of stay in the hospital than many other countries, not higher ones. That we see the physician less often in his office or her office, not more often. What we don't usually take account of in a good way because it's so difficult is once we have that encounter with the hospital or with the physician it is gangbusters in terms of what happens. Again the reason this becomes important is when you think about policy issues as to what it is you might want to change or what's driving this, it's very important about whether it's just excess price per unit. It's not to say that price isn't ever an issue. We know that we have a higher price for many units that we purchase. As I look at it, it's way more the intensity of the encounter once we have the encounter. If we only think about it as length of stay or number of visits we miss the whole point of what's been happening in the U.S. and we miss the whole point of what we might want to think about when we talk about how we try to change this.

Michael, thank you for emphasizing the level and growth issue. It's very important. It's not that we couldn't do with a lot less spending. Most of the debate is how to slow down the rate of growth. We're here. It's not a great place to be, many might say, although it depends on whether you look at the average in terms of the return to technologies. The real concern is how we slow down the rate of growth in spending. Getting people to focus on that—and you can't really say it too often it appears because they forget very quickly and go back to the level—is going to be very important.

It's also interesting to note that when we look at the rate of growth in spending the U.S. isn't quite as much the outlier as it is when you look at the level of the spending where we know we are very much the outliers. It's for the reasons that Mike has suggested, which a substantial portion of it we think has to do with the growth in medical knowledge, the growth in medical technologies that allow us to treat differently, and something about the challenge of making use of that in a more efficient and effective way. Getting people to concentrate on those areas will be very important.

The other reason that I think talking about quantity versus price in this altered manner becomes important is within the context of where we think reimbursement will move. If we move increasingly toward either bundled payment or capitated

payments than clearly the quantity pricing issue becomes somebody else's problem. The real trick will be to get either the pricing bundle correct or to get the capitated or partial capitated, which I think is a better model, price correct. At least at a policy level, a lot of the specifics will not be a policy problem. We don't know whether that's where we're going to go yet.

We clearly, in some parts of Medicare, are moving in that direction. We're doing so in the pilots in a variety of ways. As many of you have heard me now rant for several years, when it comes to the drivers of the healthcare system, that is the physician, we are paying for anything but bundles. We are paying on extreme micro levels. That needs to either be changed or dealt with in a different manner. This question about whether we are actually moving to a more aggregate payment level will be very important again in trying to come up with the appropriate levers to change the policy.

Finally a word about the budget constraint comments and the Affordable Care Act that Henry raised. I actually regard the most important thing about the Affordable Care Act as expansion in coverage. I'm somewhat concerned, if it is seriously undone I don't think the mandate is as serious a challenge as some, as to whether or not we will come up with an alternative way to expand coverage or not. I'm much less

impressed by the delivery reform in spending constraints. Although I don't debate the comment that Henry made, which is in some form, usually extremely embryonic almost everything we've ever thought of can be found if you look long enough.

Having been there, done that as Henry alluded our history with pilots, particularly when it will take further pro-action, pressure to not only see if they work, and unfortunately they don't always work. That's a different matter. To make sure that they're expeditiously replicated and scaled up and then become actually a changed way of affecting Medicare, does not have a great history. I would have been less concerned if there had been triggers in the legislation by which successful pilots move on an expeditious path of being replicated and scaled and then part of Medicare, unless they trigger some adverse outcomes. We'll see what that does.

Finally, with regard to the budget constraint, those of us who have debated or raised the two contrasting views, it's really agreeing yes there will be a budget constraint of sorts. The real question is it via the IPAB and payment per units that has been traditionally where Medicare has worked. Or will it be a combination of that on the grounds that traditional Medicare is going to be part of our future no matter what for as far as the eye can see? Or will we also try to put pressure on the kinds of plans that people choose?

It's not just enough to say what's the marginal cost at the time of use. That can be important; what the price of care is. It's also what's the cost of the plan and how do people choose plans that have very potentially different ways of organizing themselves; tight networks, loose networks, more or less marginal kinds of technologies, etcetera. We do see some variation when we look within the FEHB program between some of the most tightly designed plans, mail handlers you knew there's always at the bottom of the pricing list and some of the others. It just does indicate that it isn't as much budget constraint or not, but where the budget constraint operates. How much do we know and how much will we try differently?

As is frequently the case in health care, particularly by people who spend so much of their professional lives talking about these issues, the distinctions become slightly more nuanced as you get people in a room who have thought a lot about these issues. Those nuances remain important nonetheless. Thank you.

SUSAN DENTZER: Great. Thanks to all of you. In typical Washington policy wonk fashion we've had not only an excellent set of discussions, but we've also merged very quickly from defining the problem into defining and debating the solution. I'm going to try to drag us back for the moment to the problem and try to put a few of these assertions that

have been made on the table so that we can reexamine them a bit further.

Mike started us off with the notion that the real problem is the slope. It's the rate of growth. It's not so much that we should be concerned that we're at 16-percent of GDP or 18-percent or 20-percent of GDP. It's the fact that we're moving so rapidly from one to the next. 16 one year, 18 the next year, etcetera, etcetera. Rate of cost growth that is growing faster than the overall GDP.

Then Hank said, it is probably, almost certainly the case that that rate of growth is driven by the price times the quantity. It would be foolhardy to try to figure out how much of it is driven by the price versus how much is driven by the quantity because obviously it's going to be driven by both. More importantly, even if we could answer that question how would we begin to influence policy appropriately? He then though went on to say that the only way out of this is going to be budget constraints, which suggest to me that you think that the problem really is the level at some level, not just the rate of growth.

Let's put that one on the table. Is the problem the rate of growth or is the problem the level? Gail then went on to say, it's not just the price times the quantity. It's the intensity. It is not, as she said, the fact that we have

longer length of stay in hospitals here in the U.S. than elsewhere. Obviously we don't. We have shorter length of stay. It's just that, as she said, once you get in there it's gangbusters. She went on to say, yes indeed we have excess prices, but the real issue in Gail's framing of it I think seemed to be more the intensity than the prices.

I guess again to stay on the problems as opposed to the solution, and the poor Affordable Care Act got dragged into this kicking and screaming. I'd like to leave the Affordable Care Act out of it for a moment if we might and just ask what do we really think here. Do we think the problem is the rate of growth? The slope as Mike said? Or is it the level? Or is it both? Mike?

MICHAEL E. CHERNEW, PHD: I've already said it once. I'll say again. It'd be better off if the level were lower. Our risk of really catastrophic problems relates to the slope.

GAIL WILENSKY, PHD: I think we understand that if we could drop the level it would buy us a little time. If we don't change the slope we'll not basically have corrected anything. To my mind, it is really the politics that make it as important to focus on the rate of growth, although the economics as well. We're here. We've actually been in this range for a number of years. What we can't easily do without putting enormous amounts of burden is to continue that excess

growth rate of spending relative to the economy. It does of course suggest that if you can help kick up the economy you will do as well as if you focus all of your energies on the level of spending.

We see that when we look back at the 1990s, which was a very unusual decade where we had far less excess growth. We started and ended very close to 13-percent of GDP. It bumped up a very little depending on exactly when you looked. We had two things going on that were both helping us. The first part is very slow spending in the private sector that was then taken over by the Budget Balance Act after 1997; very slow spending in Medicare. We had robust spending in the GDP. It allowed us to keep that more or less stable relationship. It is remembering that it's the growth rate and the growth rate relative to the economy that will put a lot of burden on us. Sure, if we could knock down a couple of percentage points or a percentage point that would give us a little more time; just much more difficult to reduce absolute spending, not that it's easy to reduce the growth rate.

SUSAN DENTZER: Do the rest of you agree with the notion that more or less if health spending were growing at the rate of GDP that would be fine, even if the level continues to go up?

GAIL WILENSKY, PHD: It would be a whole lot better than what we've ever experienced. I will accept that as success. Then we can debate about do we want to have a reduction level. For me it would be sign me up.

SUSAN DENTZER: Okay.

HENRY J. AARON: I think the issue here is what do we mean by problem. It occurred to me there are problems in at least three dimensions. There's resource waste, which means we have a lower living standard than we could enjoy because we're spending a lot of money on services which I think many people believe are not yielding benefits worth what they cost. Although a recent article that you had in your own journal raises a question with respect to cancer therapy at least. Second is political stress, which is what Gail emphasized. The third area is just the way in which private markets operate, labor management relationship and the stress that arises over negotiating compensation packages. I think all three of those constitute problems. Some involve levels and some involve rates of change.

One can get used to almost anything. Certainly one can get used to a level of inefficiency in the economy. Perhaps the resource waste issue is something that falls in that category. The political stress and the market stress that arise from rapid rates of growth is what I think raises blood

pressure principally. I sort of resist the idea of having to choose here. I think that what we should be looking at over the long haul is a change in methods of payment and delivery that lower the rate of growth of spending and hence result in a lower level of spending in the future than we would otherwise have.

I am sort of like Winnie the Pooh was asked whether he wanted honey or sweetened condenses milk to eat and he said, "Both please."

SUSAN DENTZER: Alright. Let's just take a moment for some clarifying questions. We're going to have an ample discussion period following the reactor panel. If there are clarifying questions that people want to ask at this point well let's take those now.

MALE SPEAKER: Jim Hahn, CRS. I'd just like to make the point that I don't think there is any conflict between the statements. I think they are consistent because of course we care about the absolute level of spending in the end. I interpret Mike's comments to be cautionary whereas to say if you're only looking at high level areas now you're missing the picture. It's that the projected total spending in the future at these whether it goes based on where you start from; that's what the issue is about. Absolutely. In the end it's about total spending in the future based on these projections.

Mike's comments are what are you trying to look at in how you get from here to there. I don't think there's any conflict or discussion there about people saying different things at all.

HENRY J. AARON: I think part of Mike's story is simply regression to the mean. If you've had areas where spending is much below the national average on the average they're going to over time in all likelihood head back to the mean, and similarly for those that are unusually high. Mike also is party to a fascinating piece of research comparing private health care spending with spending per capita under Medicare. You'd be the one to talk about that.

MICHAEL E. CHERNEW, PHD: I'm happy to talk about private and Medicare. I'm going to defer until Susan says when we want to have that discussion. I'm happy to talk about it.

SUSAN DENTZER: Let us defer it in fact, and we'll stick with some just clarifying questions or comments at this point. Then we'll move to our reactor panel. Stu?

STUART GUTERMAN: Hi. Stu Guterman from the Commonwealth Fund. First observation; they often say about economists that we know the price of everything and the value of nothing. Having looked at data on how much prices vary it seems like we actually don't know either. That's just an observation.

Two issues; one to build on Jim's comment. It seems to me like a lot of these dichotomies are interesting to think about but we shouldn't spend a lot of time arguing which one is more important. For one thing, a high growth rate eventually leads to a high level. For another, when we look at percentage growth, low level areas are going to have higher percentage increases for the same dollar increase. I'd point out that if you say take the highest cost area and you reduce the level of spending by 2-percent there you're buying a lot of reduction in the growth rate of spending.

