Approaches to Bending the Health Care Cost Curve
Alliance for Health Reform
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ED HOWARD: Hi. I am Ed Howard with the Alliance for Health Reform. I want to welcome you on behalf of Senator Blunt, Senator Rockefeller, our board of directors, to this program to examine how we ought to try to stabilize health care spending in the United States. We all know that health care is now a huge part of our economy, accounting for almost 18-percent of GDP. That is 2 point [inaudible 00:00:28] trillion dollars to you who do not know the exact size of the GDP. That was from 2011. And I am sure the health policy students somewhere play a drinking game while watching programs like this on C-SPAN based on how many times the word unsustainable is repeated. Those same 2011 spending figures released earlier this month reveal that for the third year in a row, aggregate spending grew by just 3.9-percent, the smallest increment in decades. So to paraphrase Ross Perot's running mate in a debate many years ago, why are we here? At least one response to that question is we do not know if the health care cost dragon has been slain or is just hibernating. How much of the slow increase in cost comes from the sluggish economic recovery, more people without insurance, people postponing care over which they have any kind of discretion at all, and what about the explosion in chronic conditions, a continued development of more sophisticated and more expensive treatments

and tests. For the most expensive health program, Medicare, there is the fact that 10,000 baby boomers are joining me in the over 65 set every day. Despite the relatively encouraging numbers from HHS about 2011, there is still a lot about this issue to be discussed and analyzed. Here we are with what I think is going to be a very good program on that topic. We are very pleased to have as our partner in today's program the Commonwealth Fund, which is a century-old philanthropy set up to promote the common wheel, the common good, and we are especially pleased to have as our co-moderator today the newly installed President of the Commonwealth Fund Dr. David Blumenthal. I am not going to give David a formal introduction, but I commend to you the brief biographical sketch in your materials, which barely hit the highlights of his distinguished career. I will mention that amidst all of his policy and analytical expertise he is also a primary care physician. He has a view from many different parts of this health care system. David, welcome to not by any means your first Alliance Health briefing but your first as head of Commonwealth. We are very pleased to have you here.

DAVID BLUMENTHAL: Thank you. Thank you very much, Ed. I appreciate the Alliance's work on this briefing and many others that we have done with the Alliance—Commonwealth Fund has done with the Alliance. I also am very grateful to our two

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guests, Bob Galvin and Karen Ignagni who will be joining for this event, and to my left, Stuart Guterman. I am sure that other introductions will be made. I am just going to try to set a little bit of context for this discussion. It is, of course, about stabilizing health care spending. A Commonwealth Fund Commission on a High Performance Health System, which produced a report called Confronting Costs that Stuart will describe to you in more detail, was driven by the fundamental philosophy of that great philosopher Yogi Berra who noticed that when you get to a fork in the road you should take it. We truly are right now, in the Commission's view, at a fork in the road. We are confronting very difficult human and political choices with respect to public and private programs and how to continue to ensure America's population. The choice on the one hand is to cut payments, reduce benefits for covered beneficiaries, restrict eligibility, a whole series of things that are very hard for public policymakers and elected officials to do and which fundamentally take things away. It is the R word in everything but name. The other route, which is less discussed, harder to quantify, but in the view of the Commission holds much more promise for the future of our health care system, is to reengineer health care to get more value out of the money that we spend. Regardless of which route we take or which combination of routes we take, we believe that that

reengineering process has to go forward to mitigate the pain of the cuts that are coming, to minimize them, to avoid as many of such cuts as possible. We also believe that the opportunity is huge, huge to make the health care system work better, huge to make markets work better. We also took the perspective that this is not just a Medicare, Medicaid and public sector problem, that the costs of care fall even more on businesses, individuals, states and localities than they do on the federal government. We are having this discussion today in an office building of the Congress. That does not mean that our focus has been exclusively on the programs that are under immediate control of the Congress. We do believe that the federal government can influence private and public sector spending. So you will see from this slide that looking out to 2023, the federal government will be covering 32-percent of the total cost of health care whereas private employers will be covering still comparable amounts and households also more than a quarter of the cost. The choices that we face fall not just to the federal government but also to other stakeholders in the system. It is also clear that we need to engage consumers, not just consumers of public programs but consumers of private programs as well, in the effort to contain and make stable the costs of our health care system. It is always worthwhile reminding ourselves that 5-percent of our population accounts

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for 65-percent of the cost of health care, and that population more than any other needs assistance with better information, value-related choices, and an opportunity to control their destiny in the health care area. We cannot move forward effectively without empowering them and making the system work better for them. The panelists that you will be hearing from, Stuart Guterman, Vice President and Executive Director of the Commonwealth Fund Commission on a High Performance Health System, Karen Ignagni, President and Chief Executive Officer of America's Health Insurance Plans, and Bob Galvin, Chief Executive Officer for Equity Health care from the Blackstone Group. Thanks for your attention. We hope you will find this worthwhile. I think our first presentation will be from Stuart.

ED HOWARD: Stuart, if I can just handle a little housekeeping before you start. You know you have information in your packets including not only copies of the slides that we had available beforehand but also materials that I hope you will find useful in background. There is an additional sheet that lists a bunch of other materials that we saved trees by not reprinting. If you go our Web site at allhealth.org you can find links to all of those documents. We commend them to you. If you are watching on C-SPAN right now and have access to a computer, you can follow along with the PowerPoint slides

on our Web site, allhealth.org. Just click on the item About Today's Briefing that you will find. There will be a Webcast available tomorrow, probably, followed by a transcript of today's discussion in a few days also on our Web site. I would urge you at the appropriate time to fill out both a green question card, which you will find in your kits, and before you leave we would very much appreciate your filling out an evaluation form that you will find, the blue one, so that we can improve these briefings and be of even more value to you. As David said, we have three terrific panelists today. I should have mentioned in introducing David that in the past several years, he, in addition to his other duties, he chaired, and continues to chair I think, the Commonwealth Commission on a High Performance Health System which produced and approved the report that Stuart is going to talk about and that Stuart is the executive director of. Mr. Guterman, go right ahead.

STUART GUTERMAN: Thanks, Ed. Thanks, David. The Commission on a High Performance Health System has produced this report on confronting costs to try to address the problems that David described. As David said, the underlying principle here is that it is a health system problem. Health spending is something that puts pressure across the board on federal, state and local governments and also businesses and workers and their families and that the problems that health spending causes need

to be addressed system wide as well because they reside system wide. Pushing down on one part of the system to address those problems will not do away with those problems even if it does solve some of the imminent, apparent symptoms. The first thing that the Commission said needs to be done is that we need to set a total health spending target to GDP growth. The figures are well known. The United States spends much more money on health care than any other country in the world. The Commission felt that holding health spending to GDP growth ought to be a legitimate target that is set nationwide, not just federal government. It also they viewed this as a motivating force similar to the action taken by the Massachusetts state legislature which set a target for state health spending. They felt that this would drive action to take, to implement policies that are effective in controlling health spending, but they did not mean this as a pro-Crusty's (misspelling? 00:12:44) bed, that is if you do not fit, we will chop off your feet to get there. They mean to propose a set of policies that they feel are going to be effective at addressing rising health spending and that if that target is not met by implementing those policies then those policies ought to be accelerated further. There are three pillars that they are recommending, a three-pronged approach to addressing health spending growth. One is provider payment reforms, and that

means to move toward better payment that pays for what we want to see the health care system produce rather than increasing volume and increasing intensity without necessarily concomitant benefits to patients. The second prong, the second pillar, is to provide and support high value choices by consumers. As David said, that means not just to increase skin in the game but also to provide better choices that consumers can make and provide them with the information to make those choices and reward them for making those choices. And then the third pillar is to make markets work better so that regardless of what approach you take that the incentives that are embedded in the system will work better and be more effective at producing the results that we want which are essentially summarized in the triple aim better health, better care, better and lower costs. The Commission developed a set of illustrative policies that we feel have the potential to save $2 trillion nationwide over 10 years. We did estimates of the potential effect of these policies, and that was the result that we got. The impact of these three sets of policies is portrayed here in this slide. You can see that two-thirds of the $2 trillion worth of potential savings is in provider payment reforms. That makes sense because the key here is to provide better incentives, better rewards, for the health care delivery system to produce the kind of care that benefits its patients in a