I think we need to, as Henry said, ask for both please because I don't think that they're that different a set of issues. On price versus utilization similarly; we can argue about whether prices or utilization are driving spending. For one thing, as Mike swore that he's not going to talk about now, shows which is really driving spending may differ between Medicare and private because Medicare controls prices, private doesn't. Private has more control over utilization, Medicare doesn't.

The other thing is also that with prices as distorted as they are, that means that faulty signals get sent about decisions about utilization. The two things aren't independent of each other. I think we need to wrap our arms around both of those things to be able to address the big problem.

SUSAN DENTZER: Yes? Comment, Mike.

MICHAEL E. CHERNEW, PHD: I agree completely with that, Stu. Although let me say at least a little bit why I think it matters in part. Let's assume that we believe that when Paul comes back some aspect of bundling payment, global payment, whatever we want to call it, is going to be part of the solution. I would put myself in that camp. I've seen a lot of good things in a lot of the places that have done that.

The fundamental question if you're concerned about their trajectory of spending is not that we simply move to bundle payment. It's what processes do you put in place to govern the rate with which that global payment rises. We spent a lot more time talking about how to start off the system than we do about designing the rate of growth in that system. It turns out that if you want to pay less in the future I agree with what Jim said. You have to worry much more about the process by which you update the rates than the rate with which you start them initially.

I'll say, because Andrew's here, I don't mean to pre-empt him. If you look at what Blue Cross Blue Shield did in Massachusetts they were much more concerned about the process they put in place for the rate of spending growth in the alternative quality contract than they were about the actual amount of money that they put in place. There were policy

makers in Massachusetts that took them to task because the amount of money they spent in Year One, the level, didn't look exactly what they wanted it to be. It was in some ways designed to do that. I should let Andrew say that. They missed the point that it was designed to deal with their trajectory.

It's very easy to get distracted in a policy debate about the shiny options that might lower your spending now and not ask the question about whether or not you've built the infrastructure even thought through how to deal with the slope. That's why thinking about them differently; they raise different policy questions.

SUSAN DENTZER: Alright. With that, let me ask our reactor panel to come up and join us up here. It's arranged such that you can all stay. I think that would be appropriate. There is going to be lots of discussion back and forth so best that you stay.

We're going to be joined now and are being joined by Helen Darling from the National Business Group on Health; Nancy Dickey from Texas A&M Health Center and former AMA President; Teri Fontenot, Board Chair of the American Hospital Association; John Rother, National Coalition on Healthcare; Dan Mendelson of Avalere Health; and Andrew Dreyfus, BCBS, Blue Cross Blue Shield of Massachusetts.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

I'm sure all of you think this has been a fascinating economic disquisition about whether it's price versus quantity or level versus rate. You all live in the real world and have to make decisions day-to-day about what either to argue for in terms of payment, what to put in terms of benefits packages, what to put in place in terms of state, discussions about global budgets, or what have you. Let's move if we could to all of you. If you would just give us a few minutes off the top of your head about how you think the group that you're essentially here more or less representing views these topics and essentially if there is a predominance of opinion here on whether we need to address the rate or the level at a policy level in addition to what you are doing individually. What is the best way to do that?

Helen, I'd like to start with you.

HELEN DARLING: Okay. Thank you, Susan. It's always interesting to come to these meetings in Washington, especially when you come from the employer world because you feel like you've gone into a bubble, a totally different bubble. First private spending is unsustainable. We take that for granted. It gets to be pushed to the side. Oh well, the private sector will take care of that. Already many large employers do not create new jobs. This isn't a political statement. You could blame everybody for this. It's not just health care. It's

overall labor cost. It's not just those two things. It's the fact that we're not making the investments that allow us to have the talent we need; engineers, scientists, you name it. Anything to do with math and science we don't have.

Money is going to the healthcare system; perhaps Medicaid, nursing homes, and things like that. The investments are not being made at the state level that will give us the standard of living that we would all like to have.

Michael's chart reinforces what happened in the past five years, especially in the Great Recession. We're not out of it in the employer sector, no matter what the headlines say. Employers reduced headcount, reduced hours, reduced our suspended 401K match. For the most part they didn't make many changes to help benefit. They did those other things, which of course affects income in the families.

Employers are now also focusing; they did increase cost sharing, but not a whole lot. They also are focusing on what they consider the number one problem; employees poor health habits. I know we're not going to talk about that, but that's a big problem. Employers are going to be reducing costs in terms of health care costs, and it will have some effects obviously.

I would also just say one thing. This is to me very startling. The idea that it's just growth and spending whereas

if you just go across town that way to Fifth Street to the IOM you will see work going on that continues to document over and over 20 to 30-percent of the base we're talking about that the spending growth is on is either wasteful or harmful or risky. To Gail's point about intensity; when somebody gets in that situation they start having tests done to them, some of which are harmful, many of which are risky, and some are totally useless, have no clinical value, although they do get paid for it.

The American Board of Internal Medicine Foundation recently after two years work, which Susan's been very involved in is actually coming out with long lists. Their problem was they were asked to limit it to five of the worse overused tasks. The biggest challenge is coming up with the five because they started off with hundreds. From our point of view, there's 20 to 30-percent of waste, risk, and harm in the base. It isn't just growth and spending. If we're going to do things like take something like the essential benefits recommendations from the IOM, which I know Michael was a part of, which recommended strongly that the number one consideration ought to be affordability. For that to be totally ignored and for the whole issue of what's going to be mandated for all of America gets turned over to the States,

which if you think political sausage making is bad at the federal level, it's really, really bad at the state level.

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.

SUSAN DENTZER: Great. Thank you very much, Helen. Nancy Dickey, I'd like you to speak next.

NANCY W. DICKEY, MD: In some ways, because I think I'm primarily here to represent medical education, the medical education is much more impacted I think in a visible measurable way by the discussions about rate increase because that is a more formalized piece of the curriculum where they talk about what tests should be done and what tests shouldn't be done. The more perhaps impactful piece is the nonverbal piece of the curriculum where the level if you will which tremendously is impacted by or impacts specialty choice, it permeates so much of the informal curriculum but is rarely frankly openly talked about.

I think that what we really need to see is both of these. If we take one Ms. Darling just said it makes good sense that we can reduce the level by taking care of the harmful, the risky, the useless, eliminating those and bringing down total spending or spending per item by 1, 2, 3-

percent and then address the slope. It seems to me that you have in fact gotten what Henry Aaron said, "Give me both please."

I think that from a medical education perspective, what we need to do is put a much more overt piece of this whole discussion into place because Dr. Aaron said we don't have good incentives in place today. That means that despite having had this conversation literally since I was in medical school we continue to train the next group of drivers with the same kinds of both formal and informal curriculum that don't tackle overtly the question about what should be done, how do we eliminate those things that are harmful, risky, and useless. How do we build in and respond to the incentives for doing the right things? Because we learned so much of our behavior, whether we're nurses, pharmacists, physicians in that mentoring informal curriculum how do we change the behavior? I can put something into a medical school curriculum but it's almost negated if I have a strong informal curriculum that's pushing increased rate and increased price per service that's there or encouraging people to pursue utilization of those pieces that should be eliminated.

I think that we have to address both and from a medical education perspective we've got to find a way to

begin to build in the incentives that Dr. Aaron says currently don't exist and aren't very effective. I suppose that usually brings me when I'm talking to a non-policy crowd to examples where we know we can put in place incentives because inevitably the lay public will say to me, "So what do we do?" The answer is you have to create the right incentives. The most powerful one I've seen in the last 10 years or so is we've talked about errors in medicine and harm for now a decade and a half.

Physicians, particularly the American Medical Association and others, stood up and said, "We do the best we can. We work diligently at making sure that we practice safe care." When Medicare said here's 10 things we're no longer going to pay you for somehow we found a great deal to do to change our behaviors and reduce the frequency at least of those 10 things. Incentives will work. The question is where do we put them in place. Whose job is it to create the incentives and enforce the incentives? How do we integrate that into the vast majority of a delivery system that's already in place versus the new hopefully up incoming professionals that may bring a better understanding of some of these incentives as a result in education process?

SUSAN DENTZER: Thank you very much, Nancy. Teri?

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

TERI G. FONTENOT: Good morning. I'd like to thank everyone for the opportunity to be here today. I think this is a wonderful panel. Also the participants here today to have a very intelligent dialog about what's driving the cost and the prices as well hopefully—I know we're not supposed to talk necessarily about solutions today but it's kind of hard to separate the two because they do go hand in hand.

I'm here representing the American Hospital Association and I am a hospital CEO in Baton Rouge, Louisiana. My remarks will not be as economic-driven as maybe more on the ground driven. The hospital field is first and foremost focused on providing excellent patient care. Whether that's individual patients or focusing through the Affordable Care Act and some other initiatives, trying to move more towards managing the health of populations then we want to be a part of the solution for that. We're encouraged with some of the opportunities that we see before us.

Also, hospitals are large employers. While we're a provider and we consume a lot of the health care costs, we also are large service organizations. Most of the time in smaller communities we are the largest employer in the community. Even in large cities generally hospitals are in the top five or ten employers. We're concerned as well about rising health care costs.

What I thought I'd spend just a few minutes on is talking a little bit about why we think some of the costs are increasing in hospital system and what possibly we can work together to do to start to continuing to bend that rate of growth. We have seen that the rate of growth has in fact declined somewhat over the last few years. In fact, in the last decade the percent of hospital care to total health care spending has declined from 43-percent to 33-percent. We'd like to think that we're starting to make some end roads.

Dr. Dickey mentioned just one thing and that's looking at never events and incentives for those. I think that's very important when we can isolate a particular problem and throw resources and share best practices and evidenced-based medicine toward it to work together, and then sharing the information, the transparency, and the accountability.

Just a short list of why you see hospital costs increasing is, Dr. Chernew talked about it, 50-percent of the rise in health care expenditures over the past several decades is due to evolving technology. In our own organization the most expensive piece of equipment we have is our clinical information system. We've spent about 20 million dollars on it so far. Many organizations, large health systems, have spent over 100 million dollars. We're

not there yet. It will provide better data for improved care. It does not reduce the number of FTEs that you have to run the hospital. In fact, our IT department is the fastest growing department that we have in our facility. We don't bill patients for IT.

America is certainly graying. We all know that. Most of us in the room are baby boomers. We will be putting some stresses on the system as well. We have chronic conditions and even younger patients have chronic conditions. Obesity was one of them that was just mentioned. While I understand the graph about the cause of obesity to the overall health care spending, I see every day in our organization, we're a large obstetrics facility, that patients regularly come in pregnant, ready to deliver and they're over 300 pounds. That adds to the health care cost of caring for that patient, increase their risk. It's very different from providing obstetric care to a patient that is normal weight.