more efficient and effective way. The increases in information and better choices for consumers was estimated to produce about $190 billion in savings over the 10-year period from 2013 to 2023. A couple of the policies, I only mentioned a couple of the policies that are embedded in some of these pillars. Among provider payment reform we are talking about accelerating bundled payments for acute care episodes to force the issue on providers getting away from thinking about providing services to the patient in front of them but rather thinking more broadly about how the patient can be treated and the bundle of services provided to those patients. We are talking about strengthening patient center primary care and providing support care teams for high cost complex patients, because that is where the money is, as was illustrated in the slide that David presented. It is also where most of the benefit can be because these folks who have multiple chronic conditions are folks who are in dire need of more coordinated care. Under policies to expand and encourage high-value choices by consumers, we are really talking about restructuring a Medicare benefit package we are referring to as Medicare Essential that will provide integrated benefits across what is currently split out into Part A, Part B, separate Part D, private plans, and then a Medigap policy that most – or a supplemental policy – that most Medicare beneficiaries have who are in traditional Medicare,

and to provide positive incentives for the use of high-value care and care systems to provide better information by enhancing clinical information available on outcomes of care and patient experiences and accelerating meaningful use of health information technology. That is necessary even though it accounts for a relatively small proportion of total spending, the total savings estimated. It is necessary to make the system work better because, as was pointed out, you really do need to engage consumers, but engage them with positive incentives. There has been some interest in this Medicare Essential option. We are in the process of trying to get that paper published. We are currently in review, and we will hopefully have that paper published before long. We would be glad to talk with folks about that details post of that proposal. Under making markets work better, we are talking about simplifying and unifying administrative policies so that you have reduced administrative ways in our health care system. We are talking about malpractice reform that focuses on the adoption of best practices and rewards physicians and other practitioners by adopting best practices. Hopefully that will not only increase patient safety but also reduce malpractice claims and reduce malpractice premiums that many doctors find so burdensome. The $2 trillion in potential savings over a 10-year period also fall across each of the different major

sectors of the health system. The federal government, we estimate, will save about a trillion dollars of that over the 10-year period because health care costs will grow more slowly. They will be better integrated, better informed, and because there will be incentives in place that do not bribe providers to provide better care but reward them for providing better care instead of punishing them for doing many of the things that benefit their patients, as the current payment system does. State and local governments will benefit because of savings in the Medicaid program, also because state and local governments are large employers in their areas. Private employers will benefit, again, because they will have better health care system to buy their employees into and the health care costs will grow more slowly. Of course households will be a major beneficiary to the tune of about $500 billion in direct savings, but of course households in the end foot the whole bill for the health care system. They pay the taxes that support government expenditures. They pay premiums through their employers for health coverage. They forego wage increases that could be much higher if health costs were not growing as fast, so they really are the beneficiaries of the whole $2 trillion in the end. We are not talking about–I hear a lot of talk about the blood in the streets if there is really health reform and people fighting over a dwindling, a shrinking

pie. I would pause it that only in health care would a growth from $2.9 trillion in 2013 to $5.1 trillion 2023 be referred to as a shrinking pie. There will still be plenty of resources flowing into the health care system, just not quite as much more as would be flowing if nothing was done. So we are talking now – to give you some sense of how the magnitude of this – we are talking about a projected health spending under current policy, the red line in this graph, totaling $42 trillion over the next 10 years. If you say $2 trillion in that growth, you would be reducing health spending to only $40 trillion over the next 10 years. You would be cutting the growth in health spending from an estimated 90-percent under current policy to only 75-percent over the next 10 years. We have to keep that in mind and keep the perspective that we really have a lot of resources flowing into the health care system. Even under the best of circumstances, the idea is to use those resources more effectively to benefit our people. Now we have this set of policies that has the potential to bend the cost curve, but the easy part is to identify the policies. The hard part is to get them passed, enacted and implemented effectively. To do that, we need a set of actions. We need to be building on current momentum in public and private sector programs. We have a lot of examples of real action taking place now among providers, among purchaser groups pushing for

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action. We can build on that and accelerate that, so this is not a fantasy that we are talking about here. We are talking about accelerating actual things that are going on. We need to use federal policy to accelerate, to promote that acceleration and to promote bottom-up innovation. We need more collaboration with states, private payers, employers, provider and consumer groups, all of the parties that are involved in this to push towards system improvements. We need to look at the vehicle that is being put in place beginning in 2014 through the health insurance exchanges or health insurance market places and see how they can serve as a vehicle for promoting alignment within and across public and private sectors. I want to thank all my colleagues in putting together the report, and of course the Commission. I look forward to the questions.

ED HOWARD: Very good. Thanks very much, Stuart. Let us turn to Karen Ignagni.

KAREN IGNAGNI: Thank you. Good afternoon. I want to say we are very, very happy to participate in this important discussion, have been long fans, longstanding fans of the Alliance and Ed's leadership. We think the Commonwealth Fund under David's leadership has now put something on the policy table that will reignite the discussion about costs. We appreciate being here and talking about that. I tried to think

in light of what Stuart was going to do and what you may be thinking either here in your perspective on Capitol Hill or in the stakeholder community and been thinking what Bob would talk about, it struck me how to be most helpful to you would be to talk about two things. One is a strategy that we might be thinking about systematically to address health care costs before we turn to specifics, and then turning to specifics, how do we think about the policy agenda. Stuart said this, and I want to come in behind him, that not just the agenda at the federal level–often in Washington we primarily talk about that–but also to think about at the state level and the private sector and how you align all the different strategies. That is what I would like to take in the few minutes just to kick off the discussion. Strategically, I think there are five things we want to think about, and David began this way as well. First, widen the lens. We need to begin to talk broadly in the policy community about total cost containment as opposed to a silo-by-silo approach. A silo-by-silo approach, whether it is focusing on Medicare, focusing on Medicaid public programs, leads to cost-shifting to the private sector. That leads for the public sector to broader, higher tax expenditures, higher spending. From the perspective of the government, that is bad because we have to bring all of that under control, but from the commercial perspective, individuals purchasing on their own

and businesses wanting to stay and continue to offer coverage to their employees, which is bad from that perspective. We have to begin to have a broad discussion about total costs. Second, do not reinvent the wheel. There are very significant developments now going on in the private sector that we think can be actually done synchronously with public sector initiatives that we can actually move the needle much faster. Having discussions about exactly how to capture that and what to do, that is very important, so not reinventing the wheel. Three, I think we need to broaden the discussion, not only to total costs but to think about how you achieve an agenda where the federal policy agenda, the state policy agenda, and the private sector initiatives are aligned. What will move the needle? What will provide incentives to move in the direction of cost reduction? I want to talk about a couple of things to do that. That is the policy question, how to align these different strategies and how to think broadly about all of them at the same time. Next, I think we need to clear the barriers that are standing in the way. I know Bob is going to talk about consolidation. He has been part of a very important organization that is done a significant amount of work. That is one example. I want to give you another example. In the commercial area, for private purchasers and for individuals purchasing on their own, in the private sector we are doing