Lifestyle factors also contribute to the prevalence of the chronic diseases already been mentioned. Hospitals are expected many times to take care of those kinds of conditions, even though they're not directly related to the reason that they're in the hospital. I really appreciate Dr. Wilensky mentioning the intensity of the encounter. We

continue to see that as well. Hospitals are measured on case mix index. If you look over the past several years, the CMS, the case mix index, has definitely gone up. That is an indicator of the way we code for the care that the patients are getting in the hospital. It shows that patients are sicker, are receiving more resources when they're in the hospital.

In addition to that, when they're in the hospital we're also being expected and asked to provide some preventive care. Examples are flu and pneumonia vaccines. Patient doesn't have flu or pneumonia but they're elderly and it's an opportunity to provide some preventive health care services. Those costs are also included in what's being provided with respect to patients being in hospitals.

Administrative and regulatory burden is huge for us. This is probably among the top three priorities right now for the American Hospital Association. Every day we receive new directives either from commercial payers or from federal or state or local governments regarding additional regulatory burdens, surveys, inspections about the way we code, about the way the care is provided. We are willing to provide that information, but it also increases our overhead significantly. Again there's no direct correlation to that

in patient care, but it is a true cost that we're all incurring.

That's one of the reasons many physicians have decided that they want to work for hospitals. They can no longer run a small business because it's become so sophisticated, so complicated you need people with such expertise that they simply can't afford it just to be able to get a bill out the door and to code it properly.

Then the last thing I want to mention is defensive medicine. It's been touched on a little bit. I really appreciated the article that's been referred to a couple of times about the different professional societies identifying those tests that are not completely necessary in all cases but patients get them. Often they get them because physicians are afraid of being sued.

I know in my own organization an obstetrician was sued when a child, when they entered school, was determined to have a learning disability. The family sued the obstetrician because they were convinced that the patient had some sort of birth injury. Now she regularly orders a specific lab test to prove that the baby did not have a condition at birth that would have lead to the learning disability that can't be diagnosed until the child starts school.

What are we doing to reduce those costs? We are forming partnerships among hospitals, physicians, and other providers, post-acute care providers, as well as community agencies, and state and local governments to try to improve care and better coordinate the care. Much of the care that is provided in hospitals, as we all know, is delivered because the patient did not have access to the right care and the right setting at the right time. Hospitals, particularly emergency rooms, are over run with patients who do not have the ability to pay. There's no incentive for hospitals to have that type of care provided in emergency rooms. We want to do what we can to keep people healthy. As I said at the top of my remarks, keeping people healthy really is our number one concern.

We also embrace transparency and accountability right now between CMS and joint commission, state and local governments, commercial payers, and many other organizations. We are reporting on the Internet and other ways over 40 or 50 different measures. It's scheduled to go up to 150 in a year or so. That takes a lot of resources, but we are doing it because we know that it leads to better care. We're also a pretty competitive bunch. We like to think that our organizations are providing exceptional care. When we can see where there's an opportunity we are seizing on it.

I'd like to just close with saying that we really are encouraged by the opportunities that we see to further integrate care. Regardless of what happens with the decision on the Affordable Care Act at the Supreme Court, what we say is that the toothpaste is out of the tube. We are running with trying to find ways to improve care through evidenced-based practice, through transparency and accountability and through working with others to collaborate to make sure the patient is getting the appropriate care at the appropriate place in time. Thank you.

SUSAN DENTZER: Great. Thank you very much, Teri. John Rother?

JOHN ROTHER: Good morning. I'd like to acknowledge the leadership of the Alliance in putting a terrific event together. I'm now with the National Coalition on Health Care. Our mission is system wide affordability and value. Our attention is focused on the deficit reduction that's likely next year that we'll focus on federal health plans. I think the issue is much more immediate than I think has been acknowledged to date.

Most of my career has been spent as a consumer advocate. Today I'm going to try to address the consumer role, particularly in volume. I think we have to acknowledge that there are many underlying behaviors that create the

demand for health care and that we too frequently just give them rhetorical support, and we're not effectively trying to do something about them. Many of these are easily preventable and yet, I think we as a collective health policy community are not sufficiently focused because after all these do drive volume.

In particular I think we have an epidemic going on in terms of chronic conditions that is a system-wide problem, but it's particularly a problem in Medicare. Part of that of course is the growing enrollment in Medicare. If we look at the patterns of the actual care delivered chronic care is taking over.

We do have some tools today that consumers could use to be more a part of the solution. They could choose more efficient health plans if there were sufficient costs and quality transparency, which I believe we're still a long way away from. They could go to a patient-centered medical home, particularly those with multiple chronic conditions, once those homes become more available. There are ways to utilize technology as a consumer. One obvious example is the simple act of taking prescriptions as prescribed. A shocking number of patients do not do that today, even though there are ways to encourage people to follow their doctor's prescription. When they do follow it of course they need to look for more

affordable options such as generics. They need to think longer-term. Despite years of advocacy at AARP around encouraging people to think about end of life and execute durable power of health care attorney we're still quite a ways away from making a serious impact on consumer's use of such kinds of tools.

In addition, a couple of people have already referred to the campaign announced last week, the choosing wisely campaign that identified many procedures, five per specialty, that should not normally be performed. I salute the leadership of the medical societies and the ABIM foundation that I'm privileged to serve on as being for the first time in years very public about problems around over use and the serious cross problems that come from that.

There are some policy levers that could address the consumer's role in health care cost. One that's been talked a lot about is value-based benefit design. The idea would be to vary cost sharing so that you would have very low cost sharing on high value procedures such as prevention screening, and perhaps very high cost sharing on some of these things that we've just mentioned in terms of its using wisely list where there's very scant evidence of value.

I think that the evidence on cost sharing does show that it could reduce total health care cost, but not if it's

done in a very clumsy way because then you'd just simply encourage delay and result in higher costs eventually. You have to be smart about how to do this. I think that as more consumers today, especially in the workplace have high deductible plans, this will become a much more important issue. How do we guide appropriately consumers who face very high out-of-pocket costs to make more value-based decisions about their own care?

I think that I have to close though on a caution. The caution is that any talk about cost sharing and the role that that plays must recognize the fact that cost sharing is extremely high today. The slide on the left shows the average cost sharing for a Medicare household, almost 15-percent of total income and much higher for people who have the multiple chronic conditions that account for most of the use. We're already above I think a level that's sustainable at the household level for people on a fixed income. This average for retirees today is only a little over 30,000.

For the under 65 population; that chart on the right. It's important to recognize that cost sharing today has a tremendously variable impact depending on the level of income of a household. High income households today only on average pay about 8-percent of their total income for health care, but middle income are 22-percent, and low income households

today are at 37-percent of total income going to health care. I would say this is a problem that needs to be addressed, not something that we can add to in terms of guiding more appropriate behavior in consumers. Consumers can be part of the solution here, but they need much better information, much better signals about the behavior we want them to engage in. They need to be partners with the physicians and hospitals that provide care. Thank you.

SUSAN DENTZER: Thank you very much, John. Dan Mendelson?

DANIEL N. MENDELSON: Again, I'll reiterate my congratulations to Alliance and thank everyone for their attention. I want to go back to the question that Susan was asking, which is what is the problem. I think that's really what we're supposed to be reacting to on this panel, and in particular this construct of price times quantity. I think that while I can't of course argue that price times quantity ultimately is equal to the amount of payment, I think it's the wrong framework. I think it's a dangerous framework. I think it's a framework that ultimately leads us to the wrong kinds of solutions.

In my view the best example of a solution that was fashioned after the price times quantity construct is the SGR. Where in '97 we looked at it and said okay, and some of

us more than others probably, but we collectively looked at this and said, the volume is going up so we're going to just reduce the price. It was unrealistic. It was a failed policy. We have failed to replace it. That to me is kind of the emblematic what happens when we go down this concept of price times quantity.

The reason why price times quantity is an inadequate framework is that it is incomplete. It does not account for the mix of services that are being used. I think that if there's one thing that we have learned is that providers will tend to optimize around price times quantity if we make adjustments there. Use of that framework I would argue kind of perpetuates the silos in the healthcare system that are really, in my view, kind of the nature of the problem. An alternative framing will be more helpful to us as we all kind of go into this journey that I think this is all leading to in 2013 where everyone in this room is going to be asked to come to the table with deficit reduction ideas. If all we have is price times quantity and we say let's reduce the price of hospital services or let's reduce the price of physician services we're going to be up a creek without a paddle.

I think the alternative framework, which is more productive, it's a focus on, is management. The major areas

where we have problems right now in the payment systems are places where we are paying for things but we are inadequately managing the service use. I'll give a couple of examples of places where I think we are inadequately managing service use and why focus on management might be a more productive construct in which to try to fashion bipartisan solutions.

The first example I'll give is in the area of post-acute care. Imagine you have an 85-year-old patient with a hip fracture who's getting discharged from the hospital. She might be sent to a rehab facility, an LTACC, or to home. Each of these different pathways has different cost implications to the federal government. Who is managing the service use on behalf of the federal government? No one. It's the fact that we have kind of incongruous or if you will kind of conflicting pathways. We are not managing the service use that gets us into trouble. Solutions are site neutrality, having an independent manager. It's really in the nature of the management as opposed to either the price or the quantity that we have the problem.

The second I would argue is care for the dual eligibles, which again is a major subject of discussion right now. I think the administration is making a tremendous amount of progress here. This is also going to be a 2013 discussion. Inadequate management. We have Medicare being

managed one way. We have Medicaid being managed another way. The two never cross. We don't look at the intersection.

A third area where I think the problem with P times Q is illustrated is Health IT. Everyone in this room probably agrees that better management of health care information is important and a prerequisite to improving quality and improving outcomes. Where does that sit in the P times Q framework? I would argue there, we have to be thinking about how do we encourage or in some cases force providers to get out there and really be actively putting the tools in place so that they can manage clinical care.

The last example I have to give is really of the SGR and the physician payment system which was kind of where I started. In contrast think about the star ratings system, which was a very important policy that was brought on by Health Reform. In the health plan environment right now you cannot find a medical director who is not being compensated for improvements in quality. Every medical director is being compensated now on the basis of whether they are improving the quality of the services. Here it is not a price or a quantity aspect. It is really a focus on quality that was the problem and is the solution.

I think that there when you think about the physician service aspect of this we have to be thinking about

management and efficiency and get away from this price times quantity construct. Those are my comments. I appreciate the opportunity to be here, Susan. Thanks.

SUSAN DENTZER: Great. Thank you, Dan. Andrew?

ANDREW DREYFUS: Thank you, Susan. I think I'm going to start where Helen started, just to say in Washington there's often a lot of focus on federal budgets and on the Medicare program, but in the world in which I live in home it's commercial health insurance premiums that are actually the first expression of health care or two high levels of health care that both families and businesses face. Our customers, including government as a customer, are absolutely giving us a message that it's unsustainable.

I work at Blue Cross Blue Shield of Massachusetts and we have been struggling with this issue since really 2007 after we passed our healthcare coverage law and realized that we needed a companion set of interventions to work on the cost and quality of care. We looked at both our past experience as a health plan, and I think it's replicated with most plans around the country, at trying to get at this volume and price issue and our efforts to negotiate lower prices have often been inadequate. Paul Ginsburg's work has validated that in several different ways.

The efforts to manage utilization in the 80s and 90s met with a lot of both physician and patient resistance. Early experiments with payment reform, especially capitation, while there were a few notably successes mostly failed. When we tried to design an intervention that would think about both the price and the quantity issue as well as some of the other issues that were raised we thought we really had to reinvent it and we had to learn from the past.

I think Mike mentioned in some of the comments. When you think about who's doing most of the decisions about care it's mostly made by physicians. We thought probably the single most important test of whether our intervention would be successful would be would physicians embrace it. By embrace I mean by that, would they actually think that their practice of medicine was improving and that their patient care was improving. We made an early decision as part of our new payment model, which some of you know is the Alternative Quality Contract, and if we had thought it had been such a success we would have called it something different. In the Blue Cross system it would have been Blue Vision or Blue Sky or Blue Futures. By the time we sent it to the marketing department to change the name it was too late. It was already known by its initials the AQC.

We made one important initial decision, as Mike said, that we would start physician practices where they were. We would accept that the current level of prices needed to be stabilized in part because the experience under capitation had been the opposite. The plans too often tried to reduce physician spending immediately.

Second of all we decided we needed a long-term five year sustained commitment between the plan and the physicians and the hospitals in order for both parties to kind of get out of the adversarial every other year negotiation and get into a deep partnership. Then we had to invest significantly in quality performance levels to really deal with the fears of capitation, which was that either care would be limited or sicker patients would be avoided. We dealt with that by having a very significant health status adjustment on all the patients, which has actually lead our practices to say to us they want the sickest patients because that's of course where the greatest opportunity is to make a difference and conserve resources.

As Mike said, we did get some criticism of that because of the widely documented payment disparities that exist in our market and in most markets. What has happened, and I know this is dipping into your third session here so my apologies in advance, is that all the drivers of cost that

we've discussed today; price, quantity, or volume intensity and the important one that Dan raised that I was also going to talk which is site of service, which is a huge issue in our market, have all been positively influenced by changing the payment incentives to physicians. For the first time in many years many of our practicing physicians as well as physician leaders are actually engaging in the kind of management that I think Dan is recommending for all their patients but most especially for their sickest patients.

Care patterns are changing. Referral patterns are changing. Practices are being redesigned. Mike is leading the team of independent reviewers funded by the Commonwealth Fund, including researchers at both Brandeis and the Harvard Medical School. The Year One results demonstrated that resource use is down and quality is up significantly. Quality is especially up for those practices that were the least integrated and organized in the past, which demonstrates that they are standard to managed care. I'm looking forward to the Year Two results, which I hope will be forthcoming soon from Mike's team.

I think it's a demonstration that when we work together in the collaborative way between physicians, hospitals, plan, and customers that we can achieve some of

the savings that seem so elusive that we've been discussing today.

SUSAN DENTZER: Alright. Thanks to all of you. Let me attempt to summarize what has been said by the stakeholder reactor panel. We heard first from Helen that private payers clearly regard the spending growth rate as unsustainable, but that they are mainly concerned at this point about the level of waste in the system; that 20 to 30-percent that is either share waste or indeterminate value if not valueless. It's not just the rate of growth from the standpoint of the private payers. It's the whole issue of reducing the base and then worry about the rate.

From Nancy we heard that certainly from the standpoint of medical education there is an awareness that intensity, Gail's word, is an issue; that the informal curriculum in medical education drives this intensity and that there's a reason to believe also within that system that reducing the level and reducing this excess intensity, unneeded intensity, will be critical. Building in incentives to do that, a combination of carrots and sticks, will be critical. She mentioned the case of the never events, which was very much a stick, not a carrot that got the attention of hospitals and hospital system, and is getting rid of those events.

We heard from Teri that hospitals as employers are as concerned about high health care cost as anybody else. Then Teri mentioned some of the things that hospitals themselves believe are driving up their spending internally now. Getting on some topics that we'll be talking about more later. For example, health information technology, clinical information systems, and expenditures that are being made there, intensity going up by virtue of case mix. Teri, I guess it would be another conversation as to whether the case mix is really getting more complex or whether things are being coded that way. That's another discussion.

She mentioned some other drivers that hospitals and other providers are concerned about; defensive medicine and so on. Also emphasized that from the hospital perspective it is clear that coordination of care will be an important remedy and more integration of care. Arguably those are factors that are designed to intense to some degree this excess care, the waste that Helen talked about; rehospitalization of people who didn't need to be in the hospital the first place but had not had their chronic illnesses sufficiently managed in the primary care setting such that they became ill, had to be hospitalized, and then are rehospitalized. Those kinds of issues it seems the

hospitals believe there's a lot of ability to drive out of the system.

We then heard from John about his concern and particularly about the drivers of volume being chronic conditions. That's a topic we're going to be taking up more next time. John believing that there would be a lot to be done to incentivize consumers to choose more efficient care providers or health plans that would wrap around more efficient care providers, and that there's also a lot to be gained by addressing some of the things that we know people are very much concerned about today with respect to things like medication adherence, not being sufficiently high such that people stay healthy and therefore out of the hospital. He mentioned the issue of end of life care and potentially more sensible patterns of end of life care spending that more closely approximate what the realities are of what health care can achieve at the end of life, etcetera, etcetera.

We turned to Dan. Sorry. I'm thinking Dawn Mets back in my office because I was thinking about getting Michael's AQC second year results published as fast as possible. From Dan Mendelson we heard about again going back to this question of what is the problem of, he mentioned in his view, it is not price times quantity, but really a question of the need for better management of the overall

system. I think this ties in with the comment about intensity and with the comment about waste. There's some convergence of opinion there I think. Let's concentrate on what is really effective care and get rid of the ineffective care. He mentioned the case of post-acute care and the lack of management there driving so much of the spending in the Medicare context.

Then we heard from Andrew. It sounds like again a convergence around the notion that this is really, largely going to be about management, that these practices now have agreed to deliver health care differently going forward to be attentive to all of these things. Andrew said price, quantity, the site of service, as well as the intensity. The whole notion being that there's going to be better management over time and that that's going to restrict the rate of growth. Of course we'll find out when Dawn Mets, who is at Health Affairs, help us get Michael's team's results published. We'll find out what the answer was for the second year of the AQC.

First of all let me ask our panelists right up front here whether you have any comments on the reactor panel. Then we'll open it up to broader discussion with the rest of the audience. Gail?

GAIL WILENSKY, PHD: I was struck by Helen's comment and also John Rother's in terms of the focus of the private payers on the current level and not just growth. Of course, almost by definition, what we began to talk about, Jim raised this and others have raised it, morphs into very close to the same thing; driving out some of the less useful if not completely wasteful. Most of the time I think it's more of a less useful as opposed to zero use. That is going to help lower spending growth over time. I guess we will see whether we get actual lower levels other than the fact that if you lower the spending growth, as I think Jim had mentioned or other people have mentioned, by definition that means you have a lower level than you would have had if you don't. Whether we'll really be able to get down below 2.8 trillion, even though we I think all agree we could, is another matter.

It may be just as much as recognizing the kinds of pressures that different decision makers are feeling; people running hospitals, people who are involved in trying to get employer-sponsored insurance out. Trying to find ways so that we can communicate more effectively because I think in fact there was considerable convergence over time on a lot of these issues.

SUSAN DENTZER: Hank and then Mike?

HENRY J. AARON: Perhaps to the distress of those from outside the beltway or from outside the economics profession I want to give a short homily on basic economics. Those in the business world may be acutely concerned about high levels of spending. I would emphasize a central fact. The total cost as a share of output of employee compensation all in, including health care benefits, has been trending down as a share of total output. Economic theory suggests that health care costs, whether paid for directly by employees or indirectly on their behalf by employers, are sooner or later borne by workers in the form of offsetting lower levels of other forms of compensation then would be possible if health care cost less than it does.

That suggests that notwithstanding the all together sincere concern that Helen and everybody else in business expresses about the burden that high health care cost plays on them in their efforts to increase productivity. The real problem is a living standard's problem for workers through the misallocation of the resources devoted to compensating them. We have lower living standards as Americans to the extent that resources are allocated to health care that produce low benefits. The implication is that businesses are not in any significant way directly burdened by those high costs.

I'm giving this short economics homily in full recognition that nobody believes it but economists. [Laughter].

SUSAN DENTZER: As you mentioned though, I guess a tie in here, Hank, is yes, granted overall compensation is what matters here. If the compensation share that is devoted to health benefits is as you said devoted to less than useful health services being procured surely there is an interest on the part of employers in rationalizing that. Surely they too would prefer to give employees more in wages than they would prefer to give them in health benefits that buy stuff we don't need.

HENRY J. AARON: Absolutely. I believe employers by and large are good citizens of this country and want to see welfare as high as possible. All I'm saying is that it does not affect their power to compete here or abroad. It's a burden borne by American workers.

SUSAN DENTZER: Alright. Mike?

MICHAEL E. CHERNEW, PHD: First of all, I feel like I should just pause and say amen. I will plow ahead. The more that we're on tape listening to that the more valuable it would be. Although I do think that it's easy to take those comments, and I don't think Henry meant them this way, as thinking that the waste in the healthcare system doesn't

matter. I don't think that's what he said at all. I actually think that the weighted healthcare system matters a lot. It's just all borne by workers. All the efforts that Helen talked about become crucial because you can't provide a worker with a set of compensation that they really like as easily if a lot of the money going to health care is just wasted.

Which brings us to the choosing wisely campaign. I'll start by saying I'm a huge fan of that for many reasons, but not the least is as a supporter of value-based insurance design, or as John calls it, value-based benefit design, but I'm going to stick with value-based insurance design. As a supporter of value-based insurance design I would love to be able to say it saves money. I think it's generally only going to save money if you can couple your reduction in cost sharing for the high value things with increased cost sharing for low value things, but you need to know what those are. Any effort to do that is incredibly useful. I already have some students trying to figure out how one might be able to implement that in various ways.

The problem is, and I will emphasize, a given healthcare service is neither high nor low value. It depends on who gets it. If you look at the stuff that was put out by the American Board of Internal Medicine folks a lot of those

things have various caveats. Imaging is not low value. It's imaging in this situation or imaging for these people or this type of stuff. That's sometimes hard to code and hard to manage. I think we have a lot of work to get us to a system where the waste can be gotten rid of. One of the advantages of bundle payment broadly is you don't require the complicated information technology back coding decision making things. You allow the physicians to do the triaging, the sorting out themselves. I think that's a real advantage.

I'm going to make another dichotomy and then call it false before everybody else does. Apart from price and quantity, which are almost true in an accounting sense, but as Dan pointed out, maybe not all that useful in some sense. I think there's a lot of debate in this country about whether we have a problem of supply meaning the supply side; the providers are doing something wrong, or a problem of demand; the consumers are doing the wrong thing. I will give my take on this.