tiering, and tiering meaning how do you identify for patients where are the high-performing networks, physicians and hospitals. We are partnering with physicians and hospitals to do that. There are some significant results to report, but in a Medicare Advantage, for example, which is the private sector part of Medicare, we cannot yet do tiering. That is one small strategy that is a barrier to actually achieving the kinds of things we are doing in the commercial arena that could be thought about. I am going to talk about a couple of more. Finally, I think that we need to think about the issue of affordability very broadly. One issue that we have been talking about here on Capitol Hill, for all of you who are here, is that to the extent there are provisions in the ACA, such as the premium tax that adds costs, that will put pressure on individuals and small businesses not to purchase. We need to get people into the pool to make it work for everyone, as demonstrated by the examples at the state level, so that is an example of that. Now moving to the policy agenda, there are seven things I want to talk about quickly. First, overhauling the payment system. This is going on in a very comprehensive way. There is not one size fits all with respect to how it is being done. It depends on the community, depends on readiness of physicians and hospitals to accept risk and to accept prospective payment. We are talking about medical homes. We

are talking about bundling. We are talking about global negotiations in terms of payment, moving from the retrospective piece rate payment system to a global approach, a more prospective approach. To emphasize not only the fact-and Stuart said this very effectively I thought-to emphasize not only the cost reduction part of that but how you align quality improvement incentives to achieve those goals, quality improvement and cost reduction. Second, talking about total costs, not a silo-by-silo approach, to make sure that we are not designing strategies that yield reductions on one side that create cost shifting on another, and that needs to be looked at. I thought the Commonwealth Fund did an excellent job talking about how we have to look across the board at all of this, what happens in the end with these various strategies. Three, aligning incentives. This is going to strike a number of you as being rather a boring part of what otherwise is a stimulating discussion, but I want to take a crack at talking about why I think this is important. We have over 500 measures out there. We need to shrink the numbers of measures, get consensus on the high value, and have a synchronistic approach from the public to the private sector so we can row the boat in the same way. It may strike you as less than challenging, shall we say, but sometimes the smaller things can be the things that we can point to that could really move the needle.

We can talk more about that in discussion. Next prohibiting barriers, I used a couple of examples when I began but I want to talk about a couple of more. There are barriers in the market today to sharing information with consumers. In some cases, health plans are forced to sign contracts with providers where they cannot share information. The whole effect now in the delivery system or the operating challenge is to provide dashboards for physicians for hospitals and patients. So to the extent we cannot share information, those barriers should be broken and eroded. Next, I think any challenge legislatively to inhibit the ability to form high performance networks, that ought to be also discarded because, again, standing in the way of moving the kinds of payment changes that I think Stuart talked about very effectively. Wellness incentives, we are working and partnering with employers to encourage participation in wellness programs, rewarding people for doing so, but we are not able to do that on the individual side. With so many people purchasing on their own, that is something that ought to be looked at. There is going to be a demonstration in 10 states for the individual market, but we ought to think more broadly about how to encourage individuals to participate in disease management and get rewarded for health risk appraisals and following the specific guidelines of their physicians. I think I want to also point to out-of-

network charges. There has not been enough focus on out-of-network charges and what that means to an individual. We talk about government payments. We talk about government costs, purchaser, employer costs, but to an individual, if they are seeking care out of network, it matters to them if a particular physician is charging 10 times Medicare, 5 times Medicare, 7 times Medicare. We are just finishing up a study and the results are eye popping in terms of out-of-network charges. We have to look at that. Stuart talked about malpractice. We ought to, if we want a high-performance system we ought to protect physicians who are practicing best practice. Surely, that is something that we can, stakeholders can agree with. I want to just say two more things, 21st Century work force. We have talked about scope of practice from the standpoint generally in the policy community, about nurses working to the top of their license. I would say that it is important to look at scope of practice breaking down barriers so physicians can practice to the top of their license, getting as much help as possible implementing coordinated care and disease management which we need to move to. Finally, I think there is real opportunities if we take the Commonwealth Fund notion of taking 2 trillion out and we look at where is the best area and what is the best way to do that. We think that there are some real potentials with respect to states and state leadership,

bringing people together in the stakeholder community to develop strategies to become less dependent for dual eligibles on nursing homes, achieving care more affordably and more effectively in the community, to deal with variation in practice at the local level. Often you see variation not only across states but within states. We talked about consolidation, but also I think building and construction, we see a very significant increase in building and construction these days, which is creating overhead demand for hospitals that are going to be very, very hard to satisfy as we deal with new payment models. So those are a couple of examples of where we think we could start, the opportunity to reward states for actually achieving reductions in the cost curve. At least given the projections of CBO about where we are going to the extent there could be reductions that are identified, that, in a gain sharing way, that could achieve some real progress in terms of moving us forward. The final thing I just want to note for those of you who are techies and interested, we have put 50 years of government data in an iPad app. It is free for the public, so here is the site where you can find it. Hopefully, it will be helpful in identifying ways and places to go to achieve costs but also places to go where stakeholders could work productively together to achieve this important objective. Thank you.

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ED HOWARD: Thanks, Karen. We will turn to Bob Galvin.

BOB GALVIN: I think I am on, and so, well, good morning, and thank you very much for asking me to speak. I thought it was a great report, Stuart. I was on that Commission for several years and it just, it is really always worth reading because I think it puts a true north and it is an aspirational view and I think it is great. I think that is nice work. Today I am going to speak on the part of employers who it is probably part of the sector that you would hear from the least so I am going to make some of the comments general at the beginning, talking about what we are doing, what we are thinking about costs. Then I am going to spend the last couple minutes talking about two challenges we are facing where I think the public and private sectors working together are really going to be necessary to make a difference. Just to bring it home to you what employers do, I think you know there is about 3 million employers that cover benefits for about 150 million Americans. For those of you working in government, for people inside companies to do this, they are like your OPM, and for those of you that are at outside companies, you know what it is like to have your benefits given to you. For a company it is a balance between trying to stay profitable so that you can make profits whether it is for the owners of the company, the shareholders, and hire new employees, and keeping very good

employees in your work force. It is always a balance between those two. That is what drives employers to do most of what they do. It is not just costs I will show you. It is the necessity to get talented, healthy employers. With that, I am going to talk in general about employers and where we are going and then get specific about sectors. So could I have the first slide? Although I am not going to talk about coverage today, I am going to talk about costs. I wanted to show this slide because when you talk to any employer today, the Affordable Care Act has really gotten their attention because it is changed the structure of the system, meaning there is going to be options for small employers today, for large employers in 2017, an option other than either covering or not covering. Although I am not going to talk about what percent I think are going to go or not go, I am happy to do that in the Q&A. I think what is important is the common denominator no matter which way an employer goes is still going to be costs. Whether you are still funding it as a sponsor and you are paying first dollar, or whether you are giving a voucher to your employees, inflation is inflation. As long as you need talented employees and health benefits are more and more important, affordable health benefits, are more and more important to employees of all kinds. Then vouchers, or defined contribution, can inflate the same way that primary dollar. I think employers are going

to stay very interested in cost. I think as you know you can see it is an unsustainable system to date. So what are employers doing about cost? I put up this equation because it really has, it does explain at the highest level kind of what employers are doing. This is now about, I think, almost a decade and a half old. Several of us put these together back in around the year 2000 after the managed care kind of experiment of the '90s did not work out so well for us in terms of containing costs and making happy employees. It really is that the way to cost control is through value enhancement. It just is no longer and has not been for a long time a cost-cutting approach. It has to be cost, but cost has to be integrated with quality. We really define quality both as clinical quality and as patient experience of care. As an aside, I would say what is so interesting to me about how the private sector, where I have been in my career, and the public sector with whom I have worked closely, is I think we both ended up at this equation coming in very different ways. Fifteen or 20 years ago the private sector was just focused on getting costs out of the system and realized it just was not going to work. I think the public sector, particularly Medicare, was just focused on having a regulated system and letting the delivery system work on its own, and they realize that does not work. We are all value purchasers now. I think

this equation actually makes a good point of how we see things. On the private sector side, we believe that the way to value is to apply in a thoughtful way market forces to health care. What do we mean by market forces? They are not the five aims but they are the five forces. It is competition, it is choice, it is information, it is incentives, it is accountability. We believe we need to do that through getting employees engaged in a way that they have not been before. Now I think what you see going on in the private sector employers today, you will see it in the exchanges, is a growth at the high deductible plans with or without savings accounts to make employees and their families price sensitive to what is going on. I think you will see more and more of this thing called VBID, this value based insurance design, which again, based on value means that employees will pay differentially based on the value of the services that they get or based on their own participation in the system. An example of that is waiving co-pays for diabetics who take their medication. Those have a lot of momentum, and I think you will see a lot of them are happy to answer their, some of them are controversial. Again, I am not going to take that on today because I want to get to two points which is that employers are also very interested in the delivery system. What I have talked about so far is the employer benefit design vis-a-vis the employee, high deductible

plans, value-based insurance design. We obviously understand that no one is ever going to be healthy enough to not need to go to doctors, hospitals, and the drug store. What happens in the delivery system is important. The same principles apply about those market forces. There is a big move to show the kind of prices that you see. This happens be in Schenectady. This actually was derived, believe it or not, by a group calling doctors' offices and calling the different providers of the services to see this gigantic variation in price for something as simple as a sore throat. I show this because we know that we are not going to save the health care system by having people shop for sore throats. I show this because nobody had any idea that this existed. In fact, this chart came about because we put in a high deductible plan when I was at General Electric and a very upset engineer from Schenectady called me. He said, "I might or might not like the high deductible plan, but you cannot put one of those in and not show this kind of price difference. I have the need to know." He said, "I could not find it from your team. I had to call all of these doctors' offices and hospitals to find out the price." Therein is issue number one where I think the sectors really do need to work together and cooperate because this is going to happen in the exchanges. Obviously less of an issue in Medicare because of the administrative pricing, but once you

get into the exchanges, people are going to want to know these prices. It is very difficult to get this information. There are still gag clauses that providers have. It is difficult for the private sector to get CMS data and put this together. And you see a lot of innovation going on in the private sector on companies that are trying to get this kind of price information to employees and having a great deal of time simply accessing the data. Let me hasten to add that I think the plan sponsors on the private sector side kind of made an agreement that we are not going to show price data without quality data because if you are going to follow that value equation I showed, you cannot show one without the other. So integrating those data sets means that you have to have access to both of them. We are really struggling, and I think you will be struggling, too, to the extent that you have anything to do with regulating or setting rules, particularly for the federal exchange. The other and last issue I bring about is what is beginning to seem like an unintended consequence of the kind of payment reform that we on the employer side, and everyone, has really been, has been supported. There is this idea of moving towards more coordinated payment, more global payment, more bundle payment. I think all of that is great. I think a move away from looking for service makes a lot of sense. If you follow the logic to do that, you need to have providers, you need to have more

organization among the people that deliver care. Again, a good thing. To bring them together brings about coordination, less silos, a good thing, and kind of appropriate consolidation. Every industry whose growth is slowing, as Stuart showed, has to consolidate, but where appropriate consolidation becomes too much consolidation becomes a problem because what happens is you now have organizations that can become so big that two things happen that we really do not want. One is that they have tremendous pricing power. And the pricing power will be the cost shifting that Karen talked about because Medicare will set its rate—let us say it is an ACO—and then to the extent that the organized system does well or does not do well, particularly the latter, they will then have the market power to potentially shift cost to the private sector. The other bad thing that happens is that innovation starts to get squeezed out. You know, as kind of a sponsor in the job I do now I buy health care for 40 different companies. And there is not a day that goes by – I have had two already – that an innovator does not come up to me – today it was an online way that they have applied CDC principles to treat diabetics online. On Friday, it was a very interesting company that was going to send health coaches out to decrease readmissions on the commercial side. All of this innovation needs an audience, and part of the worry when you get organizations that are that large is that it is

just hard to be heard and it is hard for innovation to happen. I set this chart up because that does not have to happen. I set this up because this is kind of a different, this is another fork in the road. I mean, David showed you one. This is another that I think is happening all over the country which is when providers come together, very good things can happen, and there really are tremendous examples of great care and lower prices. At the same time the potential is there for what you see on the other side of the page which is outcomes that maybe are not any better but certainly the ability to get more price and cost shift. So the question is what do we all do about it? This is my final slide and that is where I think Karen mentioned briefly this organization that was founded on the, among employers. It is called catalyzed payment reform, the initials being CPR – meaning this is an emergency – to try and rationalize what employers do on payment reform. One of the issues that we are trying to address is this issue of turning kind of this very good move to global payment into having a positive outcome for patients and affordability and not the other side. I think we need to measure it because we really have no idea what is going on. I can tell you the evidence is growing. The Web site is catalyzedpaymentreform.org. The evidence in this paper is that in more and more markets across the country, private sector

plans and employers are looking at very high price increases year to year in some of the same markets that have the ACOs that have qualified for Medicare status. So what can we do about it? Again, it is to bring out the goods. I think we need to measure it. There is no kind of funding and there is no kind of neutral party that is today authorized to measure what is actually going on. I think we actually need to make sure that anti-trust is properly funded because I know they really get it at FTC and DOJ and are on this as well. And then I think we need to make sure – and it goes back and it is my final comment to exactly what I think David said, Stuart said, and Karen said which is this has to be a whole system solution. It cannot be that one sector does better and the other does worse because real improvement is going to come when health care is more affordable and better quality for everyone. Thank you.

ED HOWARD: Terrific. Thank you, Bob. We now get to the part of the program where you get to quiz the experts. You can fill out a green question card. If you do, hold it up and someone will bring it forward and we will get to as many of those as we possibly can. There are also microphones on either side of the room where you can go and ask your question yourself. If you do that, please identify yourself and be as

brief in stating the question as you possibly can. While your – you beat me to it. Go ahead.

BOB ROBIEMJA: Thank you, Bob. Bob Robiemja (misspelled? 00:48:41). We know that there are some examples of well integrated systems that deliver quality care and generally at comparable or even lower prices than other situations. I am curious as over the past three years where there have been this period of relative stability and prices how those well-integrated systems have performed as compared with other parts of the system. So has anyone looked at that to see if there are any differences?

ED HOWARD: That is a good question. Stu? Can you take first crack?

STUART GUTERMAN: I guess, you know, the bottom line answer is that we have not done that study. I do not know if Bob, if you know, but that is certainly worth looking at to see. I think there is evidence that some of these systems are doing very well. Certainly, there is evidence that they are achieving slower cost growth through their efforts.

ED HOWARD: Do you know? Are you going to take it or not?

BOB GALVIN: Am I on here? Now I am. I do not know of a systematic–so I think it is a great question, first of all. I do not know of a systematic study but I can tell you about

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our database. So again, it is a couple billion dollars of spending which is modest by Medicare standards but enough that you can make conclusions. After the last couple of years of these kind of less highs and normal increases, what we have seen is stable utilization, actually some slight increases in quality, and all of the increase driven by prices. When we look to see what is driving the increase in price, it seems to be hospital and particularly outpatient hospital. Specialty drugs is a secondary one. When we look into the markets where that happens, it tends to be the markets that have the most consolidation. The extent you are asking, which I have not gotten to your question, is how are the truly integrated systems doing versus the others? And again, the data we have on that, which is probably not enough of a volume to have a narrow confidence interval, is they continue to outperform by a couple of points.

KAREN IGNAGNI: The only other thing that I would say to this important question is that I have now seen data in the process of being developed for publication. Some of its been published that show a real moving of the needle in terms of moving to these different payment strategies and taking physicians that are primary care physicians, for example, in individual practices, one physician, two physicians, connecting them virtually with coordinated care and actually seeing

significant results both on the price side as well as on the quality side and seeing data from important areas across the country on a real reduction, a real reduction as opposed to something less than that in terms of trend, the cost trend with respect to inpatient broadly. That is encouraging using more of a prospective as opposed to a retrospective approach, and they are all different approaches and strategies across the country. I think that is the significant thing now. It is not a one-size-fits-all but they can be harnessed in a productive way where payers and providers are working together to achieve both the cost as well as the quality results. I think we will begin to see some of these data now. We have seen some preliminary but going to third-party review and ultimately to publication, which will be important to get a sense of how all this is happening area by area.