SUSAN DENTZER: Or both.

MICHAEL E. CHERNEW, PHD: Right. My take on this is largely that the suppliers will respond to the demand side incentives they face and our goal has to be to try and set those up in a reasonable way. You'll get to good management when the providers have incentives for good management. It

was pointed out that when we changed the incentives in various ways you saw the suppliers change.

I think our challenge is how to balance those types of incentives. We're going to need both. I spent a lot of time talking about the alternative quality contract. Andrew is here. He can talk about it much better than I. You should know that Blue Cross Blue Shield has an innovative tier network product. They have a whole program to incorporate value-based insurance design.

I was on a panel with one of Andrew's coworkers, Deb Devaux, and someone asked her what the most important thing to do in this sort of alternative quality contract thing. The answer was in part to figure out how to get the consumer incentives working around what is already a well-designed supply side set of incentives. I think that is going to matter. There's going to be a lot of innovation in the marketplace about how to do that. There's a lot of issues of IT, a lot of issues with communication.

The last thing I will say as one goes through this, as we go down this journey to the extent that we think about the demand side as being public payers of which they clearly are, finding a way to have them work efficiently without an enormous amount of regulatory burden is stunningly important. Figuring out the vote to fixing the existing fee-for-service

schedule, which many of these systems are built off of, and Bob should come up here and sing from his hymnal. How much we have to devote to fixing the existing fee-for-service system to make all of this work despite all of the pathologies versus how much we can move away from it becomes an incredibly important discussion. Because in some sense prices and quantity are divided by simply how you set the fee schedule. You change what you pay for you change the definition of what's price and quantity. It's a semantic distinction in a way that I never realized.

In graduate school I thought I understood price and quantity and used to label them P and Q sometimes theta to keep the riffraff out. I thought I understood what price and quantity were. I realize more it's just much more complicated. Thinking about the actors; the suppliers, the demanders, and how the incentives work is really a more fruitful way to go.

SUSAN DENTZER: Mike, at the risk of violating my own adjuration that we were not going to talk about other topics today that we're going to deal with in other briefings, let me bring up the question of technology for a moment and tie this back to the discussion that was had on getting rid of waste and the choosing wisely campaign. If you look at the top five things that the primary care providers initially

surfaced in the list of five things not to do, one of those on the list was EKGs on healthy patients, which 15 or 20 years ago was thought of as a completely appropriate thing to do that all high-minded cardiologists would do. Then low and behold the technology shifted and the price level fell and it became possible for primary care doctors to purchase this equipment and have in their offices. They thought that they were doing the right thing. Now we know that they didn't necessarily need to do that, and there isn't a great amount of value attached to doing those tests on healthy patients.

We have to, at some point, point out that knowledge changes in health care overtime and the things that are conceived of as being useful in one era, we give you leeching, are later shown not to be appropriate. How do we deal with this problem of changing knowledge and changing technology and capturing this notion of what is not of value in medicine?

MICHAEL E. CHERNEW, PHD: I think leeching is making a comeback. That aside I think it's going to fall exactly the way these discussions have gone. It's very useful to have the organizations with the gravity to come out and call some of these things out. My personal opinion is that will only be influential if you change the incentives.

For example, although we haven't we can look to see if the contracted Blue Cross Blue Shield in place has made people move one way or another away from some of those selected things. You could decide if you're not going to do that if you want to charge people more, as John pointed out for some of those things. Both might matter. They're going to differ for different things on that list. I don't think you're going to get patients to do a great job when a physician says you need an EKG of saying, no I don't because it's this much. Some incentives and maybe some provider incentives could help there.

Then the challenge is going to be through things like PICORI and the provider boards doing exactly what they're doing. Seven more are coming out. People haven't mentioned that. There's one now but a lot of other groups are coming out with more. I think that's the process of figuring out what it is that is good through things like this and things like PICORI and other short organizations. Then putting incentives so that people don't lose a lot of money if they do the stuff that's right. Right now that's what the problem is.

What was sort of implied by your question was when the doctors have it in their office and they adopted it, some of them may have been thinking they were doing the right

clinical thing, but they weren't losing money making the choice.

SUSAN DENTZER: As Uwe Reinhardt famously said, "There are a lot of things doctors can do and still feel right with God." Gail?

GAIL WILENSKY, PHD: I think it is going to require reinforcing the notion that it is more likely a question of is this a procedure or intervention that makes sense for someone in a particular set of medical conditions or other ways of appropriately describing that person; biomarkers, etcetera. By and large it is not an issue of is this a wasteful activity or is this an activity that provides no clinical benefit. I think the likelihood of that being the case is very small. Once in a while Medicare trips on something that it just regards as not appropriate for coverage ever and with great difficulty takes it off the table.

It's mostly getting people to move to a different way of thinking and recognizing that it may well change over time as our views of what is an effective intervention change over time. That rapid learning and dissemination of information, updating this information, is a fact of life in this complex way that patients can be treated. It will, to go back to Nancy Dickey's point, require very different training for the

next generation of physicians and nurses and other in between health care providers. We haven't determined yet.

It is, as somebody with some frequency who speaks to medical students or early residents, disconcerting to me that probability and statistics are very often not a part of most clinical physician's training. It's only if they had certain kind of undergraduate backgrounds or if they're going into research that you see that. It is really a different mindset. It is both the notion of working for whom under what circumstances, and that this information may evolve over time. What we thought one generation was good practice of clinical intervention may turn out a decade later to be just flat wrong because of additional information that's now available.

This is a lot of redesign, not just in how we reimburse, and at what level can we incent the right management, but how do we train people to be thinking like that is a very different mindset than I know either my husband's generation of physicians had or my daughter-in-law who's only been in practice a couple of years. It's just not clear to me when I go out and speak, and I always ask the students in the room how many people have had statistical training or probability training.

Even at some of the very, what are regarded as excellent medical schools of the country, it is usually a very small minority. It's not the only thing that needs to be done differently, but it is a different mindset. It's just part of the point that Nancy was raising.

SUSAN DENTZER: Hank? Then let's have Nancy comment on that.

HENRY J. AARON: I'd like to pose a question and I'll give my own answer to it as well. How many here would like to go when ill to a doctor who weighs the cost to society of the care that is being provided to you in deciding whether to recommend the care to you? You're well-insured. I'm going to assume for simplicity you're completely insured at the margin. You face zero cost. Society incurs cost to the extent that resources are used in providing care.

Do you want to go see a doctor who is an agent for society or an agent for you? I will give you my answer. I want to see a doctor who's an agent for me, not one who's acting as an agent for society. There may be some in this room who are more public spirited than I. I submit you are in the minority. As long as we're talking about a system in which the goal is to provide as relatively complete insurance for serious illnesses to most or everyone, then we have a problem here because the financial incentives facing the

patient and under current methods of delivering care, the financial incentives facing the provider are working against the social objective of balancing costs and benefits.

I wish Mike and his friends Godspeed in trying to tilt those incentives with respect to specific procedures in a favorable direction. I think that in the end we're only going to make marginal progress along those lines because the analytical problem is just too complicated and for the reasons that Gail described earlier. If you're thinking about one of the major cost drivers of contemporary medical care let's pick diagnostic radiology, and you ask yourself whether an MRI for a person with suspected neoplasm is indicated the answer to that question medically requires several stages of very complicated research on whether the picture is going to make a difference in diagnosis, a difference in treatment, the difference in treatment it will make in patient outcome, and from society's standpoint whether the change in outcome is worth the cost of the string of therapy that may result from this.

Better statistical training will help, but I believe that in the end what one has to be talking about are professional norms and picking up onto Danny Mendelson's point, management structures that establish rules somewhat arbitrary and not necessarily optimally efficient for when

particular things are done. Research will help. It should be done. We can't wait until that research gets done in order to try and change the trajectory of health care spending. That's going to require I think some more brute force techniques.

Danny didn't use that term. It's my term. I think the management instruments that he's describing are such brute force devices for changing the delivery of care.

SUSAN DENTZER: Our reactor panel is having a lot of reactions. Let's go to them quickly. Nancy?

NANCY W. DICKEY, MD: Fairly quickly. I think that we can achieve some of the things we want, particularly if many of us can at least buy where I think Gail said she is. She said I may not be ideal but I can live with the current amount if we can impact the slope. Then we can always talk about trying to perhaps attack that. If I understood what you were saying, Andrew, about the contract you said, we'll accept where currently physicians are. That's terrifically important because if physicians are feeling like they're fighting the system in trying to preserve an income, they've proven over many decades that we're pretty good at that. We can gain the system. You want to talk about rate? Fine. You want to talk about slope? We'll talk about that.

I think that what we want to do is create champions out of physicians. That means we've got to begin to change their mindset in terms of what they do. The professional norms I believe, Henry, you're right, are going to drive us more than the concern about whether or not our students got statistics. If in fact we're asking students what does the data show, they'll begin to go read what the data shows. If instead you're asking them what the result of the lab test was or what other tests they might want to consider, they're not thinking about what the normative value of doing a given task is. They're thinking about what to add to the order sheet.

I think what we have to do is ask ourselves how to not make physicians the policemen. When I'm sitting with an individual patient I don't want to be the policeman or tell my patient that I'm sorry, I'm going to opt for what's best for society. HMO management taught us that doctors don't want to do that and our patients don't want us doing that. You don't want me to be the economic loser. If we can say to physicians we'll kind of preserve where we are and then build in incentives to try to attack the rate of the slope I think we're much more likely to be effective.

In so doing then I think we have to begin to ask both practicing physicians and the learners to begin to ask a

different set of questions, not whether there's any chance this particular intervention is going to help, but what's the value. Then teach the learners how to have the conversation. After 35 years of practicing medicine I can tell you that if I lay out the proper data, most of my patients don't really want an intervention that has a marginal chance of helping. It's going to cost them a fair amount of money and may even bring some risk. The problem is we don't present very many things in those kinds of data, nor do we teach students to present things in those kinds of data. We walk in and say, you're 45 years old and you're male; you need an EKG, not what's the options here.

We've got to change the conversation, which by the way will also help John Rother in terms of patients having the right data to begin to make the decision. We have for 35 years celebrated high tech. We've trained an extraordinary percentage of our clinicians to come out and be oriented to high tech. If that's the way you make your living there really isn't a lot of future in asking yourself or your patient whether they really want this high tech intervention or not because all of the incentives are built in to doing more high tech.

We've got to change the incentives if you want to change the behavior, otherwise I think what we'll see is more

intelligent people gaming the system to get to the right place for themselves.

SUSAN DENTZER: John and then Andy?

JOHN ROTHER: I'd like to repeat a couple of key items that I think have not been mentioned, but only in passing. Dan mentioned post-acute care. We don't often include the cost of long-term care in these types of discussions. Yet from a family perspective the cost is overwhelming and cannot be ignored. It's something that I think we ignore at our peril because consumers have to deal with this usually when a parent becomes ill and certainly when a spouse does.