STUART GUTERMAN: And let me just correct a mistake in response. I misunderstood your question. There is plenty of evidence of examples of integrated delivery systems that are addressing cost growth and being successful at doing that and improving the quality of care that they are providing as well. Those around the country and they are in different circumstances, and you will find case studies of a lot of those on the Commonwealth Fund Web site. Even at that you have to realize that many of these systems are operating in the context

of a health system that punishes them frequently for doing the right thing. We could have much more of that kind of success if we could address the underlying health system incentives that are running counter to doing these kinds of things. So a lot of these people on the forefront of these movements are actually bucking the current system to be able to do these kinds of things for the good of their patients.

ED HOWARD: I think actually you were there first. Go ahead.

JOANNE LYNN: Okay. I am Joanne Lynn. I am the Director of the Center for Elder Care and Advanced Illness at Altarum Institute. What you have proposed in the report is really exciting and certainly should be followed up on. I wonder though if we are not still sort of missing the obvious. For most of us in the room, our biggest expense is going to be in the last few years of our life when we are living with a very bad disease, probably almost half of our lifetime expenses. We are holding that piece of time to the same quality measures and assuming that it is part of the same market as all the rest of health care, and it seems that it really should not be. It is really as distinct at least as obstetrics and pediatrics are, and we think nothing of them being a rather different tier system. Old, frail, disabled, multiply ill does not just need a medical care team or a

medical home. We need long-term services and support, and we need an honest discussion about decline and death. We seem to still be dancing our way around both of those issues. What do you think about the possibility of really creating a marketplace that values the innovation and tries to put forth a different product that could not stand the fragmentation we now have. So we would see that period of life as being distinct and requiring a different service array. We would require care plans for each person. We would manage that system in its production aspect and in its payment aspect because it would be overwhelmingly either public or private on the way to becoming public. How many people here have the resources to endure 10 years of long-term care? You know all of us are duals in training. So it seems that that is where the money is, and yet we continue to put forward the care system that was designed around 50 year olds for that part of our lives and does not fit and it costs a whole lot. You know, we spend more on medical care than on long-term services and supports. Every other developed country spends twice as much on long-term services than they do on medical care. We end up medicalizing housing. You know, my medical school did not teach me anything about housing and yet I arbitrate whether people go into nursing homes. So I think that there is another frontier that is not quite yet on the table, and how could we get it there?

KAREN IGNAGNI: Yes. I think that you are right, and I think that every patient should have a care plan, whether they are under 65, over 65 or in the frail, elderly population. I think you are absolutely right about what that does in terms of helping that, supporting that patient, achieve the expectations that they deserve and that they seek. I think that one of the things that I can report from the health plan perspective is as we meet the needs of the Medicaid population and dual eligibles in particular, we are focusing on things like long-term services and supports. We are partnering with advocates and the advocacy community to actually look at housing, look at pathways to move people out of a nursing home back into their homes, into the community where they can be supported there. I think you have put on the table a very, very important issue. I know that not to, Ed, suggest additional programs but I do think this is an area that we really need to pay attention to. But this concept of coordination of care is very, very important. We pioneered hospice in the health plan community to make sure that people could die with dignity and with support and with their families next to them. I think we can take that concept and extend it broadly. I think it is going to take quite a lot of discussion among the entire stakeholder community, the patient community. There are real opportunities to elevate the level of care for these individuals, and do it

in the right way that each of us would want for ourselves or for our families. I appreciate you raising those issues, and they are very, very important.

ED HOWARD: And I think that is a good program suggestion, and one that we actually are hoping to be able to move for it over the next few months. We have a flood of green cards so we are going to try to integrate, if you will, questions from those cards with folks at the microphones. If I can ask you to forebear a little bit, Dr. Blumenthal has a couple of questions lined up from our audience card writers.

DAVID BLUMENTHAL: There are tons of really great questions, so apologies to those who may not get their question inserted. The first one is why have not you pursued market-based reforms that are bottom-up, such as patient cost sharing or establishing HSAs for Medicare patients?

ED HOWARD: Actually I have one from this stack of cards that addresses a question to Stu saying, quoting the report as saying that we should use federal policy to accelerate bottom-up innovation. So what specifically can the feds do?

STUART GUTERMAN: Well, in answer to the first question, I think the Commission report embeds in it an awareness of the importance of market forces. But the Commission, in the policies they are proposing, lean toward

more positive incentives that include, you know, rewarding patients for seeking care from high-performing health systems, rewarding them from seeking coverage from plans that are high performing, and introducing market accountability in a more positive way. What the Commission is less comfortable with is, you know, the pure skin in the game approach that penalizes folks for not being better shoppers and, as circumstance were there for frequently, they cannot be better shoppers, so that is one. In terms of the kinds of policies we could see having in the Medicare Essential plan that is briefly described in the report and that I mentioned, we would have a reward for Medicare beneficiaries who agree to designate a primary care provider and agree to get their services from a high-performing health system like an ACO or other similar models. They would reap the benefits of that by sharing the savings that are obtained for the program and for the system from getting better care at lower costs, so that is the kind of thing that Medicare policy could certainly encourage.

KAREN IGNAGNI: May I?

ED HOWARD: Yes. Sure.

KAREN IGNAGNI: As Stuart was talking I was thinking there might be a middle ground which is to take the concepts that you have talked about and think about in Medicare in particular the kinds of things that Bob talked about in the

private sector and that employers and health plans are working on together which is this whole concept of value-based benefits to reward individuals for getting their, participating in a care plan, having a care plan, following it, participating in disease management. I think that is why I wanted to use the example of tiering. That is the kind of thing that we are doing on the commercial side that I think could be a middle ground that could be brought to the Medicare, certainly Medicare Advantage where you have a plan to encourage people to choose high-performing networks and so on. So this concept of value-based benefits I think could begin to be looked at very productively from a patient-friendly, pro-patient point of view which is to support the kinds of high quality choices that all of us want to make.

ED HOWARD: Yes, Mike?

MIKE MILLER: Thanks, Ed. Mike Miller. I am a physician health policy and communication consultant. And Stuart you, in the report – which is great, by the way – you summarized how you guys set spending targets and that that is also the approach that Massachusetts has recently taken in their legislation in their lot to control their growth in health spending. But, you know, a lot of what we are hearing at the federal level is not spending targets, it is savings targets, kind of the flip. Given that, you know, the

projections on actual spending versus what the projections are tend to be a little bit different. I think we have seen the last few years that actual spending has been less than what was projected. Can you talk about sort of the pros and cons of those two different approaches or the ramifications of setting spending targets versus setting savings targets, particularly multi-year? Thank you.

STUART GUTERMAN: Sure. You are right that if you know, you know, how spending is going to grow with certainty then they are the same thing. But I think the emphasis needs to be on what we think a reasonable amount of resources are to devote to the health system and figuring out most importantly how best to allocate those resources, which is why I think the Commission focused on a spending target, spending growth target, rather than a savings target. The idea is not to emphasize taking resources out of the system. The idea is to emphasize putting the resources that are into the system in a way that is most effective for the patients and for everyone else involved in this system, so that is, it is a matter of emphasis.

ED HOWARD: We have two questions I want to try to hit here that touch on this same issue which is administrative costs which have come up. One questioner points out that our administrative costs in the U.S. have been found to be as much

as six times higher as the average from other countries. The question is, first, how can they be lowered outside of a Medicare-for-all system or a tightly regulated public/private system as in Germany, and second what are the current barriers to uniform claims forms and certification processes and other things that could significantly lower those administrative costs.

KAREN IGNAGNI: Okay. May I?

ED HOWARD: Please, Karen.

KAREN IGNAGNI: Just to start off, and I suspect everybody wants to comment here, I think this is a very good question. First, the aligning incentives point, we are making sure that we are having – and there is a significant amount of this going on now in the private and public sector to reach an agreement on where are the high value measures because you cannot achieve something you do not measure. So what are the priorities? How do we shrink variation? Where should we put our emphasis so that we can have everyone rowing the boat in the same direction. So it may seem small, but that can have a meaningful difference, number one. On credentialing, aligning credentialing, in the private sector we have created an organization, CAQH, to actually synchronize credentialing so physicians dealing with any one of our health plans would have the same credentialing process. We think there are

opportunities for the public sector to align with that. That is the second thing. We think that that could work out very quickly, very well, for physicians, yield higher satisfaction, and achieving the kind of quality performance we all want. Third, I think there needs to be – and David, you mentioned this I think in some of your opening comments – there needs to be a stepping back as we think about infrastructure to think about how does ICD-10, how does meaningful use, and how does administrative simplification go together strategically? What are we trying to achieve? Where do the incentives fight one another? What is the best way to actually improve performance? Where, again, should we put our emphasis both public and private? Those conversations are beginning in the public sector and in the private sector, but I think we need to really think about how do all of these things align so that we can make sure that we are achieving effectiveness and efficiency. Those are just a couple of things to start off the conversation. I am sure everyone wants to talk about this.

ED HOWARD: Bob?

BOB GALVIN: Yes, I think it is a great question. We on the employer side several years ago tried to make a run at this. It was very difficult to sustain. It is impressive. Obviously, if it were easy to do it would have been done, but it was kind of a classic commons problem that we could not

quite figure, get the group together that could make a difference even on the private sector side. So David, I do not know if you were going to hit this but I would love to see just because you have been so involved, you know, in IT in your former role, because we all were hoping that that would be kind of a way to get at it.

DAVID BLUMENTHAL: So I do think that better information and exchange of information will reduce costs. I think that the actual administrative costs that are associated mostly with claims processing, billing, and the management of the provider/payer interface will not be solved by electronic health records. There is a provision in the Affordable Care Act – and I have no idea what is happened to it – to encourage uniform billing and claims processing procedures, which would be an enormous advance if it were actual, if it were achieved. Maybe Karen, you can say something about what is happened to that.

KAREN IGNAGNI: I would be happy to talk about that. I think that one of the challenges now as we move to more of a prospective reimbursement system and away from a traditional retrospective fee-for-service piece rate system is then how do you achieve some of the objectives with respect to streamlining the administrative process. There is a significant amount of progress going on around the country with our health plans

working with physicians and hospitals not only to achieve the cost goals – we have talked a lot about that – but also to achieve quality goals and in the process look at bundling so that you are not measuring every aspect of a patient's care. If I am thinking about a bundle for either joint replacement or even today now there is been some path-breaking work going on in bundling cancer care with working hand in hand with physicians, oncologists and health plans and so on. That then streamlines the infrastructure in terms of how individual providers or hospitals are paid. As we are thinking about global kinds of initiatives, partial capitation, for example, that streamlines the under, the prophecies that undergird all of that. So I think as we move to more of a prospective system, we are going to see a great deal of progress moving away from that piece rate system. What I have seen in the market today gives me real hope, and I think it is very encouraging, about what is going on and how it is developing. As these models take hold then they challenge–and we are already seeing this in the medical home arena, we have seen that the Medicare has participated with our health plans on medical homes achieving, again, rowing the boat in the same direction, within a state. Making sure that the providers know that if they are dealing with the commercial as well as Medicare that there are similar standards and so on and so

forth. I think we will see a great deal of discussion about aligning forces and aligning incentives for change as we look more holistically at what can be done and how it can be done.

ED HOWARD: Yes, Susan?

SUSAN REINHARD: Thank you, Ed. Susan Reinhard. I direct the Public Policy Institute at AARP. I also want to indicate I am on the board of directors of the Leapfrog Group. Bob, your statements around price really intrigued me, and I am wondering if it is something that at least I should be doing more at AARP at this think tank because cost and price get so conflated in the discussions. You know, on the one hand we are working with the Institute of Medicine on the idea that patients – and you know this, patients think the higher the price tag the better the quality, so how do we, what is our role in trying to shift that view from consumers? I think sharing in the incentives would help a lot. I think that would go a long way. If I go to your website that I just learned about today, do you have an agenda around price that we should be looking at?

BOB GALVIN: No, good questions, and I am glad you are on the Leapfrog board. You know, I think that there is just a threshold question about prices in transparency, and let me address that first before I do the second, which is it is true that consumers think the more it costs, the better it is. They

think that in every market there is. They think that in health care. There is the risk that you sell price and you drive everything higher. I think that, first of all, that is why I do not think you should sell price without quality, and they always should be combined because I think you send the wrong signal otherwise. Second of all I think you just have to make a threshold decision about whether transparency is good and is going to work better for the system in the long run or it is not. Way back when we started Leapfrog Group, we had the same issue because the measures were imperfect. They were challenged, and it was a difficult decision because you did not want to put out imperfect measures. On the other hand, you just had to believe at the end of the day that sunlight is the best disinfectant and that you would commit yourself and continue to work on making it better, do no harm, but you had to commit yourself to the transparency. I think the same is true with prices. Now I do not want to get overexcited. Most of the costs in the system are it is either the 5-percent to 50 or 65-percent that David mentioned, it is a 20-percent, 80-percent, not everything is discretionary. I think the more we learn about price like that slide I showed, the more you will see how much difference there is in price that people do not know about. I think things do kind of tend to come down to the mean. That all being said, no, CPR does not have kind of an

agenda yet on price. Our agenda is trying to get the data out to be able to do something with the price, and it is so difficult simply getting the data. Many providers do not even know their prices. The plans tend to want to hold on for competitive reasons to the prices they get. Medicare is kind of conflicted about sharing its data, so we are so early on in this that we are just really having problems now even getting the data.

SUSAN REINHARD: Maybe we can work with you. Thank you.

ED HOWARD: Karen?

KAREN IGNAGNI: Just a quick postscript to come behind Bob. One thing that might be very helpful is it matters to a private purchaser, an employer, a health plan, what the charge is as a percent of Medicare. For example, if you look in Northern California, highly consolidated market, versus Southern California, you see that very, very high proportion, hospital payments, in terms, you can see the cost shifting ratio. You can see your 300-percent of Medicare. It matters to individuals. It matters to large employers or small employers whether it is 300-percent, whether it is 150-percent, whether it is 200-percent. Maybe we ought to have a cost-shifting disclosure provision that would be something that would be material, that it would put pressure on a public

discussion about that, which is what happened after Massachusetts. After the attorney general wrote her report about what they were seeing in terms of a consolidation and whether the facilities that were charging the highest prices had the highest quality, and generally they determined that is not necessarily the case for all diagnoses, so just a thought about cost-shifting measures. It means something about what is happening from the perspective of a government compression in reimbursement, what happens on the private sector side, and how do you track it? That might be another way to track it.

SUSAN REINHARD: Thank you.

STUART GUTERMAN: Let me make one more point on that because, Susan, what you mentioned leads into a discussion of what we do we do about price versus what do we do about utilization and there I have heard debates about which one is the real culprit, and the answer is they both are. Not only are they both the real culprits, among the real culprits, but distortions in price lead to distortions in utilization and vice versa. They both are the results of market signals that are distorted. When we address these issues–this is kind of a microcosm of the approach that the Commission is taking–is when you, to address this issue, you have to address the prices and the utilization, the incentives to drive them and the ability of the markets to send the right signals to the participants in

that market to make sure that resources are allocated appropriately to get what we want from our system.