Secondly I'm going to go back to one of the things that Mike showed us which is how important primary care is. In contrast to the rest of the world we have a specialists-based system more than a primary care-based system. We should be trying to change that.

Finally I think it's important to say with the epidemic of chronic conditions we need to get away from the episodic model of care delivery. It's got to be based on teams. It's got to be based on enhanced role for nurses and other physician extenders, social workers, people who can be in constant communication with the patient. That's going to require structural changes in the way health care is

delivered. That's going to require changes in fee-for-service and moving away from that. It's going to require changes in scope of practice restrictions at the state level that today get in the way of a team-based approach.

SUSAN DENTZER: Thank you, John. Andrew?

ANDREW DREYFUS: I just want to respond to the question, because the audience didn't, that Henry Aaron posed about which physician do you want. My answer is I want neither. In a fee-for-service system, yes, I want a physician who is interested in my health. In a new kind of system I want a physician who is thinking about the risks of over use, who is thinking about population health, who's incentive to conserve resources, who's thinking about patient preferences, which we know from the research often results in patients wanting less technological interventions. I guess this is to Gail's question and about new physicians about the right training.

When we look at other western democracies that have struggled with this issue they do use a brute force technique usually about setting an overall budget either at sometimes at the national level, sometimes at the provincial level. We could argue whether that would be useful in the United States, but it's probably not politically realistic in the short-term, although our state as always may be experimenting

with such a mechanism. I think what we're trying to think about now is, is it more reasonable and is the version of a softer force is to set a budget at an appropriate level a group of patients with a group of physicians and ask them to make some of these difficult decisions in consultation both with the best evidence and research that exists as well as with patient preferences. I am optimistic, and I think the early results demonstrate, that that can actually influence both the base and the trend.

DANIEL N. MENDELSON: I agree with everything that Andrew said, and if I could just add. First of all, at the idea that management constitutes brute force. In an integrated system where a physician is really caring for me I think I will do better. We're doing a lot of research right now at Avalere on post-acute care and what happens to patients as they bounce around in the system. The patients don't like it, their families don't like it, and they get hurt. Then they get readmitted to the hospital. That is what comes out of an I-am-your-advocate-type system. It's frankly gotten to the point where my parents are in fee-for-service, my wife's parents are in Kaiser, and I'm starting to think that they're getting a lot better care in the more integrated system just because of these problems that come up. It's being validated by our research.

I don't think it's really as clear as saying, well is the physician my advocate or not. I think a lot of it has to do with the kinds of things that Andrew was talking about, which is what is the context in which that physician is practicing and is there adequate care integration. Management quality incentives is something that I would add to Andrew's list; a decent health IT system that means that I as the kid of the aging parent don't have to go in and for the fifth time repeat all of the medications that my parent is on. Those are some of the things that I'm worried about.

SUSAN DENTZER: I just want to echo the comment about post-acute, and just in a brief advertisement for Health Affairs say that next month we'll be releasing, among other things, a paper that looks at the spending on the dual eligible population below age 65 and sees that not only are providers doing a fair amount of the gaming but states are doing a fair amount of the gaming as well as states push people out of the Medicaid program into a hospital setting where their care is going to be paid for by Medicare. Stay tuned.

Helen? Then Hank? Any other reactors have a reaction? Teri? Then we need to go to the audience.

HELEN DARLING: I want to stop this false dichotomy between you're for the patient. It's been said very well and

I think all of us feel like that's an argument that's 30 years old. That's not what we're talking about at all. Almost all the work that's being done in the physician community physician leadership is all about the question of what is right for the individual patient when we have especially lots of evidence that for a whole complicated set of reasons people are getting more than they need. It's risky and harmful. I think the idea that if you don't get what you think you want because the physician is taking the time to explain it to you that somehow that's a bad thing if it's harmful.

For those of you who would like to look at some data on this, if you read Rita Redberg's article on this topic, the number of now that Medicare pays for colonoscopies, which we know are valuable in any number of instances and we're glad it's paid for, but the number of 75-year-olds who are now getting colonoscopies in America is very significant and obviously way beyond what would be the predicted use for those people who have special circumstances. Obviously these are people who are not at risk. The ones at risk would be taken out of the database.

There's so much evidence that a lot of care is being provided, and there are lots of reasons for it. It isn't a question of the public versus the individual. It's all about

the individual and what the individual should be getting, and, as Andrew said, what the physician is helping you to understand is appropriate for you. That's a completely different picture. That's what's going on right now in this country.

SUSAN DENTZER: Alright. I think Teri had a comment and then Hank. Then we'll go to the audience.

TERI G. FONTENOT: Thank you. I would like to respond with some concrete examples regarding the demand side that Michael referred to and patient's expectations and physician's desires to be advocates for their patients. Right now the American Hospital Association is working very hard to disseminate information on best practices regarding eliminating non-medically necessary inductions prior to 39 weeks. It's been shown that it can be harmful to the baby, that there's no medical indication for it. This is something that the patient has demanded for years. It's more expensive as well. There are a variety of reasons the patient wants it. One is, it's convenient. Two is, she's uncomfortable. Three, it could be because the physician wants to be able to deliver his particular patient while he is available, not on a weekend when it may not be his call weekend.

There are a variety of social inconvenience issues surrounding this. The outcome is if the dates are missed

then the baby ends up in the NICU, a very expensive place for a newborn to be. It's been estimated at about—I know one billion is not a lot of money in the whole scheme of things, but one billion dollars could be saved if non-medically necessary inductions prior to 39 weeks were completely eliminated. To Nancy's point, that's the first I've heard that physicians feel like they're the policemen because the hospitals generally feel like they're the ones that are policing both the patient by refusing to schedule these things and the physicians as well.

That's one example. Another one is the da Vinci Robotic System. I don't know how many of you are aware of this but it is a very expensive piece of technology that is wonderful. It's used primarily for hysterectomies and prostatectomies. The machine costs almost two million dollars and it lasts about three years before it's obsolete. The disposables that go with it are thousands of dollars as well. The patient outcome is great. You can have a hysterectomy and be in the hospital less than 24 hours, no blood loss, very little pain. As far as changing the outcome it's no different except it's much better for the way the patient feels about it and it's a much more expensive way to have a hysterectomy.

I think while we talk about the quantity and the pricing and unnecessary procedures and that sort of thing we really shouldn't lose focus on the influence that the patient has.

SUSAN DENTZER: Great. Thank you very much. Hank?

HENRY J. AARON: I just wanted to associate myself with what Dan said about what constitutes good care. I wasn't suggesting when I imposed the question to you about whether you wanted physicians to act on your behalf or on that of society that you wanted fragmented care. Given the opportunity to have the kind of team-based care that John Rother described and that I think Dan also described that would be where my vote would go.

SUSAN DENTZER: Speaking of management and control you can see I've done an excellent job keeping us focused on prices and volume, not over the course of this day. As we imagined, things will be much the same over the next two sessions. What we really have here obviously is a broad set of discussions around what are we going to get rid of, what are we going to spend money on, and who is going to spend it and who is going to decide and how are we going to create the best possible system that gets us to the right care, the right patient, the right time without breaking the bank along the way.

With that as the newly redefined set of topics we'll discuss for the remainder of our time, let's open it up to questions or comments from all of you. Paul, since you're going to be handing us all of the solutions and all of the answers in a couple of months

PAUL GINSBURG: Sure. I was reflecting back on the discussion we were having about levels and rates of growth. I think there's something that's been missed which is what is a rate of growth? It's the sum total of changes and levels of all the different services and the 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.

If you look at manufacturing where it's one of the successes of our economic system, the high rates of productivity growth in manufacturing, that doesn't come by just turning on a button saying we want productivity growth. It really is a result of a process of continually looking for discrete changes in the processes. They're each changes in levels. In a sense I think slowing the rate of growth, which we see a real need to do, is going to work itself down to discrete changes in how things are done.

I'm going to leak into this Session Three a little bit because there were a number of comments about how some of the pilots and experiments on payment reform have worked well

because they in a sense started off providers where they are level-wise. This made it more acceptable. It's really the only way you can do it with voluntary programs. We have to keep in mind that everything we have out there now as far as reforming payment and changes incentives it's mostly voluntary program pilots. There's a point I forgot to make that's relevant to this.

If your levels are high it means reducing your rate of growth is going to be easier because you have more to look at to change. If you start off all your providers and some of them have much higher levels than others at their current level over time that's going to become untenable. Because the providers have started off as very low levels are going to run out of things that they can change in order to keep up with a lower rate of increase in your payment rates. Ultimately there's going to have to be a transition from pilots to a new payment system; as Gail was alluding to her concern about the Affordable Care Act not having made that provision.

In a sense at some point it's going to be instead of pegging everyone's rates to their past experience it's going to be transitioning to a rate that's pegged at a market level or an area level. That's going to be the real challenge in making progress in this area.

SUSAN DENTZER: We should point out that the Affordable Care Act does give the secretary the authority to take something that is demonstrated in a pilot or a demo and apply it broadly across the entirety, at least of the Medicare program. The question will be politically will she be able to do that, or he, eventually assuming that the man is once again appointed to the HHS.

Let's start here and we'll work our way this way around the room. If you would all just introduce yourselves.

JOY WILSON: Joy Wilson, National Conference of State Legislatures. I'm not going to talk about states. This is another question. On practice guidelines there's an assumption that the doctors will have a medical record and be able to know what constitutes a health patient and therefore what tests may or may not. I think there's an issue about do we have enough information to actually move that forward under the current system.

I guess then my next question would be how important to the whole cost question are the people who are outside the system. The coverage issue; how important is the coverage issue to getting a hold of the cost?

SUSAN DENTZER: Anyone want to address that?

HELEN DARLING: From the point of view of budgetary room it's pretty critical. In fact, one of the things that

we know is going to happen assuming the 32 million people come into the system in 2014 we will have a lot more people having coverage and getting care. If we don't take care of what I would consider the waste and the harm, all of those things so that there is budgetary room to pay for the things we don't pay for now, including those who will have coverage and who will be getting for the first time some care.

I might have the numbers wrong, but it's something like two to three years from the time an uninsured person because Medicare eligible before they're caught up with where they would be if they'd been covered. We know that most of the people who come in are going to be those who have not had some of the services they're going to have.

SUSAN DENTZER: Okay. Thank you for raising that great point, Joy. Let's stay here at this table and again we'll move our way back.

BOB ROEHR: Bob Roehr. I'm a journalist who writes for the BMJ among others. Other sectors in this country have undergone profound changes when they started to face foreign competition. Health care has seemed to be immune from that until fairly recently where we started to see some people outsourcing reading of x-rays, things like that; some medical tourism. Do you see that type of foreign competition as playing a role of any sort in helping to make health care in

the United States more efficient? In other words, over the last 10 years we've come to think of global health as a sector, a factor. Are we going to 10 years from now be talking about global health care?