SUSAN REINHARD: Thank you.

ED HOWARD: May I throw in a question that is relevant as a follow up to this discussion that I have in front of me from a card. In respect to cost shifting, some health economists have suggested that lower Medicare prices are the result of superior bargaining leverage in Medicare. They point out that customers in small and individual plans pay more than members in large plans. Would you argue that large plans cost shift to small plans? How should Medicare decide prices with so much variability in the private sector? So what do you think, Karen? Debate. Do some of your members shift cost to other members?

KAREN IGNAGNI: Well, the first thing is large, starting with the large employers and working to the various markets, large employers are charged based on their specific prices. In the individual and small group market, particularly in the individual market, the reason you generally have higher premiums in the individual market, you have health care costs then as a baseline, if you think about it in a building block approach. Then you have individuals who have purchased coverage tend to be the sicker, the young and the healthy, heretofore have not purchased coverage. This is what we hope

with health reform that the young and the healthy will purchase coverage which is why we are so focused on affordability to make sure that the pools can actually work the way they are desired to work. There are other factors that are not occurring in the large group space because you have a natural pooling in the individual and the small group. In the Medicare area, generally what we have seen is that there has been a compression in government contributions both in the Medicare and the Medicaid arena. That has definitely bled over to the private purchaser side, and we can track that, how much cost shifting occurs. You can track it very specifically based on the market position of various facilities. To the extent they have a market position where it is highly consolidated and they have purchased the smaller and the cheaper community facilities then you see the cost being significantly ratcheted up. Let me give you two examples. One, where large systems are purchasing community hospitals that generally had lower pricing, and in some cases higher quality for certain procedures, generally the health plan will get the call saying you are now going from 100, 100-percent of Medicare to something much higher than that just by virtue of dealing with the large system. It is also occurring as systems are consolidating and purchasing physician practices where we used to do a cardiac cath on an outpatient basis, moving that cardiac cath into the system orbit. Then it

is now a 30-percent surtax or a 40-percent surtax. I think that now that purchasers in particular, and others, individuals and the policy community, is becoming aware of that, I think that will lead to some productive discussion. How much cost shifting you have in a market is determined by the presence of large systems and their ability to actually achieve higher payments. That is why I think one of the things that could be very, very useful here is to track that cost shifting and begin to think about some transparency around cost-shifting ratios. It would at least give consumers and individuals more information than we have today to look comparatively at what is going on, which is just another way to do that in addition to looking at prices themselves.

ED HOWARD: And then Bob is in line –

STUART GUTERMAN: Okay, sorry.

ED HOWARD: – and then Stu.

BOB GALVIN: I always like the cost-shifting argument. A well-known DC economist once took me aside and said, "Bob, we realize that cost shifting occurs. We just do not have a model to explain it so I have to deny it in public." I always like that one because I do not know what to make about that. I think Karen answered that argument. I think it is actually a species argument. I think what differs between large and small employers is essentially if you are self-insured, it is the

administrative services fee, which is about 10 or 15-percent of the cost, that can vary by 15 to 20-percent. Do the math. It does not end up to the kind of issues that you see, so some are premium. It is a scale. It is how insurers have to make their costs. I think the idea that there is differences between large and small employers is being an argument that cost shifting does not exist. I think there are better arguments than that one.

ED HOWARD: Stu?

STUART GUTERMAN: One of the points that frequently gets missed in the whole cost shifting debate – and it is an observation into the theory – but I think there are theories that can explain it. But one of the things that is missed in all the discussions that I hear about cost shifting is that, you know, there is an underlying presumption that cost growth is immutable and that it is, you know, somehow handed down, you know, on the great beyond. That is what it has to be. I do not buy that presumption. I think, you know, that cost shifting is usually something that would be better described as I want to increase my costs faster than some of my payers, you know, feel it is reasonable. If I can find somebody else to bear the burden of those increased costs, I will pass that on. We need to focus more attention on the underlying costs that are being shifted because that is really where the issue is.

KAREN IGNAGNI: And can I just add one other thing? I think until fairly recently much of the discussion in the policy community has really been on premiums. Certainly, within the two years ago as we were going through health reform, that was the focus as opposed to the underlying costs. I think now we are really getting in under the hood, and I think that is important. I think one of the most exciting things about the Commonwealth Fund report–and there are many things to commend it–but one in particular that struck me just this point that you made, I think, Stuart, very effectively which is given the amount that we are going to spend in health care over the next 10 years, the idea that we cannot take 2 trillion out, it may seem like a great deal today. If you look over 10 at what we are projected to spend then, you know, that, just in four tranches, Medicare, Medicaid, tax expenditures and subsidies, we are going to spend 17 trillion over 10, and when you add the commercial sector and it is very significant. I think you guys have done something very important just to talk about what the possibility is while maintaining innovation and the system that we all want.

DAVID BLUMENTHAL: So since we are talking about whether cost growth is inevitable and getting under the hood, there was a question quoting the retiring chief actuary at CMS, Richard Foster, in Kaiser Health's News to the effect that

health providers, i.e. doctors, nurses, home health care workers, and so on, all provide hands-on services. It is generally not that easy for such professions to improve their productivity. This gets at the general question of whether the productivity, i.e. the value, of services can be materially and qualitatively improved. In the premise of the confronting cost report is that that is possible. Comments from the panelists?

BOB GALVIN: Well, I think the first questioner who asked how the integrated systems did I think got the answer that showed it. It is not as easy as it is in manufacturing. You cannot digitize the processes. You cannot globalize them. It certainly can be done at anywhere from 10 to 20 percent more efficient as I think Kaiser and other systems have shown. I think it is not necessarily making any individual more productive. I think it is kind of removing the redundancy in the system. This same form that we fill out every time we go to another specialist, except now it is online instead of on paper, and on and on and on. I think if you kind of allow the workers in the system not to spend 20-percent of their time on redundancy, you improve productivity. I think that is why systems are important.

KAREN IGNAGNI: Actually you did a yeoman's job in trying to start this conversation in the context of meaningful use. That is one way to think about it, quality outcomes. I

think that there is been a great deal of exciting discussion both across the agency at HHS as well as in the commercial arena. Now the trick is to look at things like meaningful use, look at quality outcomes, and think about stepping back and saying, well how do we actually align the high value opportunities to improve productivity? Just reducing variation and rewarding physicians that are practicing best practice, going to these new models that reward quality as well as cost reduction, I think that all of this plays a role. Unfortunately, I guess the takeaway is there is not one strategy. It needs to be a holistic strategy. I think you guys did a very good job of explaining that there are many different aspects to all of this.

STUART GUTERMAN: If you look at it one way, our health system has been incredibly productive-

KAREN IGNAGNI: Yes.

STUART GUTERMAN: —because we give it every incentive to increase volume and increase intensity. That is what we have gotten in spades. We reward folks for increasing the revenues by not tying the revenues to what we really want to see the system produce. When we are talking about the capacity of the system to improve productivity, we have to ask yourselves which system. We have to have a system that really

rewards increased productivity in terms of what we want from our health system.

ED HOWARD: Okay, we have a couple of people who have been very patient at the microphones. You are a second-timer up there, but I know you are going to be brief this time.

BOB ROBIEMJA: Thank you very much. Bob Robiemja. You know, everyone is in favor of integrated care, but sort of the flip side of that, or the part that has come around, has been the consolidation of providers. Robert mentioned the too-big-to-fail mode, which has evolved, and some sort of monopolistic practices in certain markets that have resulted in price increases. Is there a role for state governments or federal government to try and limit the consolidation to try and foster more competition between systems rather than having a couple of huge players evolve in each market? If so, how do you do that? Is there a legislative role for that?

BOB GALVIN: Well, we are going to figure all this out at the CPR meeting in April in DC. I think it is a combination. I really do. I think because you do not want to stop the systems from coming together. I think when you see the very good things that can happen in organized systems of care, you want to promote them. But you also appreciate that those are very few organized systems of care that have been around for decades that it took them to get there. How do you

create the right regulatory system, the right market system, the right amount of information to do it? That last slide I showed tried to demonstrate that it is a combination of all of them. I do not think anti-trust alone is enough. I think there has to be measurement whether this cost-shifting is occurring or not. I think you have to allow measurement at all levels of the system so you can have the kind of performance networks that Karen mentioned. I think you need eventually some kind of oversight. I think they are starting to do some of that in Massachusetts. Part of that panel, or I do not remember, that Stuart Altman (misspelled? 01:29:38) is chairing will be looking at issues like that. So I think it is a, I think it is a multi-sectorial solution. I do not know legislation off-hand that would do it. I think better funded anti-trust is important, but I do not think, you know, that is a leg of the stool. I think we have to figure this out together. I think the sectors have to work together to figure it out. And I think the right externalities have to be there – remember that chart – to kind of drive these systems down to become the really high-performing systems they can be and discourage them from going down the other path.

KAREN IGNAGNI: I think that Bob gave a great answer to that. I would just add that I think the deficit and the policy discussion has been that we have prioritized as a matter of

policy getting to this integrated state and forgotten about all of the other things that need to go along with it. What happens in local markets, I think the FTC has been doing a very good job of looking at that and playing a leadership role. I think that is very important at the federal level. I think at the state level these are the kinds of things we have seen attorneys general Martha Coakley in Massachusetts, the attorney general in California most recently, I think there will be other attorneys general that play a leadership role here. So very specifically at the state level just to take a census of what is happening, what is the competitive situation, what needs to be done, what problems are occurring. I think there has not been nearly enough focus on what happens when physician practices are acquired. Does that add an extra overhead 30-percent for a particular procedure, for example, 40-percent, what have you. Even if it is 20 that is too much because it adds to the cost of care. I think we have not really, in the policy community, looked at all of these different variables in thinking about how do we create this high-performing system which is why I think strategically as each of you in your world, your respective worlds, approach this challenge of cost containment thinking about what are the barriers to actually achieving the results we want. I think this needs to be right up there as a potential discussion.

ED HOWARD: Yes, Joe?

JOE ONNICK: Joe Onnick (misspelled? 01:32:06), The Raven Group. To what extent do global payments, particularly capitated payments, depend on risk adjustment technology? And how far advanced is the technology at the moment?

DAVID BLUMENTHAL: I was going to get to that question, Joe.

ED HOWARD: I should say that 20 years ago we did a briefing in which Joe Newhouse (misspelled? 01:32:34) said we would have a perfect risk adjustment mechanism in the next 18 months.

JOE ONNICK: I know that. That is why I asked the question.

KAREN IGNAGNI: Yes, I think that there, without a doubt, as you know, there needs to be risk adjustment as part of in the plans and the providers that are doing this now are looking at what population is being served to make sure that the providers are not only going to have the right incentives but not be penalized for serving the sickest individuals with the most extreme conditions. The flip side of this also is in the quality space and the quality measurement, right, in terms of for us and the commercial arena as we think about stars, as we think about the duly eligible, how do we think about plans serving that very challenging patient population. The risk

adjustment technology is never going to be at that 100-percent level. However, there have been significant strides made where plans and providers now are working together to make sure that they are in a gain-sharing kind of relationship across the table that there are appropriate protections. Without a doubt there need to be appropriate protections to make sure you are not penalizing providers that are doing what they should be doing which is trying to get the most intense patients from the standpoint of the numbers of services that they need into a care system that works more prospectively rather than retrospectively.

ED HOWARD: David, go ahead. I should say, can I just say, we are coming down to the last few minutes of the time we have allotted. We do not want to disrespect your time so I would ask you as you are listening to the question and the answer to fill out the blue evaluation forms before you go. Thank you.

DAVID BLUMENTHAL: So this is a two-prong question, very different two questions. Can a case be made that increased health care spending is not so bad because of the jobs it supports? What are examples of overhead cost in Medicare that could and should be reduced?

KAREN IGNAGNI: Kate Baker wrote a very compelling piece, I think it was the New England Journal, not too, within

the last several months raising this issue on the first point with respect to the job growth. If you look at the new job growth, quite a significant amount of new job growth is in the health care space. We are talking today about reducing health care costs. And I think it gets back to how do we think about where are the – what needs to be done with respect to creating and redesigning a work force necessary to support care management, disease management, moving people who do not need to be in institutions, whether it be a nursing home or a hospital, into the community. Surely, there is more work that needs to be done, opportunities for developing career paths, et cetera, in that regard. We need to have those conversations. To the extent that we are bringing more people in to support the existing traditional fee for service system that encourages people to do more because that is the way they get paid, that is not a good thing. We need to have some discussion about what is in bucket one versus bucket number two. Without taking too much time, I think those are the kinds of discussions that really need to be held at the state level because you want to look at building and construction, you want to look at what is going on. There is been explosions of building and construction. How do we maintain, how do you possibly deal with the overhead demands that that creates in the future as we think about reducing health care costs? How do we really think

about opportunities to develop and encourage the right set of workers working hand in hand with physicians and hospital administrators, medical directors, et cetera, to carry out the challenges of these new care systems? How do we think about variation which Stuart talked about very effectively? All of these things I think are better talked about at the local level, the state level in particular, if not the local level below that, particularly for large states, as opposed to necessarily dealing with them in Washington where we are far away from how all these issues play out. So that is why I think it is going to be important to think about what are the levers that could be worked at the state level versus the national level and then how do we align what is going on in the private sector to achieve the results that all of us want. I think that is the way to begin thinking about this question of work force so we get the, it is the – everybody wants the right care, right time or the right setting. How do we get the right work force there? How do you have more efficiency, as David posed the question, at the same time you do not have this system that is not sustainable. Every five years we have been all participating in programs where we talk about the sustainability of a system and it manages to sustain itself. With the focus on our economic challenges nationally, health care is such an important part of that I think we have really

hit the point where we have to take that fork in the road, but it is not an easy series of choices at all. We ought to think about where is the best place to have these discussions and where can and should we make these kinds of choices?

STUART GUTERMAN: When you are thinking about job growth throughout the economy, just picture a health care sector that only grows 75-percent over the next 10 years that takes, that frees up $2 trillion of economic resources, 500 billion of those in the pockets of households people, workers and their families, that they could use to spend on other priorities for their own lives. That has the potential to create a tremendous number of jobs elsewhere in the economy, taking the pressure off employers by slowing the growth of health spending, frees them up to engage in more innovation and create other jobs that are not necessarily in the health care sector without losing much in terms of the number of, the amount of revenue and the potential employment in the health care sector. I think we need to look beyond the health care sector and really think about how we could better use those resources to support not only public endeavors like education and public safety and roads but also money that could be pumped into the private sector as households have more disposable income to be able to use for other things that they want to purchase.

ED HOWARD: Comments? Well, David, if you have another question or comment, we are almost at the end of our time but we can squeeze one –

DAVID BLUMENTHAL: I think we have got way too much.

ED HOWARD: – okay. Well, I think we have not at all exhausted this topic. We may have exhausted our panelists and some of you but we will return to it. This has been, at least for a poor country lawyer, a very enlightening discussion of some of the economic issues. We have not really done too much of the politics. I suppose there might be a smidgen of that in some of the decisions that get made over the next months. Let me take this occasion to thank you for a plethora of wonderful questions and for hanging in there in a very difficult topic. Thanks to our friends at the Commonwealth Fund for not only providing us with co-sponsorship but great direction in the shaping of this program. Ask you to join me in thanking our panel for a terrific discussion on a very difficult topic.

[Applause]

[END RECORDING]

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