SUSAN DENTZER: Eureka. We may be back to a discussion about price. Will the fact that prices for care are lower abroad—you can go to India and get a heart bypass for a fraction of what you can pay here with equally well-trained physicians in even more state of the art institutions. Is that going to drive prices anywhere here? Mike or Hank?

MICHAEL E. CHERNEW, PHD: I'm going to go for the most part not to a big degree. I would say no. Not zero, but I wouldn't view that as a big—

HENRY J. AARON: I'd give the same answer Mike does and support it with an example from Great Britain, which is that there were vast differences and waiting lists for procedures across different health service areas in Great Britain that persisted over extended periods of time because nobody moved. That was within one country where the cost of transportation was relatively small, the cultural differences, the environment were comparatively similar. I think the idea that any significant number of people are going to go abroad for costly care is extremely improbable.

HELEN DARLING: Susan, can I just respond. First of all, we're not going to see the global tourism in that sense that you mean, but what we are seeing already is domestic tourism which is related to price and cost. The growing number of large employers, they're not talking about sending people to India. They're talking about sending people to the Cleveland Clinic and Johns Hopkins. That's I think the trend that will grow significantly in the United States. The main reason is quality and safety. The secondary reason is on balance it costs the employer other work, as Dr. Aaron would say, next to nothing if they go to these places and they have fewer complications, they're away from work less. On balance it's a benefit to everyone.

SUSAN DENTZER: Andrew, not to put you on the spot, but isn't it the case that almost all the major insurance companies have gone over to places like India and checked out these hospitals and credentialed them for care, it's just that you all don't want to be ham handed and make people get on a plane and go these places?

ANDREW DREYFUS: It has started, but I agree that it's modest at best thus far.

DANIEL N. MENDELSON: Yes. I think that the point though is it's a very good question. I think probably everybody up here would agree that in the radiology area it's

like to affect things. In the lab test area it is likely to affect things. The European use of biosimilars for example I think does effect the U.S. experience. Increasingly as evidence is being analyzed globally and as the inputs are being deployed globally that is likely to change significantly. I think what is less likely to change is the desire of an individual to have a relationship with a human being who is directing their care. I would expect to see some significant change with globalization over time, albeit perhaps not in the present model.

ANDREW DREYFUS: One other point is that we may also see as the affordability and cost issue becomes preeminent in health care in the United States more technology is being invented here, which provide an equivalent service to what we've been seeing in the past. Lab is a good example of that that do it at a much lower price. That actually I think has the potential for some disruptive technologies to change the trajectory in some spaces within the health sector.

DANIEL N. MENDELSON: A related question if I could. If biosimilars are available in Europe and they're not available in the United States and you have an individual who cannot afford the innovator product are they likely to go outside of the U.S.? That's a question we don't know the answer to that yet. I've never seen it studied. That is the

kind of question that I think you should be thinking about in trying to get an answer to the perceptive question that you're asking.

SUSAN DENTZER: Okay. Let's move to the next table back.

JACK RODGERS: I'm Jack Rodgers. I actually just had a question with respect to Massachusetts. Perhaps Andrew could tell us. I know we're not supposed to be talking about health reform in general, but since it's so related in terms of coverage leading back into P times Q or whatever, what do you think has happened in Massachusetts because of health care reform in terms of health care costs overall?

ANDREW DREYFUS: The leaders who worked on developing our law that was passed in 2006 made a very explicit political and I would argue economic decision to not make cost central to our original loss. It was really a lot about coverage in part because past efforts in Massachusetts around the country that coverage expansions have been held hostage to the cost question and never solved and therefore coverage was postponed.

Now that the state has expanded coverage and we have 98.2-percent of our adults and 99.8-percent of our children with a regular source of insurance coverage and in most cases with a regular source of care it's forced the political

system and the health care system in the state to focus very directly on cost and affordability. We've had a series of laws that have passed quietly over the last few years that have raised a lot of questions about cost. In the next few weeks we will see our state legislature debate potentially some brute force interventions as well as some other ones. As a consequence of all the lead up to this as well as I'd like to think some of the introductions of both new payment models and the new products and benefit structures that Mike had alluded to earlier, we've seen dramatic reductions in the growth and premium.

For example, in our small group and individual market premiums are growing at 15 or 16-percent two years ago. The average increase of that market this year is about 2-percent. Some of that is a result of the nationwide economic changes that have affected cost and premiums around the country, but some are very specific to the culture in Massachusetts that has made this commitment to coverage and now is making an analogous commitment to affordability.

SUSAN DENTZER: Great. Next table back.

FEMALE SPEAKER: Thank you, Susan and thanks to everyone. This has been really a terrific conversation and touched on so many points. Susan, I apologize. I probably will take us into the world of solutions a little bit here.

As I reflect on the conversation, and Michael your comments early on, about how to get to that marginal value out of all of the new knowledge and technology and then the evolution towards management being an important aspect of how we get there one of the things that in the supply and demand discussion we didn't touch on is the power of the political voice, not just the individual patient but the political voice in demanding more around particular kinds of solutions. I wondered how the panelists think about that element of the discussion; not just what the consumer wants but what the political calls out as a negative say for insurers if they are the ones applying management and how that's going to affect the changes over the course of the next year.

SUSAN DENTZER: Anyone want to take a stab at interpreting the political environment currently with respect to these issues? Mike?

MICHAEL E. CHERNEW, PHD: No, I don't. I will say I agree with that. There's a constant tension. I think the bottom line with economics would tell you is everybody wants a lot of stuff and they don't want to pay for it. We will face the exact challenge you said that as some systems come into play you can envision a large backlash. We had one a few decades ago.

I think that one of the things you see and one of the things we're looking at for example in Massachusetts is how the consumers have responded. In some of these broader models where the physicians have control and the management is working well you don't nearly see the same level of backlash that you might have seen in similar things 10, 15 years ago. There are other very important things. I think the liability system, which I said in my talk was not a big driver of health care spending, which I would stand by that statement, but I think thinking about how to manage a liability system in a world that has a different payment model is a crucial thing and will be quite political that I won't venture into. That section probably would be in my top three aspects of this.

The other thing I would say is given the budget projections we're in a world where things happen that I never would have thought would have happened regarding say fixing the SGR which is many things but not sustainable. [Laughter]. I never would have told you, you would have had two month fixes with hold your bills and then do it. When the scoring in places is requiring everything to be budget neutral for a whole series of reasons the political system now in its stunningly messy and often shocking ways, it at least has to try and internalize the cost and the gain at the

same time in a way that might not have been true in the past. Although I think it often makes decisions that are really ridiculous and worthy of the ridicule they get, I nevertheless believe that that connection will help us have at least two sides of the debate instead of the debate which is you can't do this because. A lot of that has gone on in the past and I think it's harder and harder to do.

DANIEL N. MENDELSON: It's a very important question. I think by and large our elected officials are cowards. I think the whole discussion about advanced directives is the best example of this where having Medicare pay for advanced directives is the right policy. It should be broadly embraced and it's not.

I think if there is a potential road out of it it's focusing on care integration and quality as a place where everyone can kind of come together to move forward in the discussion. There's always this immediate short-term expedience of criticizing the other side and criticizing their policy and saying that they're going to ration care. That's inevitably the way it all plays out. I think the only safe territory is really focusing on care integration, compliance, quality, those kinds of issues where the two sides can actually come together and there's no short-term

benefit of criticizing the other guy for political expedience.

SUSAN DENTZER: John?

JOHN ROTHER: I think this is a fascinating question. I think the broad cross-section of consumers will always be interested in lower premiums, but that's not who drives the politics. Who drives the politics are people who have a diagnosis for themselves or in the family who are very motivated to make sure that their condition is fully covered. I think you have a tension between low involvement consumers who want low premiums and very highly motivated smaller groups focused on particular benefits. This will play out in the essential benefit package and it's going to play out in efforts to prevent adverse selection within the health exchanges. It's going to be an ongoing tension that's just inherent in the politics in health care.

HELEN DARLING: In the private sector more and more people are buying on price, which means they're getting the less generous plan. If you look I think an article in your own journal, the exchanges people are likely to do the same. They're going to be selecting the plan that is more affordable for them. If that's true we're going to be at a point where half the country are made up of people who have a

lot less generous coverage; the other half, the ones who kind of win the political battles.

It's going to be a little bit like what's happening now with retirement packages and retiree medical with public employees. You'll have cities and towns going bankrupt because they've over promised and under funded some of their promises. We're going to have that in health coverage, unless we go to complete social insurance system. We're going to have really two very different worlds. It's going to be less and less likely that the people who have to pay for that through taxes are willing to see everybody else get something that they don't have because it's going to be their money that's financing that largess.

SUSAN DENTZER: Great argument for staying healthy. Let's take this center table here.

BRUCE CHERNOF, MD: I'm Bruce Chernof. I'm the president and CEO of the SCAN Foundation, but I'm also a physician. I just want to wear my physician's hat for a second and build on something that Dan said. I want to say something provocative and just give you guys a chance to respond. Since, Susan, we're talking about problems I kind of want to put a problem on the table building on something that Dan said around management.

My provocative statement is I think health care policy suffers from a very serious last mile problem the way transportation used to where enormous amounts of money would get spent and huge theoretical structures would be built and policy built around those and then laws built and rigs built around that. Then it's really about not how you get all the way across the country that's so hard. It's really that last step from the subway station to my house that turns out to be the real problem.

When you fail to solve that last mile problem you're sort of stuck. As a physician I think the reality is health care is still delivered one patient at a time either in one exam room or one hospital room or one nursing home room or one something. I love population health. It's all good, but it's still about a doctor or a provider or nurse practitioner or somebody and a patient and their family.

I think that at the end of the day all this stuff comes down to the tip of the pen or fingers on a keyboard that actually drive all these costs. Then there's really sort of true drivers. For the average provider there is a path of least resistance, which is usually one that's funded. Hospitals are always open. Nursing homes are relatively easy to admit to rather than build a community-based long-term plan of care. There are those sorts of basic drivers that

happen one person at a time. Then there's the information challenge. The reality is even if the front of a doctor's office is say well-wired to delivery an electronic claim the doctor, him or herself in the exam room, is probably still waiting for the pony express to ride up and deliver the printed version of these brand new guidelines of which there are probably six or eight or ten or twelve other guidelines that have been created in the last month.

I think that the solutions really lie on trying to drive solutions all the way to the point of care. That's where the management point comes in. That's where the care that's of questionable value gets decided. The tools aren't really there yet. I think there are places like the VA for example which do a really good job of pushing information all the way into the provider's office, that there are good reminders, that they implement guidelines. I do think organized systems have a way of getting there. I think that remains a real challenge.

We can talk about all these solutions today, but you've still got to operationalize them at the moment when care is delivered. I think that's a real challenge.

SUSAN DENTZER: Mike?

MICHAEL E. CHERNEW, PHD: In our first article on the AQC, I should say in independent I wasn't involved in the AQC

at all, but published in *Health Affairs* we talked about three pillars of the AQC. One of them was the financial model which has been discussed. One was this quality pay-for-performance thing, which is quite robust. I haven't talked about it. The third one and the one that surprised me the most was this sort of—and Andrew can discuss—what I loosely call this in-health consulting kind of activity which they've invested in to help people and to help organizations try and get the final mile.

I think it's true that it is naïve to think that you're going to change the incentives physicians face and they aren't going to say I'm not going to do this or that. It's all about the management structures around them. That's all about the incentives that those management structures put in place and the information they get. There's a very rigorous set of activities that are undertaken to feed information back both for general notion; you can save a lot of money if you quit doing EKGs on healthy people. I'm not sure that literal one. More specific types of information that might tell you you're patient is in the hospital now; you better go figure out what's going on and sort of a direct management thing.

Those information flows only work when the incentives allow them to flourish. I think that's one of the things

which makes the effort to this type of global payment and a lot of settings, I just know one better, worked better than you might have seen in the 1990s where the model was much more, we're going to change your payment; you know what to do and so you'll just do it as soon as we change your payment. That was much less successful.

ANDREW DREYFUS: I would just add that payment reform is a means. The end is better care through delivery reform. It kind of reminded me of at least one physician leader in one of the practices who talks about the tyranny of the visit and that their whole practice is focusing on between visits because there's insufficient time and everything else you said to make the visit satisfying or producing the outcomes that we want from the systems. We do have to move beyond; not easy at all, but I think we're taking the initial steps.

SUSAN DENTZER: Okay. Let's take a question here. Forgive me. The lights are very bright, so I'm having trouble seeing all the hands that are up, let alone the faces.

LEE GOLDBERG: I'm Lee Goldberg with the National Academy of Social Insurance. I wanted to ask a question to go back to the Ps and the Qs. How much is either the level of growth or the rate of growth affected by distortions in pricing? There are so many healthcare markets where you have

monopsonies and monopolies where you have rampant price discrimination. How much does that affect what we've talked about?

MICHAEL E. CHERNEW, PHD: Now I get to talk about the study that Henry said. I'm thrilled. Obviously in Medicare you don't have quite those same problems. You see a lot of cost growth in Medicare. You see a lot of that in the commercial sector and a lot of the work we're doing for the IOM in others talks about pricing problems in the commercial sector, and I think they're well-known. There's what I would call a static answer and a dynamic answer. The static answer is this is a level issue more so than a rate of growth issue that you're not having higher spending growth because of greater and greater and greater distortions of the type that you talk about.

I think Nancy made a point that is very important which is, and I tried to make bleakly in my comments, the incentives by these prices one way or another influence things like the development of technology, the choices of specialists in primary care that physicians go into and stuff. Getting the prices wrong has a whole series of pathological problems in the system and how it might affect growth one way or another.

It's hard to quantify for example how much of these problems are arising because we got to pricing or how much of our problem is because Medicare over paid for some type of services and drove everybody into those services and that pervaded the entire system versus a whole series of other reasons why that might be the case. I can't quantify it but I think there's a little of both.

DANIEL N. MENDELSON: I think you're putting your finger on a huge problem in Medicare because we pay different amounts for the same service in many cases. It tends to drive patients more to the places where a different service. It is that the price ultimately profoundly affects the mix of services. It's perhaps not a price quantity issue but a price mix issue that we have in the Medicare system. The post-acute care example is just one example.

SUSAN DENTZER: Bob Berenson, you want to respond to that?

ROBERT BERENSON, MD: Now that Mike has set me up, let me pick up your example of the EKG to make two points. The unnecessary EKGs; actually you primary care docs have been doing it for 50 years, not just 15 years. As a very nice profit center I did many unnecessary EKGs myself.

Here's the point I want to make. The cost savings that I've seen, and I love the work by the ABIM Foundation,

but on this particular subject the cost savings are based on transaction prices. They're not based on the real cost of producing an EKG which is pennies. The reimbursement is many dollars. In fact, we're talking about a service that if it were priced correctly has basically zero cost. Then the question is, is there any marginal added value. It happens that last week, the week after the ABIM Foundation came out a new JAMA article is out suggesting that a routine EKG does have positive value. I'm not going to adjudicate how much and who's right.

I think this has two implications. One is, you want to move to payment systems in which the group internalizes the cost of the activity and get away from transaction prices as much as you can. That I think moves you towards risk-based approaches. Then also you need the docs on the ground to be sorting out this literature. Obviously there's a major role for the specialty societies in providing assistance, but central government or a third-party payer can't keep up with the moving literature on this. Gail mentioned earlier that there are some times when the evidence is so strong and the service is so expensive that yes, you say this is not covered. Most of the time we're going to rely on providers to sort this out.

I'm just where the third meeting is going to be is what are the payment incentives that are going to sort of lodge with the physicians the responsibility for making more prudent decisions.

NANCY W. DICKEY, MD: I think Bob just kind of skirts along the side of what I'm going to say. As we talk about the patient's role and the current system you talk about the EKG costing pennies, which is represented by a very different number if you look at the charge to the patient. Yet another number if you look at the reimbursement, in fact probably a half a dozen numbers depending on who's doing the reimbursing, and it becomes exquisitely difficult to try to assist patients in my case currently rarely because they're my patient, more because they're a friend, a neighbor, an employee to figure out what the ultimate charge for something is let alone what the ultimate cost for something is. I would say as we're dealing with this issue we've also got a strange accounting process that has evolved that's going to make everything we're talking about much more complex.

You're right. If we can deal with things like the EKG by saying we're going to pay you to manage this person's primary care and if you think it's worth the pennies to do the EKG fine, it comes out of your share of what you're paying as opposed to I'm going to add on the EKG, a couple of

lab tests, and four imaging studies because at the end of the day that adds a few dollars to my transaction and that's what pushes us in the direction of doing marginal, I'd like to believe we don't intentionally do needless, but marginal things could in fact if it adds dollars at the end of that visit, you lean unintentionally in the direction of doing it.

SUSAN DENTZER: Yes, Teri?

TERI G. FONTENOT: I'm really glad this point has been raised. There's a lot of difference for hospitals between price and cost. We don't talk about price. We talk about cost. Over half of the patients that are in hospitals are paid for by state or federal government. Almost 60-percent are covered by Medicare or Medicaid. There's another large number growing every day of uninsured patients for who we get paid nothing. What we charge, what the price is, is really completely irrelevant. Even the commercial payers who are in the minority now for hospitals have risk-based contracts; either capitated or partial capitation or like the alternative quality contract that has been discussed.

Pricing to hospitals is really irrelevant. When that EKG is done then that's a cost. When we talk about incentives and aligning incentives it's really a penalty to a hospital if an EKG is done for a patient that's unrelated to the reason they're in the hospital.

SUSAN DENTZER: Great. Thank you. Was there another hand up? I thought I saw one more. Yes?

MALE SPEAKER: I'd just like to add one comment related to the question that was asked earlier about the political environment and Dan's comment about our elected officials being coward. I might not go quite so far.

DANIEL N. MENDELSON: I never said that.

MALE SPEAKER: I might not go quite so far.

SUSAN DENTZER: The truth is on your side, Dan, on that one.

MALE SPEAKER: I would say that from where I sit and the interactions that I've had with people on the hill even if they do want to do something they are under a lot of constraints, particularly today. This is a comment that I know everybody knows but it hasn't been made yet today. The political gamesmanship and the political tallying and score keeping that's going on right now is really constricting a lot of the options that are available to some members of Congress. If there's a position related to health care that might look like one political side or the other comes out favorably that's going to count on that ledger sheet. The other side is going to demand or want to have another tally on the other side, whether it's in defense or revenues or whatever.

All of these discussions that are going on in health care play out in the political context in a bigger picture of what the gamesmanship is going on. There are a lot of constraints right now, even more than certainly I've seen in my time on the hill than there used to be.

SUSAN DENTZER: I don't think you're going to get any disagreement from the reactor panel on that one. Thank you very much. [Audio gap]. -of material that has surfaced today. One is I think we had a reasonable amount of agreement around the notion that we really want to slow the rate of growth of overall health spending. We don't want it to go to zero. Something around the rate of growth of GDP would be seized upon widely as a successful outcome. As Paul Ginsburg pointed out, that is going to mean lots of discrete changes in how things are done because presumably we don't want to slow the rate of growth across the board. There are going to be things we want to do more of. There are going to be things we want to do less of and things that we'd like to stay about the same.

This didn't get a lot of attention but I hope that when we get to the next meeting we'll put back on the agenda also that we not just want better health care out of this, we do want better health. There is that other key point of the triple aim that we probably should keep in focus somehow even

as we're discussing mainly health spending which is mainly health care.

I think we also had some convergence around the notion that in our system, which is as Paul went on to say, we're starting out largely here with voluntary programs that may have to transition to something more permanent over time. As Andrew said in the case of the AQC underscore and as others of you said, it's going to be best to meet providers where they are now rather than attempt something radically different, but to move over time to something that is more sustainable which is probably going to be more of a definitive set of payment arrangements in particular that we have now.

Inherent in that is going to be more management, more care integration, more focus on quality, more focus on value. I think it was Dan who said, that is the safe territory that there could be a lot of buy-in around. Nobody is going to go campaign against value in health care or less management or less quality. To the degree we can organize the changes that we make around those themes and drive toward those themes we will make progress.

Finally a point that there is going to be a role for many, many, many players in the system to get us there. It's going to be

payers paying differently. It's going to be providers taking a much greater role as the choice of choosing wisely showed, calling out the care that is of no value, emphasizing the care that is of more value, and creating a structure over time to continue to evaluate all of the innovations that are going to come along in order to make decisions about how we're going to allocate our recourses and what we're going to do and what we're not going to do for patients.

With that I think we are launched very nicely onto our next discussion which will be on May 29th, 9 a.m. to 12:15 back here at the Kaiser Family Foundation. We're going to try to have a focus on technology and poor health, that is chronic conditions and the role of consumer behavior as well. Of course we will also get to our favorite topic, the aging of the population.

At that event Joe Antos is going to be making overall remarks about technology. Ken Thorpe from Emory will be making overall remarks about poor health. Our reactor panel is going to include Melanie Bella from the office of the Dual Eligibles. Bruce Chernof from SCAN Foundation, Susan Reinhart from AARP, Diane Rowland from Kaiser Commission on Medicaid and the Uninsured and also from MACPAC, Joe Newhouse of Harvard, and others. Of course many of you will be back

here who were in the audience today to be our broader set of reactors and stakeholders on that conversation.

With that let me say a special word of thanks to Mike and to Hank. Gail had to leave us to get on to another engagement. Thanks first of all for a terrific set of setups for us, and to our reactors thank you for reacting as vociferously and interestingly and intelligently as you did. Thanks finally to the audience for a great discussion. Hope to see you back here on May 29th. Thank you so much.

[END RECORDING]